Sinh Ta, D.D.S.
Ela Jamiolkowski, D.M.D.
Leslie Yuan Gazdeck, D.D.S.

1. Patient Information:

Patient Name: ______________________________ **Nickname:** ____________________

Child's Age: _______ **Birth date** __________________ **SSN#** ____________________

Home Address: ____

2. Person Responsible for Account:

Name: ______________________________ **DOB:** ____________

Relationship to Child: ____

Address: ____

Home phone #__________ **Cell phone #** __________ **Email Address:** _________________

Name of child's parents ____

How did you hear about us ____

3. Primary Dental Insurance:

Insurance Company Name: _______________________________________

Insurance Company Address: _____________________________________

Group # __________________ **Policy Owner's Employer** ______________________

Policy Owner's Name: _________________________ **Policy Owner's DOB** _________________

Relationship to Patient: ________________________ **Social Security #** _____________________

4. Dental History:

What is the reason for today's visit? ____

When was your child's last visit to a dentist? ____

Have past dental experiences been satisfactory? ____

Has your child had any of the following? (Please check all that apply to your child)

Bleeding Gum	Broken Filling	Chronic Bad Breath	Decayed teeth	Grinding
Injury to teeth	Lip Sucking/ Nail Biting	Nursing/Bottle habit	Loose teeth	Painful or Locking jaw

Sensitivity to sweet, hot ,cold & biting	Sores or swelling in mouth	Thumb & finger sucking

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5. Medical History:

Does your child have or have a history of the following? (Please circle all that apply to your child)

- ADHD
- Autism/ Spectrum Disorder
- Anemia, hemophilia, other blood disorders
- Asthma, Cystic Fibrosis/Respiratory disease
- Autoimmune disease
- Abnormal bleeding, prolonged healing, bruising easily
- Cancer
- Developmental Delays
- Diabetes
- Epilepsy/seizures
- Glaucoma/eye disorders
- Heart murmur
- Heart disease (describe)
- Hepatitis/liver diseases/jaundice
- HIV/ Sexually Transmitted Disease
- Kidney disease
- Sickle Cell Disease/Trait
- Skin, muscle, joint disease
- Speech/Hearing Impairment
- Thyroid disease
- Tuberculosis
- Ulcer/digestive disorders

Please list ANY medical conditions not listed that the child has had:

____

Is your child currently under the care of a physician? Yes_____ No_____

Physician____

Tel #___________________________

Date of last physical exam:____________________

Please list all medications your child is currently taking as well as over-the-counter medications, herbal remedies, vitamins, homeopathic remedies:____

Allergies/reactions to medications, or other allergies?

____

Please describe any impending or past operations, recent injuries or other information the dentist should be aware of:

____

Which of the following categories best describes your child's learning abilities?
___Delayed___ Normal___ Advanced
How do you think your child will cooperate for this appointment?

___Well-behaved ____Unsure ____ Uncooperative

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

Patient signature____________________________________Date___________

Dentist's initials___________

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Ela Jamiolkowski, D.M.D.

TO OUR PATIENTS AND FAMILIES

Thank you for choosing Tribeca North Dental for your child's dental care. We consider families to be an essential participant in your child's care and wish to support and respect your needs while your child is under our care. We want you to understand your rights and responsibilities as families and patients at Tribeca North Dental.

Parents in the Back

You may choose whether or not you accompany your child to the treatment room for his/her appointment. Although we are sensitive
to the fact that you may have more than one child and that more than one family member may want to participate, we ask that only
one adult come to the back. Our goal is to not only provide the highest quality of care but also to effectively communicate with you
and your child to provide as much dental education as possible. This is very difficult if both you and your child are distracted by other
siblings or when a child is trying to get the attention of both of their parents at the same time.

Missed/Broken Appointment Policy

Due to the limited space in our schedule and the need to provide timely service to all of our patients it is very important that you keep
your scheduled appointments. It is understandable that occasionally you may need to reschedule due to an emergency or illness. We
ask that you give us the courtesy of a 24 hour notice so that we will have the opportunity to use your appointed time to provide
treatment for others in need.

INITIALS ___________

Assignment of Benefits (AoB) and Release of Information (RoI)

• I consent to and authorize that payment of benefits for healthcare related services be made to Tribeca North Dental. This consent specifically authorizes Tribeca North Dental to release Protected Health Information (PHI) to insurers, governmental agencies and their agents for billing purposes and determination of benefits.

• I assign any benefits payable for provider services to the provider or organization providing the services.

**• I understand that there is no guarantee of reimbursement or payment from any insurance company or other payer. I
acknowledge full financial responsibility for, and agree to pay, all charges of Tribeca North Dental and of providers rendering services not otherwise paid by my health insurance or other payer. All charges due are payable upon receipt of the bill. If
payment is not made within 60 days after receipt of bill, a delinquent charge or interest of 18.00% (1.5% monthly ratewill be added. I agree to pay all costs of collection including attorney fees, collection fees and court costs.** • The terms of this AoB and RoI will be until final payments are made for all services.

• If and when there are any changes to my insurance plans, I will notify Tribeca North Dental staff and sign a new agreement.

Insurance

AT THIS OFFICE WE FOLLOW THE GUIDELINES OF THE AMERICAN ACADEMY OF PEDIATRIC DENTISTRY IN
REGARD TO FREQUENCY OF **X-RAYS, CLEANINGS, FLUORIDE TREATMENTS, AND RESTORATIVE CARE**. AS
SPECIALISTS WE CONSIDER THESE GUIDELINES TO BE THE STANDARD OF CARE (BEST TREATMENT FOR YOUR
CHILD). **THESE GUIDELINES ARE NOT DICTATED BY DENTAL INSURANCE AND IT IS YOUR RESPONSIBILITYTO UNDERSTAND WHETHER YOUR PARTICULAR INSURANCE PLAN WILL REIMBURSE YOU FOR THESE SERVICES. PLEASE CALL YOUR INSURANCE COMPANY WITH QUESTIONS REGARDING FREQUENCIES.**

____

Print Patient's Name Date

____

Parent/Guardian Signature Printed Name Relationship to patient(s)

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Practice Terminology

In order to improve the chances of your child having a positive experience in our office, we are selective in our use of words. We
avoid words that may scare children due to previous experiences. Please support us by *not using* negative words that are often used for
dental care. We appreciate your cooperation in helping us build a good attitude for your child!

DON'T USE	**OUR EQUIVALENT**
Needle or shot	Cold water squirter/ Snowman maker
Drill	Tooth Cleaner/ Tooth tickler
Drill on tooth	Clean a tooth/Tickle a tooth
Pull or yank tooth	Hug a tooth
Decay or cavity	Sugar bug/dirt
Examination	Count teeth
Tooth cleaning	Tickle teeth
Explorer	Tooth counter
Isolite	Mr Fishy
Gas or nitrous	Magic air/ ice cream maker

Parent Guidelines

You may choose whether or not you accompany your child to the treatment room for his/her appointment. Although we sense that
some children do better without parents being present, we are open to having you with your child. If you choose to be present, we
suggest the following guidelines to improve chances of a positive outcome.

- Allow *US* to prepare your child
- Be supportive of the practice terminology
- Please be a silent observer—support your child with touch.
    - This allow us to maintain communication with your child
    - Children will normally listen to their parent rather than us and may not hear our guidance
    - You may give incorrect or misleading information
- If asked to leave, be ready to immediately walk away
    - Many children will try to control the situation
    - "Acting out" is normal, but unacceptable during fillings
    - This is intended to "short circuit" the control attempt
    - We will continue to support your child at all times
- We may at time use 'voice control' in trying to control a situation. This may mean that we will raise our voice and speak in a stern tone. Please understand this is one way in trying to control your child's behavior and if it does not have positive results we will discontinue its use.

These are very important ways that you can actively help in the success of your child's visit. We are confident that all will go well and
hope these guidelines will help prepare you with confidence for the upcoming appointment.

Please let us know if you have any concerns/questions or comments! We would like to further speak with you on any topic!

____

Print Patient's Name Date

____

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NOTICE OF PRIVACY PRACTICES

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information over the last 6 years (but not before April 14, 2003). That list will not include disclosures for treatment, payment, healthcare operations, as authorized by you, and for certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the top of this notice for more information about fees.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. Your request is not binding unless our agreement is in writing.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. You must specify in your request the alternative means or location, and provide satisfactory explanation how you will handle payment under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why we should amend the information. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS
If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed
at the top of this notice.

If you believe that:

- We may have violated you privacy rights,
- We made a decision about access to you health information incorrectly,
- Our response to a request you made to amend or restrict the use or disclosure of your health information was incorrect, or
- We should communicate with you by alternative means or at alternative locations,

You may contact us using the information listed at the top of this notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

I have read and understand the above Patient Rights to Privacy Information.

____
Signature of Patient (Or Parent/Guardian if Child)

____
Date

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BROKEN APPOINTMENT POLICY

Our office values your time and takes great effort to stay on schedule. When you reserve a time with us, we request you make every attempt to make your appointment, as it is set aside specifically for you.

We have a 2-BUSINESS DAY cancellation policy. If you need to change or reschedule your reserved time with us, please give us at least a 2-BUSINESS DAY notice so we will be able to fill this time with others waiting for treatment. If you cancel, fail to show for your confirmed appointment, or you arrive excessively late and treatment cannot be completed as planned, we must charge you a Broken Appointment Fee of $100.
We understand that unforeseen circumstances arise, so as a courtesy to our patients, we do allow one unexpected cancellation without notice or excessively late arrival. Other than this exception, we will exercise our right to charge the above Broken Appointment Fee.
We appreciate your cooperation and understanding.

_______________________________________ _________________
Signature of Patient or Guarantor Date

IT IS YOUR RESPONSIBLITY TO PAY ANY DEDUCTIBLE, AS WELL AS ANY OTHER BALANCE NOT PAID BY YOUR INSURANCE ALONG WITH ANY FEE'S DUE TO CANCELED APOINTMENTS.

I have read and understand the above. I am aware that my card is being placed on file but will not be charged unless I have missed an appointment without a cancelation notice

Patient Name:____

Card Holder Name:______________________________ CVV:_________________

Acct Number:______________________________Acct Type:_______ Exp Date:________

Signature:__________________________________Date:__________Zip_____________