Welcome Kids

We would like to welcome your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime!

1 Tell Us About Your Child

Today's Date: ____________

Child's Name: ____________ (Last / First / MI)

Child's Birthdate: ___/___/___ Child's Age: ____________

Nickname: ____________ ☐ Male ☐ Female

School: ____________ Grade: ____________

Hobbies: ____________

Child's Home #: (____)____________ SS #: ____________

Child's Home Address: ____________ Apt / Condo #

____________ (City / State / Zip)

2 General Information

Who is accompanying the child today?

Name: ____________ Relation: ____________

Do you have legal custody of this child? ☐ Yes ☐ No

Whom may we Thank for referring you? ____________

Other siblings: ____________

Previous / Present Dentist: ____________ Last Visit Date ____________

Dentist's Phone #: (____) ____________

Relative or Friend not living with you:

Name: ____________ Phone: (____) ____________

Address: ____________ (City / State / Zip)

3 Parent's Information

Who is responsible for account? ____________ Parent's Marital Status ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced ☐ Separated

☐ Father ☐ Step Father ☐ Guardian

Name: ____________ Birthdate: ___/___/___

Address: (If different than Child's) Hm #: (____) ____________

____

____

SS #: ____________ DL #: ____________

Wk #: (____)____________ Ext: ____ Cell/Other #: (____)____________

Email: ____________

Employer: ____________

Employer's Address: ____________

____________ (City / State / Zip)

If you have Dental Insurance Coverage for the Child, please fill out below:

Insurance Co. Name: ____________

Insurance Address: ____________

____________ (City / State / Zip)

Insurance Phone: (____)____________

Group # (Plan, Local, or Policy #): ____________

☐ Mother ☐ Step Mother ☐ Guardian

Name: ____________ Birthdate: ___/___/___

Address: (If different than Child's) Hm #: (____) ____________

____

____

SS #: ____________ DL #: ____________

Wk #: (____)____________ Ext: ____ Cell/Other #: (____)____________

Email: ____________

Employer: ____________

Employer's Address: ____________

____________ (City / State / Zip)

If you have Dental Insurance Coverage for the Child, please fill out below:

Insurance Co. Name: ____________

Insurance Address: ____________

____________ (City / State / Zip)

Insurance Phone: (____) ____________

Group # (Plan, Local, or Policy #): ____________

4 Release

I certify that my child is covered by ____________ Insurance Co. and I assign all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

____________ Signature of Parent or Guardian ____________ Date

Continued on Back

5 Dental History

Why did you bring the child to the dentist today? ____________________

____

____

Has the child ever taken any diet pills such as Phen-Fen? (Also known as Redux or Pondimin.) If so, when? __________ ☐ Yes ☐ No

Is the child currently in pain? ☐ Yes ☐ No

Does the child require antibiotics before dental treatment? ☐ Yes ☐ No

Has the child ever had a serious/difficult problem associated with previous dental work? ☐ Yes ☐ No

Is the child's water fluoridated? ☐ Yes ☐ No

Is the child taking fluoridated supplements? ☐ Yes ☐ No

Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Does the child brush his/her teeth daily? ☐ Yes ☐ No

Floss his/her teeth daily? ☐ Yes ☐ No

Child's Physician: ____________________

Phone #: __________ Date of Last Visit: __________

Is the child currently under the care of a physician? ☐ Yes ☐ No

Please describe the child's current physical health:

☐ Good ☐ Fair ☐ Poor

Please list all prescription / over the counter or herbal supplement drugs that the child is currently taking:

____

____

Aside from the items below, please list all drugs/things that the child is allergic to:

____

____

Yes No **Latex** Yes No **Metals/Nickel** Yes No **Plastic**

6 Medical History

Has the child experienced the following medical problems?

Y	N	Abnormal Bleeding / Hemophilia	Y	N	Heart Murmur
Y	N	ADD/ADHD	Y	N	Hepatitis
Y	N	AIDS/HIV+	Y	N	High Blood Pressure
Y	N	Anemia	Y	N	Hives
Y	N	Any Hospital Stays/Operations?	Y	N	Kidney Problems
Y	N	Artificial Bones/Joints/Valves	Y	N	Liver Problems
Y	N	Asthma	Y	N	Low Blood Pressure
Y	N	Cancer	Y	N	Lupus
Y	N	Chicken Pox	Y	N	Measles
Y	N	Congenital Heart Defect	Y	N	Mitral Valve Prolapse
Y	N	Convulsions	Y	N	Mononucleosis
Y	N	Diabetes	Y	N	Prosthetics
Y	N	Epilepsy	Y	N	Rheumatic Fever
Y	N	Exposed to HIV, but Neg.	Y	N	Scarlet Fever
Y	N	Handicaps/Disabilities	Y	N	Skin Rash
Y	N	Hearing Impairment	Y	N	Tuberculosis (TB)

Are the child's immunizations current? ☐ Yes ☐ No

Anything you would like to discuss with the Doctor in private? ☐ Yes ☐ No

Please discuss any serious medical problems the child experiences/ed:

____

____

Does/did the child experience any of the following?

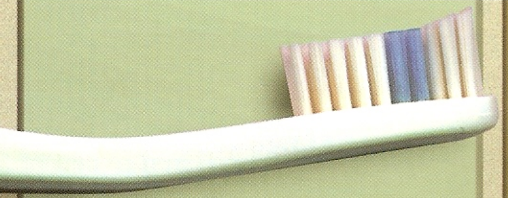
Y	N	Breast Fed	Y	N	Nursing Bottle Habits
Y	N	Chewing on Objects	Y	N	Speech Problems
Y	N	Clenching/Grinding Teeth	Y	N	Thumb/Finger Sucking
Y	N	Lip Sucking/Biting	Y	N	Tongue/Cheek Biting
Y	N	Mouth Breather	Y	N	Tongue Thrust
Y	N	Nail Biting	Y	N	Used Pacifier

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

____

Signature of Parent or Guardian Date



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I have verbally reviewed the medical/dental information above with the parent/guardian & patient named herein. ____________________

Signature of Dentist Date

Dentist's Comments: ____________________

____

Medical History Update

Has there been any change in your child's health status since their last visit? ☐ Y ☐ N

If Yes, please explain. ____________________

____

Has there been any change in your child's health status since their last visit? ☐ Y ☐ N

If Yes, please explain. ____________________

____

Parent/Guardian Signature Date

Dentist Signature Date

Parent/Guardian Signature Date

Dentist Signature Date

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AUTHORIZATION FOR SIGNATURE ON FILE

RELEASE OF INFORMATION/FINANCIAL RESPONSIBILTY/ AUTHORIZATION FOR PAYMENT

I, ______________________________, and/or ______________________________

NAME OF PATIENT OR GUARDIAN IF MINOR NAME OF INSURED

hereby authorize the office of Dr Sheri B. Glazer DDS, to affix my name to any and all claims or documents as related to any and all health benefits due me any my dependents through my employment with ______________________________. I hereby authorize payment of dental benefits otherwise payable to me, directly to the office listed above. I have reviewed the treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating claim.

This "Authorization" will be valid from this date and shall expire in one year.
A photocopy of this document may act as an original.

______________________________ ______________________________

SIGNATURE OF INSURED WITNESSED BY

____

SIGNATURE OF PATIENT (PARENT/GUARDIAN IF MINOR)

Today's Date: ____________________

Expiration Date: ____________________

SHERI B. GLAZER, D.D.S.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I, ______________________________________ have received a copy of this office's Notice of Privacy Practices

____
PLEASE PRINT NAME

____
SIGNATURE

____
DATE

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of out Notice of Privacy Practices but the acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

____

____

____

SHERI B. GLAZER, D.D.S.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: ____

Address: ____

Telephone: __________________ E-mail: ________________________

Patient #: ___________________ Social Security #: ____-____-_____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENT CAREFULLY.

Purpose of Consent: By signing this form you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations

Notice of Privacy Practice: You have the right to read our Notice of Privacy Practice before you decide whether to sign this Consent. Our Notice provides a description of out treatment payment activities and healthcare operations of the use and disclosures we may make of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy. If we change our privacy practices we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of out Notice of Privacy Practices, including any revisions of our Notice at anytime by contacting

Contact Person: Sheri B. Glazer DDS
260 Middle Country Rd. Suite 202
Smithtown, N.Y. 11787
(631)-361-3666

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE:

I, ______________________, have had full opportunity to read and consider the contents of this Consent form and your notice of Privacy Practices. I understand that by signing this Consent form I am giving consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature: ______________________________________ Date: ______________________

If this consent is signed by a personal representative on behalf o the patient complete the following:

Personal Representative Name: ______________________________________

Relationship to Patient: ____

* YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT*

Dr. Sheri Glazer DDS
260 Middle Country Road
Smithtown, New York 11787
(631) 361-3666

Dear Patient:

In an effort to provide you with flexible payment arrangements, we have expanded our payment policy.

PAYMENT ARRANGEMENTS ARE REQUESTED AT THE TIME OF YOUR VISIT.

We now offer the following payment options:

____ Payment by cash
____ Payment by check
____ Payment by credit card
____ Automatic monthly billing to your Visa or MasterCard
____ Guarantee any amount not covered by insurance with Visa or MasterCard
____ Care Credit (No Interest Plan 3, 6, 12, months)
(Extended Payment Plans 11.9% -24, 36, 48, 60 months)

Please indicate which form of payment you choose to settle your account.

____

Signature of Patient/Responsible Party Date