

Welcome Kids

We would like to welcome 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!

Tell Us About Your Child

Today's Date: _____

Child's Name: _____
Last First MI

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

Nickname: _____ ☐ Male ☐ Female

School: _____ Grade: _____

Hobbies: _____

Child's Home #: (____) _____ SS #: _____

Child's Home Address: _____
Apt / Condo #

City

State

Zip

General Information

Who is accompanying the child today?

Name: _____ Relation: _____

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

Whom may we Thank for referring you? _____

Other siblings: _____

Previous / Present Dentist: _____ Last Visit Date _____

Dentist's Phone #: (____) _____

Relative or Friend not living with you:

Name: _____ Phone: (____) _____

Address: _____

City

State

Zip

Parent's Information

Who is responsible for account? _____

Parent's Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced ☐ Separated

☐ Father ☐ Mother ☐ Step Parent ☐ Guardian

Name: _____ Birthdate: ____/____/____

Address: (If different than Child's) Hm #: (____) _____

SS #: _____ DL #: _____

Wk #: (____) _____ Ext: _____ Cell/Other #: (____) _____

Email: _____

Employer: _____

Employer's Address: _____

City

State

Zip

If you have Dental Insurance Coverage for the Child, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____

City

State

Zip

Insurance Phone: (____) _____

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

☐ Mother ☐ Father ☐ Step Parent ☐ Guardian

Name: _____ Birthdate: ____/____/____

Address: (If different than Child's) Hm #: (____) _____

SS #: _____ DL #: _____

Wk #: (____) _____ Ext: _____ Cell/Other #: (____) _____

Email: _____

Employer: _____

Employer's Address: _____

City

State

Zip

If you have Dental Insurance Coverage for the Child, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____

City

State

Zip

Insurance Phone: (____) _____

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

Release

I certify that my child is covered by _____ Insurance Co. and I assign all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature of Parent or Guardian

Date

Dental History

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

Has your child ever been prescribed Fosamax or any other bisphosphonate? If yes, when? _____ ☐ Yes ☐ No

Is the child currently in pain? ☐ Yes ☐ No

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

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

Is the child's water fluoridated? ☐ Yes ☐ No

Is the child taking fluoridated supplements? ☐ Yes ☐ No

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

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

Floss his/her teeth daily? ☐ Yes ☐ No

Child's Physician: _____

Phone #: _____ Date of Last Visit: _____

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

Please describe the child's current physical health: ☐ Good ☐ Fair ☐ Poor

Please list all prescription / over the counter or herbal supplement drugs that the child is currently taking: _____

Aside from the items below, please list all drugs/things that the child is allergic to: _____

☐ Yes ☐ No Latex ☐ Yes ☐ No Metals/Nickel ☐ Yes ☐ No Plastic

Medical History

Has the child experienced the following medical problems?

<input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Bleeding / Hemophilia	<input type="checkbox"/> Y <input type="checkbox"/> N Hearing Impairment
<input type="checkbox"/> Y <input type="checkbox"/> N ADD/ADHD	<input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur
<input type="checkbox"/> Y <input type="checkbox"/> N AIDS/HIV+	<input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis
<input type="checkbox"/> Y <input type="checkbox"/> N Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure
<input type="checkbox"/> Y <input type="checkbox"/> N Any Hospital Stays/Operations?	<input type="checkbox"/> Y <input type="checkbox"/> N Hives
<input type="checkbox"/> Y <input type="checkbox"/> N Artificial Bones/Joints/Valves	<input type="checkbox"/> Y <input type="checkbox"/> N Kidney Problems
<input type="checkbox"/> Y <input type="checkbox"/> N Asperger Syndrome	<input type="checkbox"/> Y <input type="checkbox"/> N Liver Problems
<input type="checkbox"/> Y <input type="checkbox"/> N Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N Low Blood Pressure
<input type="checkbox"/> Y <input type="checkbox"/> N Autism	<input type="checkbox"/> Y <input type="checkbox"/> N Lupus
<input type="checkbox"/> Y <input type="checkbox"/> N Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N Measles
<input type="checkbox"/> Y <input type="checkbox"/> N Chicken Pox	<input type="checkbox"/> Y <input type="checkbox"/> N Mitral Valve Prolapse
<input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Defect	<input type="checkbox"/> Y <input type="checkbox"/> N Mononucleosis
<input type="checkbox"/> Y <input type="checkbox"/> N Convulsions	<input type="checkbox"/> Y <input type="checkbox"/> N Prosthetics
<input type="checkbox"/> Y <input type="checkbox"/> N Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic Fever
<input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy	<input type="checkbox"/> Y <input type="checkbox"/> N Scarlet Fever
<input type="checkbox"/> Y <input type="checkbox"/> N Exposed to HIV, but Neg.	<input type="checkbox"/> Y <input type="checkbox"/> N Skin Rash
<input type="checkbox"/> Y <input type="checkbox"/> N Handicaps/Disabilities	<input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis (TB)

Are the child's immunizations current? ☐ Yes ☐ No

Anything you would like to discuss with the Doctor in private? ☐ Yes ☐ No

Please discuss any serious medical problems the child experiences/ed: _____

Does/did the child experience any of the following?

<input type="checkbox"/> Y <input type="checkbox"/> N Breast Fed	<input type="checkbox"/> Y <input type="checkbox"/> N Nursing Bottle Habits
<input type="checkbox"/> Y <input type="checkbox"/> N Chewing on Objects	<input type="checkbox"/> Y <input type="checkbox"/> N Speech Problems
<input type="checkbox"/> Y <input type="checkbox"/> N Clenching/Grinding Teeth	<input type="checkbox"/> Y <input type="checkbox"/> N Thumb/Finger Sucking
<input type="checkbox"/> Y <input type="checkbox"/> N Lip Sucking/Biting	<input type="checkbox"/> Y <input type="checkbox"/> N Tongue/Cheek Biting
<input type="checkbox"/> Y <input type="checkbox"/> N Mouth Breather	<input type="checkbox"/> Y <input type="checkbox"/> N Tongue Thrust
<input type="checkbox"/> Y <input type="checkbox"/> N Nail Biting	<input type="checkbox"/> Y <input type="checkbox"/> N Used Pacifier

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.

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest 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

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

Signature of Dentist

Date

Dentist's Comments: _____

Medical History Update

Has there been any change in your child's health status since their last visit? ☐ Y ☐ N
If Yes, please explain. _____

Parent/Guardian Signature _____ Date _____

Dentist Signature _____ Date _____

Has there been any change in your child's health status since their last visit? ☐ Y ☐ N
If Yes, please explain. _____

Parent/Guardian Signature _____ Date _____

Dentist Signature _____ Date _____



DELAWARE
Star Dental

INSURANCE

Primary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone#: _____

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

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____/____/____ Insured's ID # _____

Insured's Employer: _____

Employer's Address: _____

Secondary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone#: _____

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

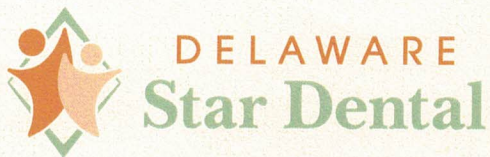
Insured's Name: _____ Relation: _____

Insured's Birthdate: ____/____/____ Insured's ID # _____

Insured's Employer: _____

Employer's Address: _____

Whom may we Thank for referring you? _____



PATIENT AUTHORIZATION FORM

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of test, procedures and financial information. Under the requirements for H.I.P.P.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your dental information, any diagnostic test results and/or financial information released to any family members you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Delaware Star Dental to release my records and any information requested to the following individuals.

1. _____ Relation to Patient: _____
2. _____ Relation to Patient: _____
3. _____ Relation to Patient: _____
4. _____ Relation to Patient: _____

Authorization Regarding Messages (please check all that apply)

____ I authorize you to leave a detailed message on my home or cell number regarding appointments.

____ I authorize you to leave a message with anyone who answers the phone

Patient Name (PLEASE PRINT)

Date

Patient Signature



DELAWARE
Star Dental

FINANCIAL POLICY

Thank you for choosing our office for your superior dental care. We are committed to providing you with the best possible care. We are pleased to discuss our service with you at any time. Your clear understanding of our financial and liability policies is important to our professional relationship. By signing below, you are in agreement with our policies.

Insurance

Insurance is a contract between you and your insurance company. We file claims on your behalf as a courtesy to our patients. We will not become involved in any disputes between you and your insurance company regarding deductibles, co-payments, covered charges, "usual & customary" charges, other than to supply factual information as necessary. You are responsible for a timely payment of your account. Not all necessary services are covered benefits in all contracts. The majority of carriers have a dental maximum that they will pay in any benefit year. Any fees not covered by your insurance company are due at the time of treatment. A dental benefit estimate will be made when services are provided.

Self Pay

If you do not have dental insurance, payment is expected in full at the time of your visit. If a payment plan is necessary, arrangements must be made prior to beginning any treatment. Any balances that extend over 90 days are subject to a monthly finance charge. We accept Cash and Checks, Visa, Mastercard, and Discover.

Cancellation Policy

A minimum of 24 hours notice is required for all cancellations. A charge will be made in the second violation of this policy.

Professional Liability

I understand that dentistry is not an exact science and therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding dental treatment, which I have requested or had been recommended to me. I understand that I have the opportunity to ask any questions prior to any dental treatment.

I have read the above policies and fully understand this agreement.

Patient's Name

Date



DELAWARE
Star Dental

No Show, or Missed Appointment Office Policy

When our staff books your appointment, we are setting aside a dedicated time slot just for you. Your materials are ordered, and we make special arrangements to be ready for your visit. Except for emergency treatment for another patient, you can expect us to be prompt.

We ask that if you must reschedule your appointment, that you please provide us with at least 24 hours notice. This courtesy makes it possible to give your reserved time slot to another patient who would be more than happy to accept.

Delaware Star Dental will charge \$50.00 for not providing us with at least 24 hours notice to cancel an appointment, or any missed scheduled appointments.

Repeated cancellations or missed appointments will result in loss of future appointment privileges.

Name

Date



DELAWARE
Star Dental

PHOTOGRAPH RELEASE FORM

I, _____ give Delaware Star Dental the right to use photographs of me. I authorize Delaware Star Dental to use and publish images in print and/or electronically. I agree that Delaware Star Dental may use such photographs of me with _____ or without _____ my name and for any marketing purpose, including but not limited to publicity, illustration, advertising, brochures, office displays, and web content, etc.

I have read and understand the above:

Signature: _____

Print Name: _____

Date: _____

Witness: _____

Delaware Star Dental

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 (MM/DD/YR) 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.

Payments: We may use and disclose your health information to obtain payment for service 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 the 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 location) 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 nation 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 \$_____ 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 Website 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 practice 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 may submit a written 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: Dawn Flannagan
Telephone: 302-994-3093 Fax: 302-994-5699
E-mail: dawn.drsyed@gmail.com
Address: 5507 Kirkwood Highway, Wilmington, DE 19808

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This form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY/SECURITY PRACTICES DELAWARE STAR DENTAL

**** You May Refuse to Sign This Acknowledgement ****

I, _____, have reviewed and understand this office Notice of privacy Practices. I agree with the policies and procedures outlined and have been given an opportunity to select alternative methods of communication/ payment and/or restricting communication.

(Please Print Name)

(Signature)

(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, 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)**

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