Tiny Sparkles Pediatric Dentistry

164 Main Street, Port Washington, NY 11050
(516) 888-9789
www.TinySparkles.com
info@tinysparkles.com

Please fill out this form as completely as possible. If you have any questions, we will be happy to help.

Child's Info: Last: _____ First: _____ MI: ___ Birthdate: _____

Parent Information

☐Mother's ☐Father's Name: _____ ☐Mother's ☐Father's Name: _____

DOB: ____/____/_____ Home #: _____ DOB: ____/____/_____ Home #: _____

Work #: _____ Cell #: _____ Work #: _____ Cell #: _____

Home Address: _____ Home Address: _____

City: _____ State: ____ Zip: _____ City: _____ State: ____ Zip: _____

SSN: _____ Occupation:_____ SSN: _____ Occupation:_____

Email: _____ Email: _____

Parents' Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other:_____

Primary Dental Insurance

Person Responsible for Account: _____

Insurance Company Name: _____

Insurance Company Phone#:_____

Policy Holder ID #:_____

Group #:_____ Group Name:_____

Policy Owner's Employer: _____

Secondary Dental Insurance

Person Responsible for Account: _____

Insurance Company Name: _____

Insurance Company Phone#:_____

Policy Holder ID #:_____

Group #:_____ Group Name:_____

Policy Owner's Employer: _____

*Most insurances offer 100% coverage for preventative care; and 50-80% for restorative or other advanced procedures. Please contact your insurance company directly for your policy's specific coverage.

* First time patients, please bring your dental insurance card to office, or email copies of both sides in advance of appointment.

How Did You Hear About Us? (Please List Name)

☐Referred by Doctor _____ ☐Google ☐Yelp ☐ Facebook

☐Family/Friend _____ ☐Local Newspaper ☐Flyer/Postcard

☐Insurance Company: _____ ☐Nassau Parent ☐Walked/Drove By

☐Daycare/School Visit: _____ ☐ Other_____

Individuals Authorized to Bring My Child to Subsequent Visits:

Name: _____ Phone: _____

Name: _____ Phone: _____

I certify that my child is covered by the above insurance company and I assign directly to Tiny Sparkles Pediatric Dentistry all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefit. In the event I am unable to bring my child in for an appointment, the individuals above have my permission to accompany my child and make any necessary decisions for my child's care. This includes consent to any necessary treatment plan changes. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____ _____

Date Signature of Parent/Guardian

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We are excited to welcome you and your family to our practice. We look forward to working with you to maintain your child's oral and dental health. Please fill out this form as completely as possible. If you have any questions, we will be happy to help.

Today's Date: _____/_____/_____

Dental History

Child's Name: _____
Last First MI

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

Nickname: _____ ☐ Male ☐ Female

Favorite TV Program: _____

Is this your child's first visit to the dentist? ☐ Yes ☐ No

Reason for today's visit: _____

If not, who was the previous dental care provider for your child?

Doctor: _____ Phone: _____

When was your child's last exam? _____

When were x-rays last taken? _____

If x-rays were taken, please ask previous office to email all records to **info@tinysparkles.com**

Require a pre-medication beforehand? ☐ Yes ☐ No

Has your child had a history of the following, and if so, when did they stop?

☐ Bedtime bottle ☐ Fluoride Vitamins ☐ Pacifier
☐ Breast feeding ☐ Iron Supplements ☐ Sleep Apnea
☐ Bottled water ☐ Mouth breathing ☐ Snoring
☐ Thumb sucking ☐ Fingernail biting
☐ Other habit: _____

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

Is the child taking fluoridated supplements? ☐ Yes ☐ No

Do you use well water or live in a non-fluoridated area?

☐ Yes ☐ No

What type of multivitamins does your family use, if any?

☐ Chewable ☐ Gummy ☐ Liquid Drops ☐ None

Does your child use:

☐ Floss/Flossers ☐ Fluoride Rinse ☐ Liquid Drops

How frequently does your child floss?

☐ Daily ☐ Frequently ☐ Infrequently ☐ Never

Please list any additional questions, concerns, or comments:

_____

Health History

Child's Physician: _____

Physician Phone: _____

Date of last physical exam: _____

Ever been hospitalized? ☐ Yes _____ ☐ No

Vaccinations up to date? ☐ Yes ☐ No

Ever had surgery? ☐ Yes: _____ ☐ No

Please list any unlisted significant medical issues/allergies:

_____

_____

Does your child have any allergies?

☐ Yes: _____ ☐ No

Preferred Pharmacy: _____

Pharmacy Phone: _____

Any adverse reactions to medications? ☐ Yes ☐ No

If yes, please list medication: _____

Please list all medications and dosages:

_____

_____

Has the child ever had any of the following conditions?

☐ Abnormal Bleeding
☐ ADD/ADHD
☐ Anemia
☐ Asthma
☐ Autism/Asperger's/PDD
☐ Cancer
☐ Cerebral Palsy
☐ Cleft Palate/Lip
☐ Congenital Heart Defect
☐ Convulsions/Epilepsy
☐ Diabetes
☐ Exposed to HIV, but Neg
☐ Headaches
☐ Hemophilia
☐ Hepatitis
☐ HIV/AIDS
☐ Jaw Problems TMJ/TMD
☐ Kidney/Liver Problems
☐ Measles
☐ Metabolic Disorder
☐ Mononucleosis
☐ Rheumatic Fever
☐ Sensory Issues
☐ Sickle Cell Disease/Traits
☐ Skin Rash
☐ Tuberculosis (TB)
☐ Ulcerative Colitis
☐ Other: _____

I understand that the information that I have given is correct to the best of my knowledge, that 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.

_____ _____
Date Signature of Parent/Guardian

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OFFICE POLICIES

FEES AND PAYMENT POLICIES

In an effort to make needed services more affordable, payment for professional services is due at the time dental treatment is provided. If you have insurance, then your estimated co-payment is due as service is rendered. If an account shows an overdue balance, future treatment may be delayed until balance is cleared. We accept cash, Visa, MasterCard, Discover and American Express.

APPOINTMENTS

We ask for your utmost courtesy regarding your scheduled appointments. Please allow 24 hours prior to the appointment time if you must cancel or reschedule. We understand unforeseen business and personal emergencies do occur; however, repeated last minute cancellations and broken appointments will incur a charge of $50. Most insurance companies will not reimburse the cost of a missed appointment.

ABOUT INSURANCE

Fact 1 – No insurance pays 100% of all procedures. Dental insurance is only meant to be an aid in receiving dental care. Many patients think that their insurance pays 100% of all dental fees. This is not true. Most plans only pay between 50-80% of the average total fee. Your employer has determined the amount of coverage according to the contract set up with the insurance company.

Fact 2 – Benefits are not determined by our office. Insurance companies often state that the dentist's fee has exceeded the usual, customary, or reasonable fee (UCR). This statement is very misleading and inaccurate.
The insurance company gathers data and arbitrarily chooses a level they call "allowable" UCR fee. The data is usually 3 to 5 years old, and the "allowable" fees are set by the insurance company so they can make a profit. Most dentists' fees are higher than what the insurance company considers and average fee.

Tiny Sparkles Pediatric Dentistry is a preferred provider for several insurance companies. It is the policyholder's responsibility to: ensure coverage is intact; understand certain insurance companies require an annual deductible be met; understand their maximum annual deductible; and, understand that not all procedures will be paid 100% by the insurance company.

We are pleased to bill the insurance providers directly – as long as we have been supplied with all the necessary subscriber information. Without the necessary insurance information, we cannot submit claims to them, and will therefore require payment in full at the time of service. An estimated co-payment is requested at each appointment as service is rendered.

If the office does not participate with your family's respective dental insurance plan, the office will still be happy to see your child and work with your family's dental insurance plan! Please speak to our office for details.

Please understand that we file dental insurance as a courtesy to our patients. We do not have a contract with your insurance company, only you do. We are not responsible for how your insurance company handles its claims or for what benefit they pay on a claim. We can only assist you in estimating your portion of fees for treatment. We at no time guarantee what your insurance will or will not do with each claim. We cannot be responsible for the accuracy of any insurance information. Your insurance company representative has provided this information to us. It is your responsibility to be familiar and understand your insurance policy and terms.

You are responsible for payment of any balance due not paid by your insurance company, including any unpaid deductible amounts or if your plan only allows one fluoride application per year, etc.

*The parent who brings the patient in for treatment is responsible for all fees incurred at the time of services are rendered. We cannot send statements to others/other parents.

I hereby state that I have read and understand the above conditions of treatment and payment and agree to the policies of Tiny Sparkles Pediatric Dentistry, PLLC.

Date: _____ Signature: _____

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Child's Name: Last: _____ First: _____ MI: ___ Birthdate: _____

CONSENT FOR TREATMENT

TREATMENT

I am aware that dental treatment will be rendered by the doctors of Tiny Sparkles Pediatric Dentistry - licensed practitioners in the specialty of pediatric dentistry, as well as trained dental auxiliaries. I consent to treatment as indicated by sound and prudent dental practices that are diagnosed or discovered during the course of my child's dental care. The nature and purpose of the treatment to be rendered will be explained to me and no guarantee will be made that the results will be to my complete satisfaction although it is believed that such results will be satisfactory.

I agree to the use of topical and local anesthetic agents as indicated for my child's dental treatment, if warranted. I further consent to the taking of radiographs (x-rays), photographs, and impressions when they are indicated for the purpose of diagnosing and planning treatment. I understand the office employs the use of digital radiography, and adopts the philosophy "As Low As Reasonably Achievable (ALARA)" in its approach to dental x-rays in children. I expressly agree that the office may use such materials for educational and scientific purposes including seminar instruction, publication of literature, and demonstration of methods and techniques of pediatric dentistry. I understand that suitable measures will be taken to maintain my child's anonymity. I understand that all original dental records are the property of Tiny Sparkles Pediatric Dentistry and cannot be taken or sent from this office. Copies of dental records will be provided upon written or verbal request of a dentist, physician, parent, or legal guardian.

BEHAVIOR MANAGEMENT TECHNIQUES

Tell-Show-Do
Tell-show-do is a technique used with children to explain what is expected at each visit. It is the most commonly used approach used at our office. The doctor will **tell** the child what will be done, **show** children how it will be done, and then **do** what has been explained to children. Praise is used to reinforce the child's cooperative behavior.

Voice control
Voice control is a method used for a child who is capable of understanding, but is not listening to requests. The attention of a child is gained by changing the tone or increasing the volume of the dentist's voice **without** getting angry with the child. Praise is used to support the child's attention to the dentist.

Restraint
Active: Active restraint by parent or dental personnel protects the child from injury during a dental procedure. The parent, dentist, or assistant helps hold a child's head, arms, or legs to prevent harmful movements during treatment.
Passive: Passive restraint with a pedi-wrap is sometimes used to prevent injury to an uncooperative child and to enable the dentist to provide the necessary treatment. The pedi-wrap is mainly used for young children that require emergency treatment, especially seen in hospital emergency rooms to provide care such as suturing lacerations.

Nitrous oxide
Nitrous oxide (laughing gas) is administered to the anxious child through a small breathing mask, which is placed over the child's nose. This allows the child to relax during the procedure, but does not "put the child to sleep". After the mask is removed, the effects of the gas wear off in approximately 5 minutes through breathing with 100% oxygen (what is seen in football games.)

Sedation/operating room
If we are unable to gain your child's cooperation with the following procedures, the doctors of Tiny Sparkles Pediatric Dentistry may recommend treatment under sedation or general anesthesia. This is a separate appointment and will be discussed further if and when it is recommended for your child.

I hereby state that I have read and understand all of the above information and give my written and implied consent for my child to be treated by Tiny Sparkles Pediatric Dentistry, PLLC.

Signature: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that my child has rights to privacy regarding his or her protected health information. These rights are provided under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) which went into effect on April 14, 2003. I understand that by signing this consent I authorize Tiny Sparkles Pediatric Dentistry and their staff to use and disclose my child's protected health information to carry out:

- Conduct, plan, and direct my or my child's treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications

I have received, read, and understood your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used, or disclosed, to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient name: _____ _____ ____ _____
Last First MI Birthdate

Relationship to patient: _____

Signature: _____ Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices, but was unable to do so as documented below.

Date:	Initials:	Reason: