welcome!

We would like to welcome you and 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.**

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.

1. ABOUT YOUR CHILD

Name: _____
Last First Initial

Nickname: _____

Birthdate: ____/____/____ ☐ Male ☐ Female
Month Day Year

SS #: _____ Age: _____

Special interests, sports or hobbies: _____

_____

_____

Home address: _____

_____
Apt/Condo # City State Zip Code

Home phone: (____)_____

Referred by: _____

2 ABOUT YOU

Your name: _____

Birthdate: ____/____/____

SS #: _____

Relationship to child: _____

Your home phone and address, if different from child's:

(____)_____
Home Phone

_____
Address

_____
Apt/Condo # City State Zip Code

Occupation: _____

Employer: _____

Work phone: (____)_____

Cell phone: (____)_____

INSURANCE 3

DENTAL INSURANCE COMPANY #1

Dental Ins. Co.: _____

Insurance Co. Phone #: (____)_____

Group / Policy #: _____

This Dental Insurance is provided through:

Policy owner's name: _____

Relationship to child: _____

Policy owner's SS #: _____

Policy owner's birthdate: _____

Policy owner's employer: _____

Employer's Address: _____

_____
City State Zip

DENTAL INSURANCE COMPANY #2

Dental Ins. Co.: _____

Insurance Co. Phone #: (____)_____

Group / Policy #: _____

This Dental Insurance is provided through:

Policy owner's name: _____

Relationship to child: _____

Policy owner's SS #: _____

Policy owner's birthdate: _____

Policy owner's employer: _____

Employer's Address: _____

_____
City State Zip

CONTINUED ON BACK

4 DENTAL/MEDICAL HISTORY

Has your child been to the dentist before? ☐ Yes ☐ No

If yes, the approximate date of last visit: _____

Are there any dental problems that you are aware of at present? ☐ Yes ☐ No If yes, please explain: _____

_____

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

Please rate your child's oral health: ☐ Good ☐ Fair ☐ Poor

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

Child's physician: _____

His / Her phone #: _____

The approximate date of last visit: _____

Please rate your child's medical health: ☐ Good ☐ Fair ☐ Poor

Is your child allergic to any drugs or other things? ☐ Yes ☐ No

If yes, please list: _____

Is your child taking any prescription drugs? ☐ Yes ☐ No

If yes, please list: _____

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

5 Has your child ever had any of the following medical conditions or problems?

- Y N Any Hospital Stays
- Y N Any Operations
- Y N Bleeding Problems of Any Kind
- Y N Cancer
- Y N Convulsions / Epilepsy
- Y N Diabetes
- Y N Hearing Impairment
- Y N Heart Murmur
- Y N Heart Problems of Any Kind
- Y N Hemophilia
- Y N HIV+ / AIDS
- Y N Hyperactive
- Y N Rheumatic / Scarlet Fever

6

In the event of any emergency, whom should we contact?

Name: _____ Relationship: _____

Phone: _____ Phone #2: _____

Are there any other medical conditions or problems relating to your child? ☐ Yes ☐ No

If yes, please list: _____

I understand that the information that 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 in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

The Parent or Guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.

Signature of parent or guardian: _____ Date: _____

Thank you for filling out this form completely. It will enable us to give your child the best dental care possible.

If you or your child have any questions, please feel free to ask us at any time.

Edward J. Smith, D.M.D.
Family, Cosmetic and Implant Dentistry

SMILE ANALYSIS

Did You Know*?*

- ***9 out of 10 Americans agree that an attractive smile is an important asset***
- ***¾ of Americans agree that an unattractive smile can hurt a person's chances for career success***
- ***Only ½ of Americans are satisfied with their smile***

How's Your Smile*?*

(Look in the mirror as you answer these questions)

	YES	NO
Do you feel uncomfortable or self-conscious about your smile?	_____	_____
Do you cover your mouth when you talk or smile?	_____	_____
Do you like toe color of your teeth?	_____	_____
Do you like the shape of your teeth?	_____	_____
Can you see dark restorations in your teeth when you smile?	_____	_____
Do you have spaces between your teeth that bother you?	_____	_____
Are your teeth too crowded?	_____	_____

Your Wish List*:*

(In order of priority the things you would like to improve about your smile)

1. _____

2. _____

3. _____

Your Name*:* _____ ***Date:*** _____
(Please Print)

Edward J. Smith, DMD
2 West Hanover Avenue, Suite 201
Randolph, NJ 07869
(973) 895-5111

ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____ have received a
(Please print your name)

copy of this office's Notice of Privacy Practices.

_____ _____
(Signature) (Date)

_____
For Office Use Only

We attempted to obtain written Acknowledgement of Receipt of Notice of Privacy Practices but 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)

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 1, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0._____ for each page, $_____ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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.

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).

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.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled 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 the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end 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.

Contact Officer: Dr. Edward Smith

Telephone: 973-895-5111 Fax: 973-895-5142

E-mail: edsmithdmd@aol.com

Address: 2 West Hanover Avenue, Suite 201, Randolph, NJ 07869

Edward J. Smith, D.M.D.
Family, Cosmetic and Implant Dentistry

Office Appointment Policy

Our objective is to provide you with the highest quality dentistry available. To accomplish this it is imperative that you keep your scheduled appointments so that we may perform all your treatment in the proper sequence and in a timely manner. We realize that unexpected things do come up that require you to change your plans. We would appreciate 24-48 hours notification of schedule changes. If inadequate notification is given, we reserve the right to charge a $50 fee for your appointment time. If subsequent appointments are missed, we will call you when a time slot becomes available. As a courtesy, we will send you an automated email or text message confirming your upcoming appointments. Please provide us with your contact information. Your cooperation is greatly appreciated.

Office Payment Policy

In order for us to provide you with the highest quality dental care, it is necessary for us to collect our fees as treatment proceeds. Those patients with dental insurance will need to make their co-payment at their office visit. Those patients without dental insurance will be required to pay for treatment in full at the time of the visits, unless other payment arrangements have been made.

Please ask our Office Manager about the affordable monthly payment and zero interest payment options we offer – options that can make it easy to fit your dental care into your budget.

A 1.5% monthly interest charge may be added to all account balances over 60 days.

We will gladly file your insurance for you. However, you must supply us with complete and accurate insurance information and keep us updated with any changes in your coverage. Because insurance companies do not guarantee benefits, payment is ultimately your responsibility.

We try to make each visit to our office an exceptional experience. When we succeed, we would welcome your telling your friends, family and co-workers about our office. Your referral is the highest compliment we can receive and is greatly appreciated.

Thank you for your cooperation.

_____ _____

Patient Name (Please Print) *Date*

_____

Patient Signature (Parent/Guardian if Patient is Minor)