Philip J. Pistolas D.D.S.
Children's Dentistry
including
Functional Orthodontics
41 Main Street Sparta, New Jersey 07871 Tel: 973-729-7785 www.pistolassmiles.com

Patient Information: **Today's Date: _____**

Name: _____

Preferred Name, if any: _____ Sex: Male Female

Birthday: _____/_____/_____

Address: _____

_____
City State Zip Code

Marital Status of Parents: Married _____ Divorced _____ Separated _____ Single _____

Who has legal custody of patient? _____

Person responsible for payment of account? _____

Mother's Information:

Name: _____ Mother Stepmother Guardian

Birthday: _____/_____/_____

Address: _____

_____
City State Zip Code

Home#: _____ Cell#: _____ Work#: _____

Employer: _____

Address: _____ Occupation: _____

_____
City State Zip Code

SS#: _____-_____-_____ E-mail: _____

Insurance Information:

Circle one: Primary Secondary

Dental Ins. Co. Name _____

Subscriber's Name _____

Group/Policy #_____ ID#_____

Relationship _____

Signature _____ Date _____

Father's Information:

Name: _____ Father Stepfather Guardian

Birthday: _____/_____/_____

Address: _____

_____
City State Zip Code

Home#: _____ Cell#: _____ Work#: _____

Employer: _____

Address: _____ Occupation: _____

_____
City State Zip Code

SS#: _____-_____-_____ E-mail: _____

Insurance Information:

Circle one: Primary Secondary

Dental Ins. Co. Name _____

Subscriber's Name _____

Group/Policy #_____ ID#_____

Signature _____ Date _____

Patient Registration and Medical History

Date:_____ Home Phone #_____

Patient Name:_____

Your Name & Relationship to Patient:_____

Street Address:_____City:_____Zip:_____

Sex:___M___F Age:_____ Birthdate:_____

In case of emergency, who should be notified (other than yourself):_____

Their phone number is: _____

Whom may we thank for referring you? _____

Medical History

Physician's Name:_____Date of last physical:_____

Has you child ever had, been exposed to, taken medication for, or treated for any of the following?

__Pneumonia
__Heart Murmur
__Circulatory Problems
__Hemophilia
__Jaundice or Liver Disease
__Epilepsy
__Chronic Diarrhea
__General Allergies
__Thyroid Disease
__Hepatitis
__Stroke
__Chemical Dependency
__Gland Disorder
__Other Heart Problems
__Radiation Treatment
__Recent Weight Loss
__Diabetes
__Cancer
__Blood Disease
__Tuberculosis
__Venereal Disease
__"A.I.D.S." or other Immunosuppressive Disorder
__Artificial Heart Valves or Joints
__Brain/Nervous System Disorders
__Bone Disorder
__High/Low Blood Pressure
__Rheumatic Treatment
__Back Problems
__Respiratory & or Disorders
__Psychiatric Care
__Arthritis
__Ulcer

Does the child have any drug allergies or has the child ever had an adverse reaction to any

medication? _____If so, what_____

Is the child under the care of a physician? _____Yes_____No
If yes, for what conditions? _____
Is the child taking any current medications (Name & Dosage)?

_____

Print Name _____

Signature _____ **Date** _____

Dental History Information:

How did you hear about our office? _____

Is this your child's first visit to the Dentist? Yes No

Previous Dentist? _____

Any injuries to teeth, face or mouth? Yes No
If yes, please explain: _____

Do you or your child have specific concerns? _____
_____

How many times a day does your child brush? _____
Floss? _____

Does your child have any of the following habits?

Yes	**No**	Lip Sucking/Biting
Yes	**No**	Thumb/Finger sucking
Yes	**No**	Pacifier
Yes	**No**	Nail Biting
Yes	**No**	Tooth Grinding
Yes	**No**	Mouth Breather/Snoring

Yes	**No**	Does your child drink well water?
Yes	**No**	Is your child taking fluoride supplements?
Yes	**No**	Is your child using fluoride toothpaste?
Yes	**No**	Does your child floss his/her teeth daily?
Yes	**No**	Does your child drink soda?
Yes	**No**	Does either Parent have untreated tooth decay?
Yes	**No**	Does either Parent have a history of smoking?
Yes	**No**	Does either Parent have a history of missing teeth?

Is your child having problems with any of the following?

Cavities *Toothache* *Sensitive Teeth* *Trauma* *Gum Infection* *Color of Teeth*

Tooth Alignment *Jaw Joint popping/clicking* **Other**_____

Print Name _____

Signature _____ **Date** _____

HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice of Privacy practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that, relates to your past present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your dentist, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the dental practice.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your dental care and any related services. This includes the coordination or management of your health care with a third party. We will also disclose protected health information to other dentists who may be treating you. For example, your protected health information may be provided to a dentist to whom you have been referred to ensure that the dentist has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your dentist's practice.
For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your dentist is ready to see you. We may use or disclose your protected health information, as necessary to contact you to remind you of your appointment.
We will share your protected health information with third party "business associates" that perform various activities for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. You make revoke this authorization, at any

time, in writing, except to the extent that your dentist or the dentist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

Your have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains dental and billing records and any other records that your dentist and the practice use for making decisions about you. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your dentist is not required to agree to a restriction that you may request. If your dentist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternative, i.e. electronically.

You may have the right to have your dentist amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint**. This notice was published and becomes effective on/or before **April 14, 2003**. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. You may contact our HIPAA Compliance Officer in person or by phone at our main number. Signature below is only acknowledgement that you have received this Notice of our Practices.

Print Name _____

Signature _____ **Date** _____

Insurance

Dental Insurance is different from Medical Insurance. Your dental benefits are based on the agreement your employer negotiated with your insurance carrier. Please review the insurance benefit booklet provided by your employer to better understand the benefits they make available as part of your insurance coverage. The patient payment portion covered for procedures varies depending on the coverage provided by your employer.

An estimate of the amount covered by your insurance company will be provided at the time of your treatment, based on the information they provide to us. The estimate is never a guarantee of benefits or the amount that will be paid. We will file all insurance claims as a courtesy to our patients. This does not however, transfer the responsibility of your financial obligation to the insurance company. If the amount paid by the insurance company is less than or greater than the estimate, then you will be billed the difference or issued a credit on the account in the event of an overpayment. Please let us know if you have questions about our financial policies or financing options prior to your treatment.

I hereby authorize payment of dental benefits otherwise payable to me, directly to the office of Dr. Pistolas, 41 Main Street, Sparta, NJ 07871. 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 benefit plan. I understand that Dr. Pistolas is non-participating with all insurance companies. I authorize release of any information relating to the claim allowable by law.

Print name of insured _____

Signature of insured _____ ***Date***_____

My dental insurance company is _____

I understand that most insurance companies will pay the office directly. If my insurance company will not pay here directly, then I must forward and sign over Dr. Pistolas the insurance checks along with any out of pocket expenses that I have incurred.

Printed name of insured _____

Signature of insured _____ ***Date***_____

NO INSURANCE

I certify that I am the parent/legal guardian of the patient _____ and I agree to be responsible for payment for all services rendered to my child.

Printed name of Parent_____

Signature of Parent _____ ***Date*** _____