Twinkle Little Star™
Pediatric Dentistry

Grace E. Chin, DDS
NJ Pediatric Dental Specialty # 06080
259 Kinderkamack Road
Westwood, NJ 07675
(201) 358-0800

New Patient Information Form

Name ______________________________________ Date ____________
First Middle Last

How do you wish to be addressed ______________________________

Address ______________________ City ______________ State ________ Zip ________

Cell # ______________ Home phone ______________ Birthdate ____________

Email ______________________ Soc. Security # ______________________

Check Appropriate Box ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If college student, F.T/P.T., name of school ______________________ City ____________ State ________

Patient or parent's employer ______________________ Work phone ______________

Business address ______________ City ______________ State ________ Zip ________

Spouse or parent's name ______________ Employer ______________ Work phone ______________

Whom may we thank for referring you ______________________________

Person to contact in case of an emergency ______________________ Phone ______________

Responsible Party

Name of person responsible for this account ______________________ Relationship to patient ____________

Address ______________________________ Home phone ______________

Driver's license # ______________ Birth Date ______________ Soc. Security # ______________

Method of Payment: ☐ Cash ☐ Credit Card ☐ Check

Email Address: ______________________________

Employer ______________________________ Work phone ______________

Is this person currently a patient in our office ☐ Yes ☐ No

"Helping your child's teeth sparkle,
one smile at a time."

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Insurance Information

Name of insured ______________________ Relationship to patient ______________

Birthdate ______________ Soc. Security # ______________ Date employed ______________

Name of employer ______________ Union or local # ______________ Work phone ______________

Employer address ______________ City ______________ State ________ Zip ________

Insurance Co. ______________ Tel. # ____________ Grp. # ________ Policy/I.D.# ______________

How much is your deductible ______________ How much have you used ______________ Max annual benefit ______________

Do you have any additional insurance ☐ Yes ☐ No If yes, complete the following:

Name of insured ______________ Soc. Security # ______________ Date employed ______________

Name of employer ______________ Union or local # ______________ Work phone ______________

Employer address ______________ City ______________ State ________ Zip ________

Insurance Co. ______________ Tel. # ____________ Grp. # ________ Policy/I.D. # ______________

Ins. Co. address ______________ City ______________ State. ________ Zip ________

How much is your deductible ______________ How much have you used ______________ Max annual benefit ______________

Consent

1. I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.
2. I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.
3. I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.

   ______________________ ______________________

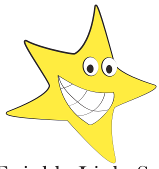
4. My consent to disclosure of records shall be effective until I revoke it in writing.
5. I authorize payment directly to Twinkle Little Star Pediatric Dentistry, LLC or the dentist of insurance benefits, otherwise payable to me.
6. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts.
7. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor.
8. I have read, understand and agree to abide by the Office Policies of Twinkle Little Star Pediatric Dentistry, LLC.
9. I attest to the accuracy of the information on this page.

X______________________________ ______________

Signature of patient (or parent, if minor) **Date**

Print Name (or parent, if minor): ______________________________

"Helping your child's teeth sparkle, one smile at a time."



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Patient's Information: ____
Last | First | Initial | Nickname | Date of Birth

Parent's or Guardian's Name: ____

DOCTOR'S COMMENTS

DENTAL HISTORY - CIRCLE THE APPROPRIATE ANSWER

1. Is this your child's first visit to a dentist? .... YES NO
2. If not, how long since the last visit to a dentist? ______________
3. Were any x-ray or radiographs taken when your child previously visited the dentist? ... YES NO
4. Does your child eat between meals? .... YES NO
5. Does your child eat sweets, such as candy, soda pop, or chewing gum? .... YES NO
6. When does your child brush his/her teeth?
   ☐ Upon arising ☐ After eating any food ☐ Right after meals ☐ Before going to bed
7. How does your child receive Fluoride?
   ☐ Community water (level _____ ppm) ☐ Well water (level _____ ppm)
   ☐ Fluoride drops or tablets ☐ Fluoride rinse or gel
8. Have any cavities been noted in the past? .... YES NO
9. Does your child suck his/her thumb or fingers? .... YES NO
10. Were any teeth (baby or permanent) removed by extraction? .... YES NO
    Was it suggested that the space be maintained .... YES NO
    Was an appliance placed .... YES NO
11. Have there been any injuries to teeth, such as falls, blows, chips, etc.? .... YES NO
    If so describe ______________
12. Has your child had any problem with dental treatment in the past? .... YES NO
13. Has anyone in the family, including parents, had orthodontics? .... YES NO
14. Has your child ever received a local anesthetic? .... YES NO
15. Has your child ever had occlusal sealants? .... YES NO
16. Does your child think there is anything wrong with his/her teeth? .... YES NO

MEDICAL HISTORY

1. Does your child have a health problem? .... YES NO
2. Is your child under care of physician? .... YES NO
   If yes, since when and why? ______________
3. Name of physician ______________
4. Is your child receiving any medication? .... YES NO
   What? ______________
5. Is your child allergic to penicillin, antibiotics or other drugs? .... YES NO
6. Is your child allergic to or sensitive to any metals or latex? .... YES NO
7. Does your child have any other allergies? .... YES NO
8. Has your child had any serious illness? .... YES NO
   When ______________ What ______________
9. Has your child ever had surgery? .... YES NO
10. Does your child have a heart murmur? .... YES NO
11. Is surgery contemplated? .... YES NO
12. Does your child experience severe or prolongated bleeding? .... YES NO
13. Does your child have AIDS or has he/she tested HIV positive? .... YES NO
14. Has your child tested positive for hepatitis? .... YES NO
15. Is your child subject to nervous disorders? .... YES NO
    ☐ Fainting? ☐ Seizures? ☐ Dizziness? ☐ Behavioral/Learning problems?
16. Does your child have frequent headaches .... YES NO
17. Has your child had history of: (Circle appropriate responses) diabetes, heart trouble, asthma, kidney infection, rheumatic fever, epilepsy, cerebral palsy, liver problems, congenital birth defects, mental retardation, eyesight problems, cancer, infections, speech impairments, hearing loss.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN SIGNATURE ______________________ DATE ______________

DENTIST'S SIGNATURE ______________________ DATE ______________

ANEST. MED. ALERT

CHILD DENTAL AND MEDICAL HISTORY

Twinkle Little Star™
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Office Policies

No Show Policy

We expect patients to be present at all scheduled appointments exclusively reserved for them. To avoid a $50 missed appointment/late notice fee, 48-hour notice is required. This fee must be paid before being scheduled again.

Missed Appointments

After two "No Show" appointments (missed appointments without 48-hour notification) you will be subject to dismissal from our practice.

Late Arrivals

Late arrival for a scheduled appointment leads to inadequate time to accommodate the remaining patients on the schedule. Late arrivals of greater then 15 minutes risk not being seen. We will try to accommodate late appointments as time permits; however, those patients who are here at their assigned time will be seen first.

Financial Policy

For those without insurance, full payment is due at the time of service, regardless of who accompanies the patient on the day of his/her appointment. For those with insurance, we file claims as a courtesy to our patients and we gladly accept assignment of benefit payments from most insurance companies. This will reduce your immediate, out of pocket expenditures. However, we will collect the estimated portion of your fee at the time that services are rendered. Keep in mind that this is only an estimate - if there is any difference after your insurance pays, we will contact you and make the proper adjustments.

You are responsible for the timely payment of your account. If your insurance company has not paid your claim in full within 30 days, you will be notified so that you can discuss the matter with your insurance company. If the claim is not paid within 45 days, the balance and all follow-up with the insurance company becomes your responsibility and all remaining balances will be billed to you.

It must be stressed that your insurance is a contract between you, your employer, and the insurance company. Please contact your insurance company prior to your first visit to ensure you have coverage with our office and to review your benefits.

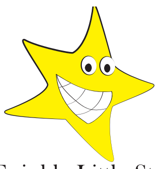
We accept cash, checks and credit cards.

Thank you for reading our Office Policies. Please let us know if you have any questions or concerns. We appreciate the trust and confidence you have placed in us for your child's dental care.

I have read, understand and agree to abide by the Office Policies of Twinkle Little Star Pediatric Dentistry, LLC:

Print Name:____

Signature:____ Date:_____________________________



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Acknowledgement of Receipt of Privacy Practices Notice

Section I: Patient Information

Name: ____

Address: ____

Telephone: ____

Email: ____

Social Security Number: ____

Section II: Acknowledgement of Receipt of Privacy Practices Notice

I, ____,

acknowledge that I have received a Notice of Privacy Practices from Twinkle Little Star Pediatric Dentistry, LLC.

Signature: ____

Date: ____

If a personal representative signs this authorization on behalf of the patient, complete the following:

Personal Representative's Name: ____

Relationship to Individual: ____

Section III: Good Faith Effort to Obtain Acknowledgement of Receipt of Privacy Practices Notice

Describe your good faith effort to obtain the patient's or patient's personal representative's signature on this form:

____

____

____

Describe the reason why the individual would not sign this form:

____

____

____

Section IV: Signature

I attest the above information is correct.

Signature: ____

Print Name: ____

Date: ____

Privacy Policy/HIPAA Compliance

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.

We understand that medical information about you and your health is personal "Protected Health Information" ("PHI") and we are committed to protecting your medical information. PHI includes individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for such health care.

We use and disclose PHI about you for treatment, payment, and health care operations.

Treatment:

We may disclose PHI to your insurance provider, our dentist(s), and other dental care providers for treatment purposes. For example, your dentist may wish to provide a dental service to you but first seeks information from your insurance provider as to whether the service has been previously provided.

Payment:

We disclose your PHI in order to fulfill our duty to check your coverage, determine your benefits, and secure payment for services provided to you. For example, we use your PHI in order to request process of your claims by your insurance provider.

Health Care Operations:

We disclose your PHI as a part of certain operations, such as quality improvement. For example, we may use your PHI to evaluate the quality of dental services that were performed.

We may be asked by the sponsor of your health plan to provide your PHI to the sponsor. If we are asked to do so, we intend to honor such requests unless we are prohibited by law.

We may use or disclose your PHI without your authorization for several other reasons. Subject to certain requirements, we may give out PHI without your authorization for public health purposes, auditing purposes, research studies, and emergencies. We provide PHI when otherwise required by law, such as for law enforcement in specific circumstances, or for judicial or administrative proceedings. In any other situation, we will ask for your written authorization before using or disclosing your PHI. If you choose to sign an authorization to allow disclosure of your PHI, you can later revoke that authorization to stop any future uses and disclosures (other than for treatment, payment, and health care operations).

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and send the new notice to you. You can also request a copy of our notice at any time.

Individual Rights

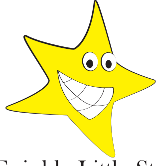
In most cases, you have the right to view or get a copy of your PHI. You also have the right to receive a list of instances where we have disclosed your PHI without your written authorization for reasons other than treatment, payment, or health care operations. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. You may request in writing that we not use or disclose your PHI for treatment, payment, and health care operations except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request but are not legally required to accept it. You also have the right to receive confidential communications of PHI by alternative means or at alternative locations, if you clearly state that disclosure of all or part of your PHI could endanger you.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we have made about access to your records, you may contact the address listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. Customer Service can provide you with the appropriate address upon request.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice. If you wish to inspect your records, receive a listing of disclosures, or correct or add to the information in your record, or if you have any questions, complaints, or concerns, please contact our office.



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DENTAL DESIGNEE FORM

I, _______________________________, (*parent's/legal guardian's name*)
hereby give permission for any and all dental attention to be administered to my child____ (*child's name*)
in the event of accident, injury, routine care, etc. under the direction of the person(s) listed below. I also assume the responsibility for the payment of any such treatment.

- Relative:
  - Name: ____
  - Relationship: ____

- Babysitter or Nanny
  - Name: ____

Signature (Parent/Legal Guardian): ____

Date: ____

NOTE: Designation expires 30 days from the date this form is signed, unless the form is notarized, whereby the designation expires 6 months from the date this form is signed.