133 East 58th Street
Suite 402
New York, NY 10022
(646)590-4234
espdnyc@hipaamail.net

East Side Pediatric Dental

http://www.espdnyc.com/

Chart #. _____
FOR OFFICE USE ONLY

Patient Name:* _____ * _____ _____ _____
Last First MI Preferred Name

Title: _____ Gender:* ◯ Male ◯ Female Family Status:* ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date:* _____ Prev. Visit: _____ Email Address: _____

Phone:* _____ _____ _____ _____ Best time to call: _____
Home Work Ext Mobile

Address:* _____ _____

* _____ * _____ * _____
City State Zip Code

What is the purpose of this visit?

_____

Parent/Guardian's name, relationship; Date of Birth, and Contact #:

_____

Parent/Guardian's name, relationship; Date of Birth, and Contact #:

_____

I prefer to be contact by

☐ Cell Phone ☐ Email ☐ Text ☐ Home Phone

Pediatrician's name and contact#:

_____

Language:

* _____

133 East 58th Street
Suite 402
New York, NY 10022
(646)590-4234
espdnyc@hipaamail.net

Whom may we thank for referring you to our practice?

In an emergency, who should be notified? Please enter name, phone number and relationship below

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If there's any changes in the information provided, I will inform the doctors and the staff at the next appointment without fail.
Name of parent/s and or Guardian/s: Date:

*

133 East 58th Street
Suite 402
New York, NY 10022
(646)590-4234
espdnyc@hipaamail.net

☐ *Pre-Med - Amox	☐ *Pre-Med - Clind	☐ *Pre-Med - Other	☐ ADD/ADHD
☐ Allergy - Aspirin	☐ Allergy - Codeine	☐ Allergy - Erythro	☐ Allergy - Hay Fever
☐ Allergy - Latex	☐ Allergy - Other	☐ Allergy - Penicillin	☐ Allergy - Sulfa
☐ Anemia	☐ Arthritis	☐ Artificial Joints	☐ Asthma
☐ Autism/Asperger's	☐ Blood Disease	☐ Cancer	☐ Cleft Lip/Palette
☐ Development Delayed	☐ Diabetes	☐ Dizziness/Fainting	☐ Epilepsy/Seizures
☐ Excessive Bleeding	☐ Glaucoma	☐ Head/Neck/Jaw Injury	☐ Heart Disease
☐ Heart Murmur	☐ Hepatitis	☐ High Blood Pressure	☐ HIV/AIDS
☐ Jaundice	☐ Kidney Disease	☐ Liver Disease	☐ Mental Disorders
☐ Nervous Disorders	☐ Other	☐ Pacemaker	☐ Pregnancy
☐ Radiation/Chemo	☐ Respiratory Problems	☐ Rheumatic Fever	☐ Rheumatism
☐ Sinus Problems	☐ Speech Delay	☐ STD/HPV	☐ Stomach Problems
☐ Stroke	☐ Tuberculosis	☐ Tumors/Growths	☐ Ulcers

List any and all medications taken at this time?

Have you been admitted to a hospital or needed emergency care during the past two years?

* ☐ To the best of my knowledge, all of the preceding answers and information provided are true and correct. If there's any changes in the information provided, I will inform the doctors and the staff at the next appointment without fail.

Name of parent/s and or Guardian/s: Date:

*

133 East 58th Street
Suite 402
New York, NY 10022
(646)590-4234
espdnyc@hipaamail.net

* ☐ CONSENT:

This informed consent and authorization is given to PROVIDERS OF EAST SIDE PEDIATRIC DENTAL after having first received a full explanation of the proposed treatment, alternative treatment and treatment risks. Based upon my symptons and the full wxplanation I have received, I have been advised that I have the following condition:

TREATMENT:

I here by authorized and consent to the following procedure(s):

Exam, Emergency Visit, Cleaning (prophy), Fluoride (topical or varnish), X-ray(s), Patient's photo, Restorations (fillings), Pulpotomy (baby root canal), Pulpectomy (root canal on baby tooth), Crowns (white color or stainless steel), Space maintainer(s), Extraction(s).

Alternative Treatment:

I have been advised that alternate treatment exists, which may include but is not limited to:

No treatment (not advised), treatment at another office (referrals to another specialist or seed a 2nd opinion), treatment under general anesthesia at the hospital.

I have, however, elected to treatment my condition by the proposed treatment under rather than any alternative treatment.

Treatment Risks:

I understand that in herent to any procedure, and because of an indiviual's variations, certain risks are involved with this treatment. They may include, but are not limited to:

Paresthesia, possible infection, sensitivity

ADDITIONAL COMMENTS:

Additional fees apply for utilization of Nitrous Oxide Gas, Office Sedation with an Anesthesiologist (paid directly to the Anesthesiologist)

By Signing below, I acknowledge that I have read this document, understand the information presented, and have had all my questions answered satisfactorily.

Name of parent/s and or Guardian/s: Date:

*

133 East 58th Street
Suite 402
New York, NY 10022
(646)590-4234
espdnyc@hipaamail.net

Primary Dental Insurance

Name of Insured: _____ (Last) _____ (First) _____ (MI)

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____ _____

_____ _____ _____ _____

City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____

_____ _____ _____ _____

City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____

_____ _____ _____ _____

City State Zip Code

Insurance Authorization

* ☐ By checking this box,
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Name of parent/s and or Guardian/s: Date:

* _____

133 East 58th Street
Suite 402
New York, NY 10022
(646)590-4234
espdnyc@hipaamail.net

Secondary Dental Insurance

Name of Insured: _____ (Last) _____ (First) _____ (MI)

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____ _____

_____ _____ _____ _____

City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____

_____ _____ _____ _____

City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____

_____ _____ _____ _____

City State Zip Code

☐ By checking this box,

I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Name of parent/s and or Guardian/s: Date:

_____

133 East 58th Street
Suite 402
New York, NY 10022
(646)590-4234
espdnyc@hipaamail.net

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

* ☐ By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the AdministrationForm.

Name of parent/s and or Guardian/s:

*

133 East 58th Street
Suite 402
New York, NY 10022
(646)590-4234
espdnyc@hipaamail.net

HIPAA Acknowledgment

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

* ☐ By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.

Name of parent/s and or Guardian/s: Date:

*

Consent for Email and Postal mail Communications

I hereby consent to have my child and East Side Pediatric Dental communicate with me or members of East Side Pediatric Dental Team, where appropriate or other dentists, physicians, nurse practitioners, dental and medical assistants, office managers and pharmacists via e-mail or postal mail regarding the following aspects of my child's dental care and treatment: (x-rays, preliminary findings, treatments, medical history, prescriptions, appointmnents, bilings, et..). I understand that e-mail and postal mail is not a confidential method of communication. I further understand that there is a risk that e-mail and postal mail communications between my dentist, physicians, nurse practitioners, dental and medical asistants, office managers and pharmacists regarding my child's dental care and treatment may be intercepted by third parties or transmitted to unintended parties. I also understand that any e-mail and postal mail communications between my child's dentist and me or members of his/her office staff., or between my child's dentist/s and other dentists, physicians, nurse practitioners, nurse practitioners, dental and medical assistants, or phyarmacists regarding my child's dental care and treatment will be printed out and made a part of my dental record. I understand that in an urgent or emergent situation I should call my child's provider or go to the Emergency Room and not rely on e-mail or postal mail.

Name of parent/s and or Guardian/s:

*

Response Date: