Welcome!

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form, as completely as you can. If you have any questions, we are glad to help!

1. PATIENT INFORMATION

Patient name/ Nombre De Paciente:

____ (Preferred Name)
Last First MI

Date of Birth/ Fecha De Nacimiento: _____/_____/_____ SSN: ________________________

Gender: ☐ Male ☐ Female

Address/ Direccion:

____
Street Apt #

____
City State Zip Code

Home Phone: ( )___________________ Work: ( )____________________ Cell: ( )_____________________

Email: ____

2. RESPONSIBLE PARTY/ PARIENTE RESPONSABLE

☐ Mother ☐ Father ☐ Other: _______________________

Date of Birth: ______________SSN: ___________________

Employer: _________________Occupation_____________

Work Phone: ( )____________ Cell: ( )___________

Status: ☐ Single ☐ Married ☐ Divorced ☐ Partner

☐ Mother ☐ Father ☐ Other: ________________________

Date of Birth: ______________SSN: ___________________

Employer: _________________Occupation_____________

Work Phone: ( )____________ Cell: ( )___________

Status: ☐ Single ☐ Married ☐ Divorced ☐ Partner

3. HOW DID YOU HEAR ABOUT US/ COMO SE ENTERO DE NOSOTROS?

Family Member? Familiar?__________________ Friend? Amigo? ___________________________

Pediatrician?Medico?_________________________________Other Dentist?/Otro Dentista ________________

☐ Practice Website ☐ Internet Search ☐ Insurance Website ☐ ZocDoc ☐ Radio ☐ TV ad

☐ Building Sign ☐ Billboard ☐ Flyers ☐ Postcard ☐ Community Fair ☐ School Referral

☐ Facebook ☐ Newspaper

4 DENTAL HISTORY/ HISTORIA DENTAL

Is this your child's first dental visit? Es la primera visita al dentista?____

Reason for today's visit? Razon por la visita de hoy? ____

Does your child think anything is wrong with their teeth? Su nino(a) piensa que algo esta mal? _____________________

Has your child ever had an unpleasant experience in a dental office? Mal experienca en el dentista ?____________

Does your child have any dental habits? Malos Habitos?

____Thumb/finger sucking/Mamar dedos____Nail biting/Mordiendo Unas ____Pacifier/Bobo____Bottle at night/ Biberon

5. MEDICAL HISTORY/HISTORIA MEDICA

Child's physician or pediatrician/ Nombre del Pediatra: ____ Phone: _____________________

Has your child ever been hospitalized or needed emergency care? Su nino(a) hacido hospitalizado? ☐ Yes ☐ No

If yes, please explain/ Porfavor Explique:

Does your child have any allergies to food or drugs? Alguna allergias? ☐ Yes ☐ No

If yes, please explain/ Por favor Explique:

____

Is your child currently taking any medications? Esta tomando medicaciones? _________________________________

Does your child have a history of the following disorders? Please circle Yes or No. Historia De Alguna condicion? Circule

ADD/ADHD	Y	N	Dizziness	Y	N	Herpes	Y	N	Respiratory Problems	Y	N
AIDS/HIV Positive	Y	N	Down Syndrome	Y	N	High Blood Pressure	Y	N	Rheumatic Fever	Y	N
Allergies (Seasonal)	Y	N	Drug Addiction	Y	N	Hypoglycemia	Y	N	Rheumatism	Y	N
Anxiety/Panic	Y	N	Epilepsy or Seizures	Y	N	Jaundice	Y	N	Sinus Problems	Y	N
Asthma	Y	N	Excessive Bleeding	Y	N	Irregular Heartbeat	Y	N	Spina Bifida	Y	N
Autism	Y	N	Fainting Spells	Y	N	Kidney Problems	Y	N	Stomach Problems	Y	N
Blood Disease	Y	N	Frequent Cough	Y	N	Leukemia	Y	N	Stroke	Y	N
Cancer	Y	N	Frequent Headaches	Y	N	Liver Disease	Y	N	Thyroid Disease	Y	N
Chemotherapy	Y	N	Glaucoma	Y	N	Low Blood Pressure	Y	N	Tuberculosis	Y	N
Cold Sores/Fever Blisters	Y	N	Head Injuries	Y	N	Mental Disorders	Y	N	Tumors or Growths	Y	N
Congenital Heart Disorder	Y	N	Heart Disease	Y	N	Nervous Disorders	Y	N	Ulcers	Y	N
Convulsions	Y	N	Heart Murmur	Y	N	Pain in Jaw Joints	Y	N	Venereal Disease	Y	N
Developmentally Delayed	Y	N	Hepatitis A	Y	N	Pregnancy	Y	N	Yellow Jaundice	Y	N
Diabetes	Y	N	Hepatitis B or C	Y	N	Radiation Treatment	Y	N	Other	Y	N

Please list any illnesses not listed above/ Alguna Condicion que no esta en la lista: ________________________________

6. AUTHORIZATION AND CONSENT/ AUTHORIZACION Y CONSENTIMIENTO

I certify that I am the parent, legal guardian, or personal representative of (name of patient) _______________________ and there are no court orders now in effect that prohibit me from signing this consent. As this child's parent, legal guardian, or personal representative, I acknowledge that the information I have given is complete and correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform the office of any changes in my child's medical status. I understand that misrepresenting or withholding medical/dental information can be harmful to my child during dental treatment.

I do hereby authorize the dental staff to perform an oral examination (including any necessary x-rays and photos) and after explanation, any and all treatment for the above-named child. I consent to such methods, drugs/anesthetics, and agents that may be indicated and deemed advisable by the doctor in connection with my child's dental care, whether or not I am present when the treatment is rendered.

I authorize my insurance company to pay Yellow Bear Pediatric Dentistry, PLLC all insurance benefits otherwise payable to me for services rendered. I also authorize the use of my signature on all insurance submissions. I agree to be financially responsible for all charges for services rendered, any deductible, and any co-payment on my behalf or my dependents, whether or not it is covered by my insurance company, and that all payments are due when services are rendered.

I hereby authorize Yellow Bear Pediatric Dentistry, PLLC to release any information, including the diagnosis and the record of any treatment or examination, rendered to my child during the period of such dental care to third party payors and/or other health practitioners.

This consent shall remain in full force and in effect until cancelled in writing.

____ ________________________________

Signature of Patient, Parent, Guardian or Personal Representative | Date

____ ________________________________

Please print name of Patient, Parent, Guardian or Personal Representative | Relationship to Patient

Financial Policy

We are pleased to welcome you to our practice. Our desire is to provide you with the highest quality dental care in a caring and enjoyable atmosphere. ***It is our policy to make definite financial arrangements with you before any treatment starts.*** Below is an explanation of our payment procedures. If you have any questions, please do not hesitate to ask.

1. Payment for services is due at the time services are rendered. We accept cash, checks, and credit cards.

2. For new patient emergency visits we require payment in full at the time of the appointment.

3. As a courtesy, we will provide you with a copy of the charges to submit to your insurance carrier for your reimbursement or you may assign the payment to our office and we will file the insurance for you. **The office will accept assignment for only the primary insurance coverage**, secondary insurance coverage must be paid to the patient.

4. Our office will file your insurance claim a maximum of **two times** per appointment.

5. **If the claim is not paid by your insurance carrier within sixty days, you will be responsible for the full balance and further insurance appeal becomes your responsibility.** We will be happy to provide you with a claim form so that you can follow up on your insurance claims personally.

6. You must provide the office with a dental insurance card with the proper mailing address of the insurance company, or provide a dental claim form, which is provided by the employer. If one of these documents is not available at the time of the appointment, you will be responsible for payment of all fees and we will provide you with a claim form for you to submit for reimbursement.

7. If insurance benefits are assigned to the doctor, you will be responsible for paying your deductible and co-payments at the time of service. **You are responsible for paying all charges not covered by your insurance company, including all fees considered above your insurance company's usual and customary fee schedule.** Your insurance benefits are a contract between you and your employer. The amount of coverage you will receive will depend on the quality of the plan purchased by your employer, not the fees of the doctor.

8. **The office cannot carry balances longer than 90 days;** regardless if the insurance payment is still pending. A $5.00 monthly re-billing charge will be added to your account if it is not paid within 60 days, regardless of balance amount.

9. After 90 days, we will inform you of the delinquent account by letter and if no action is taken to clear the account, this office will be required to employ a collection service to collect payment. The responsible party agrees to pay all reasonable, related collection fees.

10. There will be a $30.00 service charge for all returned checks.

11. **The parent or guardian who brings the child for their initial visit is responsible for payment independent of what a divorce decree or custody arrangement may state. Reimbursement must be made between the divorced parents. We will not intervene.**

AUTHORIZATION

I have read & accept the above Financial Policy, understand it & agree to the terms set forth regarding payment.

Signature of Responsible Party	**Date**

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. If you have any questions about this Notice please contact the Privacy Officer, Dr. Hai Do at:

1471 Dekalb Ave., Floor 3B
Brooklyn, NY 11237
718-418-0824

Effective Date: April 14, 2003 **Revised: November 11, 2016**

We are committed to protect the privacy of your personal health information (PHI).

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI.

We are required by law to maintain the privacy of your PHI. We will follow the terms outlined in this Notice.

We may change our Notice, at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised Notice by:

- Posting the new Notice in our office.
- If requested, making copies of the new Notice available in our office or by mail.
- Posting the revised Notice on our website: **http://www.yellowbearpd.com**

Uses and Disclosures of Protected Health Information

We may use or disclose (share) your PHI to provide health care treatment for you.

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you.

EXAMPLE: Your PHI may be provided to a physician to whom you have been referred for evaluation to ensure that the physician has the necessary information to diagnose or treat you. We may also share your PHI from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

We may also share your PHI with people outside of our practice that may provide medical care for you such as home health agencies.

We may use and disclose your PHI to obtain payment for services. We may provide your PHI to others in order to bill or collect payment for services. There may be services for which we share information with your health plan to determine if the service will be paid for.

PHI may be shared with the following:

- Billing companies
- Insurance companies, health plans
- Government agencies in order to assist with qualification of benefits
- Collection agencies

EXAMPLE: You are seen at our practice for a procedure. We will need to provide a listing of services such as x-rays to your insurance company so that we can get paid for the procedure. We may at times contact your health care plan to receive approval PRIOR to performing certain procedures to ensure the services will be paid for. This will require sharing of your PHI.

We may use or disclose, as-needed, your PHI in order to support the business activities of this practice which are called health care operations.

EXAMPLES:

- Training students, other health care providers, or ancillary staff such as billing personnel to help them learn or improve their skills.
- Quality improvement processes which look at delivery of health care and for improvement in processes which will provide safer, more effective care for you.
- Use of information to assist in resolving problems or complaints within the practice.

We may use and disclosure your PHI in other situations without your permission:

- If required by law: The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. For example, we may be required to report gunshot wounds or suspected abuse or neglect.
- Public health activities: The disclosure will be made for the purpose of controlling disease, injury or disability and only to public health authorities permitted by law to collect or receive information. We may also notify individuals who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.
- Health oversight agencies: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
- Legal proceedings: To assist in any legal proceeding or in response to a court order, in certain conditions in response to a subpoena, or other lawful process.
- Police or other law enforcement purposes: The release of PHI will meet all applicable legal requirements for release.
- Coroners, funeral directors: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law
- Medical research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
- Special government purposes: Information may be shared for national security purposes, or if you are a member of the military, to the military under limited circumstances.
- Correctional institutions: Information may be shared if you are an inmate or under custody of law which is necessary for your health or the health and safety of other individuals.
- Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Other uses and disclosures of your health information.

Business Associates: Some services are provided through the use of contracted entities called "business associates". We will always release only the minimum amount of PHI necessary so that the business associate can perform the identified services. We require the business associate(s) to appropriately safeguard your information. Examples of business associates include billing companies or transcription services.
Health Information Exchange: We may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care.

Fundraising activities: We may contact you in an effort to raise money. You may opt out of receiving such communications.

Treatment alternatives: We may provide you notice of treatment options or other health related services that may improve your overall health.

Appointment reminders: We may contact you as a reminder about upcoming appointments or treatment.

We may use or disclose your PHI in the following situations UNLESS you object.

- We may share your information with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. For example, we may discuss post procedure instructions with the person who drove you to the facility unless you tell us specifically not to share the information.
- We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.
- We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts.

The following uses and disclosures of PHI require your written authorization:

- Marketing
- Disclosures of for any purposes which require the sale of your information
- Release of psychotherapy notes: Psychotherapy notes are notes by a mental health professional for the purpose of documenting a conversation during a private session. This session could be with an individual or with a group. These notes are kept separate from the rest of the medical record and do not include: medications and how they affect you, start and stop time of counseling sessions, types of treatments provided, results of tests, diagnosis, treatment plan, symptoms, prognosis.

All other uses and disclosures not recorded in this Notice will require a written authorization from you or your personal representative.

Written authorization simply explains how you want your information used and disclosed. Your written authorization may be revoked at any time, in writing. Except to the extent that your doctor or this practice has used or released information based on the direction provided in the authorization, no further use or disclosure will occur.

Your Privacy Rights

You have certain rights related to your protected health information. All requests to exercise your rights must be made in writing. [Describe how the patient may obtain the written request document and to whom the request should be directed, i.e. practice manager, privacy officer.]

You have the right to see and obtain a copy of 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. If requested we will provide you a copy of your records in an electronic format. There are some exceptions to records which may be copied and the request may be denied. We may charge you a reasonable cost based fee for a copy of the records.

You have the right to request a restriction of your protected health information.

You may request for this practice not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. We are not required to agree with these requests. If we agree to a restriction request we will honor the restriction request unless the information is needed to provide emergency treatment.

There is one exception: we must accept a restriction request to restrict disclosure of information to a health plan if you pay out of pocket in full for a service or product unless it is otherwise required by law.

You have the right to request for us to communicate in different ways or in different locations.

We will agree to reasonable requests. We may also request alternative address or other method of contact such as mailing information to a post office box. We will not ask for an explanation from you about the request.

You may have the right to request an amendment of your health information.

You may request an amendment of your health information if you feel that the information is not correct along with an explanation of the reason for the request. In certain cases, we may deny your request for an amendment at which time you will have an opportunity to disagree.

You have the right to a list of people or organizations who have received your health information from us.
This right applies to disclosures for purposes other than treatment, payment or healthcare operations. You have the right to obtain a listing of these disclosures that occurred after April 14, 2003. You may request them for the previous six years or a shorter timeframe. If you request more than one list within a 12 month period you may be charged a reasonable fee.

Additional Privacy Rights

- You have the right to obtain a paper copy of this notice from us, upon request. We will provide you a copy of this Notice the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible.
- You have a right to receive notification of any breach of your protected health information.

Complaints

If you think we have violated your rights or you have a complaint about our privacy practices you can contact:

Dr. Hai Do
1471 Dekalb Ave., Floor 3B
Brooklyn, NY
718-418-0824

You may also complain to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

If you file a complaint we will not retaliate against you for filing a complaint.

This notice was published and becomes effective on November 11, 2016.

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Yellow Bear Pediatric Dentistry, PLLC
331 Knickerbocker Ave., Suite 3B
Brooklyn, NY 11237
Tel: 718-418-0824
Fax: 718-418-0824
Email:yellowbearpediatricdentistry@gmail.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to document that the *Yellow Bear Pediatric Dentistry's Notice of Privacy Practices* was given to the patient or their personal representative, as required by federal law.
By signing this form, you acknowledge receipt of the Yellow Bear Pediatric Dentistry *Notice of Privacy Practices.* Our notice provides information about how we may use and disclose your protected health information. We encourage you to review the notice carefully.

I acknowledge receipt of Yellow Bear Pediatric Dentistry *Notice of Privacy Practices.*

I have read and understand this authorization. I have asked questions about anything that was not clear to me and I am satisfied with the answers I have received.

______________________________	__________________________
Signature of person authorized to sign for patient	*Relationship to patient*
______________________________	____________________
Print Name	*Date*

Office Use Only:
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:
Parent/Guardian refused to sign ☐
Communications barriers prohibited obtaining the acknowledgement ☐
An emergency situation prevented us from obtaining the acknowledgement ☐
Other: