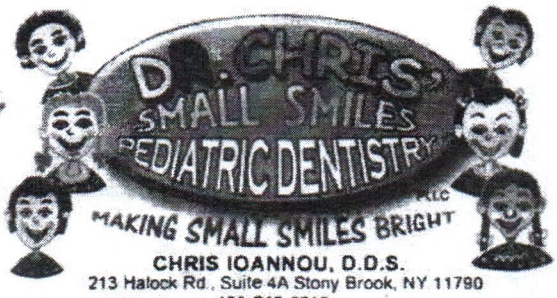
Welcome



CHRIS IOANNOU, D.D.S.
213 Halock Rd., Suite 4A Stony Brook, NY 11790
631-762-9910

Health History Form

Today's Date_____

NOTE: The parent or Guardian who accompanies the child must present ID and is responsible for payment at the time of service.

1. Tell Us About Your Child

Child's legal name:_____

Preferred name:_____ Gender:_____

Siblings that we treat _____

Child's Birthdate ____/____/____ Child's Age _____

School_____ Grade_____

Child's Home # (_____)_____

SS#_____

Child's Home Address:_____

City State County Zip

2. Parent/legal guardian #1:

Name _____

Relattonshtp to chtld:_____ Birthdate ____/____/____

Employer _____

Home Address (if different from child)_____

City State County Zip

Work # (_____)_____ Ext. _____

Home # (_____)_____

Cellular Phone # (_____)_____

SS # _____ DL# _____

Email address:_____

3. Parent/legal guardian #2:

Name _____

Relattonshtp to chtld:_____ Birthdate ____/____/____

Employer _____

Home Address (if different from child)_____

City State County Zip

Work # (_____)_____ Ext. _____

Home # (_____)_____

Cellular Phone # (_____)_____

SS # _____ DL# _____

Email address _____

4. Who is Accompanying the Child Today?

Name _____

Relationship_____

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

5. Person Responsible for Account

Name_____

Relationship_____

Billing Address _____

City State Zip

Home # (_____)_____

Work # (_____)_____

Cellular # (_____)_____

E-mail _____

6. Primary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone # (_____)_____

Group # (Plan, Local, or Policy #) _____

Policy Owner's Name _____

Relationship to Patient_____

Policy Owner's Birthdate ____/____/____

Social Security # _____

Policy Owner's Employer _____

7. Secondary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone # (_____)_____

Group # (Plan, Local, or Policy #) _____

Policy Owner's Name _____

Relationship to Patient_____

Policy Owner's Birthdate ____/____/____

Social Security # _____

Policy Owner's Employer _____

8. Who may we thank for referring you to our office?

_____

9. Dental History

Is this your child's first visit to the dentist? _____

If not, how long since the last visit to the dentist? _____

Previous Dentist's Name _____

Were any x-rays taken at previous dental visits? _____

Have there been any injuries to the teeth, face or mouth? _____

If yes, please explain _____

_____

_____

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

_____

_____

Does the child have any of the following habits?

Y N Lip Sucking / Biting Y N Nail Biting

Y N Nursing / Bottle Habits Y N Thumb / Finger Sucking

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

If yes, please explain _____

_____

Is the child's water fluoridated? Yes No

Is the child taking fluoride supplements? Yes No

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

Does the child brush their teeth daily? Yes No

Floss their teeth daily? Yes No

10. Health History

Has the child ever had any of the following conditions?

Y N Abnormal Bleeding	Y N Disabilities/Special Needs
Y N Allergies to any Drugs	Y N Hearing Impairment
Y N Any Hospital Stays	Y N Heart Disease/Murmur
Y N Any Operations	Y N Hemophilia/Blood Disorders
Y N Asthma	Y N Hepatitis
Y N Cancer	Y N HIV + / AIDS
Y N Congenital Birth Defects	Y N Kidney/Liver Conditions
Y N Convulsions/Epilepsy	Y N Rheumatic/Scarlet Fever
Y N Pregnancy	Y N Allergies to Latex Product
Y N Tuberculosis	Y N Diabetes
Y N ADD / ADHD	Y N Autism

Please discuss any serious medical conditions the child has had

_____

_____

Please list all drugs the child is currently taking _____

_____

Please list all drugs the child is allergic to _____

_____

Child's Physician _____

Phone (_____) _____

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

Please describe the child's current physical health...

Good Fair Poor

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

11. 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 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 Relationship to Patient

For Office Use Only

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

Initials _____ Date _____

Doctor's Comments _____

_____

_____

_____

NOTICE OF PRIVACY ACTS

Patients Name: _____ **DOB:**_____

* For my convenience, this office may release my information to my insurance company, and receive payment directly from them.
* I understand that if I begin major treatment that involves lab work, I will be responsible for the fee at that time along with all other copays that I might have for treatment rendered.
* If sent to collections, I agree to pay all related fees and court costs.
* Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible.
* I agree to pay finance charges of 1.5% per month (18% APR) on any balance 90 days past due.
* I will pay a fee for appointments broken without 24 hours notice.
* Treatment plans may change, and I will be responsible for the work actually done.
* I have been informed that my insurance company does not cover nitrous oxide, If I agree to this treatment I am responsible for all charges.

In the event that N20 is needed for treatment,
I have been informed that the nitrous oxide may make my child feel "tingly" or 'floaty"
The nitrous oxide will be completely dissipated from the patients system after 2-3 minutes of breathing room air. i also understand that . while its rarely occurs, nausea is a possible adverse affect of the Nitrous oxide.

MOST INSURANCES DO NOT COVER NITROUS OXIDE and I have been informed that there is a $100.00 fee that is due at the time of each visit when used.

** Anyone who is Pregnant or has MTHER Gene Mutation is not permitted in the room while nitrous oxides is in use.**

NITROUS OXIDE CONSENT

Your Dentist has recommended that your child be given nitrous oxide/oxygen (laughing gas) to breath during dental treatment to help reduce fear and apprehension. Nitrous oxide/oxygen is a blend of two gases: oxygen and nitrous oxide. When inhaled, it is absorbed by the body and has a calming effect. Normal breathing eliminates nitrous oxide/ oxygen from the body.

When breathing nitrous oxide/oxygen, your child will smell a sweet pleasant aroma and experience a sense of well being. If your child is worried by the sights, sounds, or sensations of dental treatment, he or she may respond more positively with the use of nitrous oxide/oxygen.

Nitrous oxide/oxygen is very safe, perhaps the safest sedative in dentistry. It is nonaddictive. It is mild, easily taken, and quickly eliminated by the body. Your child remains fully conscious – keeps all natural reflexes – when breathing nitrous oxide/oxygen.

INSTRUCTIONS: Your child should eat little or no food before the dental visit. (Occasionally, nausea or vomiting occurs when a child has a full stomach.) The Dentist should be informed about any respiratory condition that makes breathing through the nose difficult for your child. It may limit the effectiveness of the nitrous oxide/oxygen. Tell the Dentist if your child is taking any medication or has any genetic mutations. Tell the Dentist if your child has had any adverse reactions to nitrous oxide/oxygen. On occasion, nitrous oxide/oxygen may cause nausea and/or vomiting. To minimize the chance of this we recommend avoiding large meals prior to your appointment. All children are not alike. Please let the Dentist or staff know if you or your child is pregnant as we do not recommend the use of it around pregnant individuals. Every service is tailored to your child as an individual. Nitrous oxide/oxygen is not effective for some children, especially those who have severe anxiety, nasal congestion, extensive treatment needs or discomfort wearing a mask. Nitrous oxide/oxygen fees may not be covered by your dental insurance.

TREATMENT CONSENT The use of nitrous oxide/oxygen as well as any dental treatment required has been fully explained to me. I have given the Dentist a complete review of my child's medical history. I consent to treatment of my child as explained above and all my questions have been answered.

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.

Cancelation Policy
We understand that there are times when you must cancel an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel your appointment, you may be preventing other patients from receiving much needed treatment. Appointments are to be canceled with a minimum of 24 hours in advanced. Appointments canceled WITHIN 24 hours are subject to a $50.00 broken appointment fee per child. In addition, if a patient is 15 minutes past their scheduled time you may be risking not to be seen and will need to reschedule. As a courtesy to our patients we will gladly waive the first time missed.

Informed Consent
Since my child is a minor, it becomes necessary that signed permission is obtained from a parent or legal guardian before any dental services can be performed and completed by any Employee of Dr Chris' Small Smiles Pediatric Dentistry.

1. Initial Diagnostic Procedures: In order to help formulate treatment recommendations, the following procedures may be performed: (1) a medical and dental history, (2) discussion of your dental problems, concerns, and desires, (3) x-rays, (4) plaster cast of the mouth and teeth, (5) examination of the mouth and associated structures, (6) photographs, and (7) conference with previous or concurrent treatment health professional s. If additional diagnostic procedures or consultations are indicated, they will be discussed with you.

2. Treatment Recommendations: Are based on information gained from initial procedures and previous experience and may vary for similar situations. The ultimate goal of treatment is to assist your child in attaining optimum dental health and appearance. We will discuss with you the most appropriate and ideal treatment plan as well as reasonable alternative treatment plans. In those instances where supporting structures are compromised, recommendations can be made for a consultation with a specialist. We will also inform you of the likely dental prognosis for each of these treatment plans and

dental prognosis if no treatment is indicated at this time. You are welcome at anytime to seek a second opinion.

3. Anesthetics: Most procedures are performed with a local anesthetic. In addition, Nitrous Oxide can be used to help minimize anxiety and discomfort. In rare instances, allergic reactions may occur, so you are requested to inform our office staff of any known allergies your child may have.

4. Medical History: I understand the medical and dental history is necessary to provide your child with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency. I will notify Dr Chris' Small Smiles Pediatric Dentistry.

5. Treatment: Upon such diagnosis, I authorize Dr Chris' Small Smiles Pediatric Dentistry staff to perform all recommended treatment mutually agreed upon by and to employ such assistance as required in order to provide proper care.

Consent For Internet Communications
I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the

theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.
I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

CONSENT FOR NON-PARENT TO BRING MINOR CHILD TO APPOINTMENT
The following form is designed for those situations we are minors are on accompanied by either parents or legal guardians. This "Dental/Medical treatment authorization and consent form" is giving authority to a designated adult to arrange for medical/dental care for minor in the event of an emergency or when the parent/guardian designates for routine care. This is extremely important, in that, dental/medical care cannot be Provided to a minor without approval by the parents or legal guardians, unless there is a written consent authorizing an agent to give approval. and on the child(ren) behalf do hereby state that the power to consent that I confer shall not be affected by my subsequent disability or incapacity. The underside do hereby authorize Dr Chris' Small Smiles Pediatric Dentisty or such substitute as he/she may designate as agent for the Undersigned to consent to any X-rays, anesthetic, medical, dental, or surgical diagnosis or treatment and hospital care for the above named minor which is deemed advisable by and to be rendered under the general or special supervision of any physician and/or surgeon licensed under the Provision of Medicine Practice Act or of any dental licensed under the

Dental Practice Act, whether such diagnosis or treatment is rendered at the office or said physician or dentist at the hospital or elsewhere the undersigned may also agree to any financial obligations on behalf of the parent/legal guardian.

Signature _____ **Date**_____

FINANCIAL AGREEMENT

Name: _____ **DOB** :_____

We are required by applicable federal and state laws 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 as of 2/25/2003, 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 federal and state laws. We reserve the right to make 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 privacy notice at any time. For more information about our privacy practices, or 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. Un less you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited expectations. You may request that we provide copies in a format other than photocopies. We use the format your request unless we cannot practicably do so. (You must make a request in writing to obtain 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, $0 per hour for staff time to locate the copy of 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 heal information in that format. If you prefer, we will prepare a summary or explanation or 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 request.

Restriction: You have the right to request that we place additional restrictions on our use or discloser of your health information. We are not permitted 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 payment will be handled under the alternative means or location you request.

Signature:_____ **Date**:_____

DISCLOSURE

Name: _____ **DOB** _____

I have been informed and acknowledge that the dental treatment/services listed below may not be covered by my insurance plans benefits and fee schedule. I am aware that I will be financially responsible for paying for these services if not covered. Fees are not to exceed providers UCR.

Code	Dental Description	Fee
D9230	Nitrous Oxide	$100
D1354	SDF	$85
D1206	Fluoride Varnish	$60

I have been informed that if I pay for a non covered service that has changed to a covered service the time the service was rendered, I will be reimbursed whatever fees were paid by me for that covered service.

Signature: _____ **Date**_____