NEW HEIGHTS
PEDIATRIC DENTISTRY
DR. JAS GURAM

WELCOME TO OUR OFFICE

We would like to take this opportunity to welcome you and your child to our office! We appreciate the confidence you have placed in us. We can assure you that your child will be treated with warmth and kindness by our dental team. All efforts of understanding and tender loving care will be given to make our dental office a pleasant place to visit. Please review and complete the following forms as accurate as possible. Thank you!

Health History

General Information

First name- Patient _____ Middle name _____ Last name- Patient _____

Patient birth date _____ Gender _____ Email Address _____

Contact Information

Home # _____ Work # _____ Mobile # _____

Patient mailing address: _____

_____

_____

Patient billing address: _____

_____

_____

Emergency Information

Emergency contact _____ Emergency Number _____

Parent/Guardian Information

HEAD OF HOUSEHOLD _____

MOTHER'S NAME_____ EMPLOYER_____

SS# _____ MOTHER'S CELL PHONE NUMBER _____

MOTHER'S EMAIL ADDRESS _____ MOTHER'S BIRTHDAY _____

FATHER'S NAME _____ EMPLOYER _____

SS # _____ FATHER'S CELL PHONE NUMBER _____

FATHER'S EMAIL ADDRESS _____ FATHER'S BIRTHDAY _____

ACCOUNT INFORMATION

DO YOU HAVE DENTAL INSURANCE _____ IF YES COMPLETE THE FOLLOWING

PRIMARY INSURANCE: NAME OF POLICY HOLDER: _____

BIRTHDATE: _____ POLICY HOLDER'S SS# _____ GROUP # _____

EMPLOYER: _____ INSURANCE CO. NAME_____

MAILING ADDRESS FOR CLAIMS _____

PHONE NUMBER TO CALL FOR CLAIMS QUESTIONS _____

POLICY HOLDER'S RELATIONSHIP TO PATIENT _____

SECONDARY INSURANCE: NAME OF POLICY HOLDER _____

BIRTHDATE: _____ POLICY HOLDER'S SS# _____ GROUP #_____

EMPLOYER: _____ INSURANCE CO. NAME _____

MAILING ADDRESS FOR CLAIMS _____

PHONE NUMBER TO CALL FOR CLAIMS QUESTIONS _____

POLICY HOLDER'S RELATIONSHIP TO PATIENT _____

Dental Information

Has your child been to the dentist? YES / NO

Currently experiencing dental pain or discomfort? YES / NO _____

Problems associated with previous dental treatment? YES / NO _____

Home water supply fluoridated? (city water = yes; well water = no) YES / NO

Medical Information

Allergies

___ Acetaminophen/ Tylenol ___ Animals ___ Aspirin

___ Codeine ___ Erythromycin ___ Fluoride

___ Food ___ Hay fever/ seasonal ___ Ibuprofen/Motrin/Advil

___ Latex ___ Local anesthetic ___ Metals

___ Penicillin/Amoxicillin ___ Sulfa ___ Other

Explain (elaborate on reactions)

_____

Conditions

___ Abnormal/excessive bleeding ___ ADHD ___ Anemia

___ Anxiety ___ Autism ___ Asthma

___ Autoimmune disease ___ Blood Disease ___ Bronchitis

___ Cancer/ Chemotherapy ___ Cardiovascular disease ___ Chronic Pain

___ Damaged heart valves ___ Diabetes ___ Dizziness

___ Eating disorder ___ Epilepsy ___ Hemophilia

___ Gastrointestinal disease ___ Heart murmur ___ Kidney problems

___ Heart rhythm disorder ___ Wheelchair Access ___ Sleep Apnea

___ Pre Medication Required ___ Recurrent Infections ___ Thyroid problems

___ Tuberculosis ___ Tumors or growths ___ Other (please explain)

Is there any other disease or condition that is not listed that you think the dentist should know about?

_____

_____

-Has there been any change to your child's general health within the past year? YES / NO

If yes, what condition is being treated

_____

-Has your child had a serious illness, operation, or been hospitalized in the past 5 years? YES / NO

If yes, what was the illness or problem? _____

-Is your child taking any prescription/ over- the- the counter medicines? YES / NO

If so, please list all, including vitamins, natural or herbal preparations, and/or diet supplements.

_____

-Please list any surgical procedures your child has undergone and when they occurred

_____

-Has any physician or previous dentist recommended antibiotics before treatment? YES / NO

Name of physician or dentist making recommendation _____

Physician's phone number _____

Please read the above, and understand that the information provided in this form is accurate. A truthful health history will help ensure the best possible dental treatment. The information provided here will be used by the doctor and patient to inform any further discussion of the patient's health prior to or during an appointment. By signing below you also acknowledge that you will not hold the dentist, the dental practice, or other member of the practice staff responsible for any action or lack of action because of errors or omissions that may have been made during the completion of this form.

Patient HIPAA Consent

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This provides a safeguard to my privacy. What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other that office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient record, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access the PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Informed Consent for Pediatric Dental Treatment

- One of the most important parental policies is to "inform before we perform." Before we begin treating your child, we ask your permission for dental examinations, x-rays, dental cleanings, and fluoride application. We also need your permission to perform dental treatments, restoration, and/or appliances as needed to return all teeth to health and proper function. The purpose of all these procedures is to gain and maintain dental health, and we expect good results, although no guarantees as to the results may be given.

- Although our goal is the best oral health for your child, there are some slight risks involved in getting to that goal. Very rarely, dental treatment may be associated with numbness, bleeding, discoloration, soreness, upset stomach, dizziness, allergic reaction, swelling, and infection. But ignoring a known dental problem has an even greater risk. Not treating existing dental problems in children may result in abscess, infection, pain, fever, swelling, considerable risk to the developing adult teeth, and may create future orthodontic and gum problems.

- A visit to the dental office presents the young child with lots of new and unfamiliar experiences. It is completely normal for some children to react to these new experiences by crying. All efforts will be made to gain the confidence and cooperation of our young patients by warmth, humor, gentle understanding and friendly persuasion. High quality dental care for children is our goal. Quality care can be made very difficult or even impossible by the lack of cooperation. Behaviors that can interfere with proper dental treatment are hyperactivity, resistive movements, refusing to open the mouth or keep it open and even aggressive or physical resistance to treatment. Aggressive or physical resistance to treatment can be screaming, hitting, kicking, and grabbing the dentist's hand or grabbing her sharp dental instruments.

-There are several behavior management techniques that are used in our office to help children get the quality dental care they need:

- **Tell-Show-Do** is the use of simple explanations and demonstrations, geared to the child's level of maturity.
- **Positive Reinforcement** is rewarding the helpful child with compliments, praise, or a prize.
- **Voice Control** is getting the attention of a noisy child by using firm commands and varying tones of voice.

✔ I have read and understand this information on behavior management.

✔ I understand that dental treatment for children includes effort to guide their behavior by helping them to understand the treatments in terms appropriate to their age.

✔ If any treatment other that the above is needed, it will be discussed with me before beginning such treatment.

✔ I understand that I may refuse any or all of the above treatments or procedures. I can do this by drawing a line through the objectionable part and signing my initial next to the portion to which I refuse to consent.

Appointment Policies

At New Heights Pediatric Dentistry, we understand your time is valuable! As a private practice, we hope to maintain the feeling that you are not rushed during your appointment, receive personalized care, and are not just another patient in a big, busy, chaotic, corporate practice. To maintain this level of care, we are reinforcing our appointment policy:

- Children have very short attention spans, because of this our appointments are scheduled at 30-40 minute intervals. If you are 15 minutes late to your appointment, it may be necessary to reschedule your appointment. Every effort will be made to still accommodate seeing your child, however at 15 minutes late, half the appointment time has been missed and we reserve the right to reschedule.
- Children 4 years old and younger are seen before 1:00pm; children 5 and older can be seen anytime during the day.
- We would like to see all school-age patients after school, but that is not always possible. Therefore, after school appointments will be given on a first come first served basis. Please know your child will always be given a school excuses absence form from our office if they are seen during school hours.
- If for any reason you are unable to keep your scheduled appointment, we kindly ask that you contact our office 24 hours prior to the appointment time. If you do not call or come for an appointment this will be considered a “No Show” and a fee of $25.00 will be charged to your account. After a third “No Show” appointment, you will be required to pay a $25.00 reservation fee per child, before scheduling another appointment. When the reservation fee is received, we can then schedule your next visit; if you miss the appointment after paying your reservation fee you will forfeit the $25.00 deposit. If you come for the scheduled appointment after you have paid a reservation fee, the $25.00 credit will be applied to that day’s visit.

Financial Policies

If you have dental insurance, you will be asked to provide all necessary information that will enable us to file a claim with your company as well as a copy of your insurance card. Upon arrival in our office, we will contact your insurance company to verify coverage. If we are unable to verify dental coverage you will be asked to pay all fees prior to leaving the office.

We will be happy to file a claim with your insurance company at each visit. **However, you are ultimately responsible for the account, not your insurance.** We are not a "provider" for any insurance company so we do not accept "co-payments" in our office. You will be responsible for paying the portion insurance does not cover at the time of your appointment. On the average, this will include your deductible, approximately $50.00 per child per year, 20% of the fee for services, and nitrous oxide (laughing gas), if it is used on your child. Most insurance companies do not cover nitrous oxide. If you have more than one insurance company, we will file the primary insurance the day following the visit and your secondary will be filed when payment from the primary has been received. Secondary insurance companies will not pay until we can provide proof of payment from the primary insurance company. We are unable to file third party insurance. If payment from your primary insurance carrier is not received in 30 days you will be expected to pay the balance on your account regardless of outstanding insurance status. Filing with your insurance company is a courtesy we are happy to provide however collecting unpaid claims from your company is not our responsibility.

All fees in our office are the responsibility of the parent or guardian regardless of insurance coverage. Any account with an outstanding balance 90 days following the date of service will automatically be turned to a professional agency for collection. The fee for collection services can range from $15.00 to $80.00 depending on the course of action necessary to collect the account. These fees are added to your account to offset legal expenses incurred.

Photo Release for Minors (if Under 18)

New Heights Pediatric Dentistry has my permission to use my or my child's photograph publicly to promote their practice and profession. I understand that the images may be used on websites and social media including the New Heights Pediatric Dentistry Instagram and Facebook account. I also understand that no royalty fee or other compensations shall become payable to me by reason of such use.

☐ I do NOT give my permission to use my or my child's photograph

---

Please sign below that you understand the previous forms, accept our office policies, and all information provided is accurate to the best of your knowledge.

Parent/Guardian Name (please print): _____

Parent/Guardian Signature: _____

Date: _____