Rashmi Ambewadikar, DDS

PATIENT INFORMATION

Last Name_____First Name_____

Gender_____ Date of Birth_____

Address_____ Apt#_____

City_____State_____Zip_____

Emergency Contact: Name _____Phone_____Relation to Patient_____
(Other than yourself)

PARENT OR GUARDIAN INFORMATION

Relationship to patient: Relationship to patient:

_____ _____

1. Name_____ 2.Name_____

Date of Birth _____ Date of Birth_____

Social Security # _____ Social Security # _____

Cell Phone # _____ Cell Phone # _____

*Email_____ *Email_____

DENTAL INSURANCE INFORMATION

Primary Insurance Secondary Insurance

Company_____ Company_____

Policy/Group #_____ Policy/Group #_____

Member ID #_____ Member ID #_____

Relation to Patient _____ Relation to Patient _____

How did you hear about our office?_____

ASTORIA SMILES
PEDIATRIC DENTISTRY

Rashmi Ambewadikar, DDS

MEDICAL HISTORY

Is your child in good health?: Yes_____ No_____

Name of Pediatrician_____Pediatrician's Phone _____

Office/Clinic/Hospital_____

Date of Last Exam_____ Has your child ever had a health problem: Yes_____ No_____

Is your child allergic to anything?_____

Is your child currently taking any medications? (please give medication, dose, and reason):

_____

Please check if your child has been or is being treated for any of the following:

_____Yes _____No Asthma
_____Yes_____No Reactive Airway
_____Yes_____No Bleeding disorders
_____Yes_____No Diabetes
_____Yes_____No Heart Murmur
_____Yes_____No Liver/ GI Disease
_____Yes_____No Anemia
_____Yes_____No Kidney Disease
_____Yes_____No Rheumatic Fever
_____Yes_____No Recurrent Headaches
_____Yes_____No Frequent Infections
_____Yes_____No AIDS/HIV
_____Yes_____No Seizures
_____Yes_____No Significant Infections
_____Yes_____No Eyesight
_____Yes_____No Endocrine/Growth
_____Yes_____No Hepatitis
_____Yes_____No Speech/Hearing
_____Yes_____No Cerebral Palsy
_____Yes_____No Cleft Lip/Plate
_____Yes_____No Cancer/Tumors
_____Yes_____No Congenital Birth Defects
_____Yes_____No Adverse Drug Reaction
_____Yes_____No Mental Delays
_____Yes_____No Developmental Delays
_____Yes_____No ADHD
_____Yes_____No Autism
_____Yes_____No Personality/Social
_____Yes_____No Other_____

Please explain any item marked YES _____

Parent or Guard Signature_____ Date_____

Reviewed by_____ Date_____

ASTORIA SMILES
PEDIATRIC DENTISTRY

Rashmi Ambewadikar, DDS

REQUEST AND CONSENT FOR PEDIATRIC DENTAL TREATMENT
ASTORIA SMILE PEDIATRIC DENTISTRY

Please read form *carefully!* If you do not understand something to your satisfaction, please ask questions. We will be happy to explain it!

1. I request and authorize the treatment and procedures for:_____
   (patients name)
2. I request and authorize the taking of digital x-rays and the use of such anesthetics as may be considered necessary to treat the patients's dental problem(s). X-rays may be considered necessary by Dr. Ambewadikar to diagnose and/ or treat my child's discomfort, abscess growth, development and detection of dental caries, and any abnormalities.

3. I **understand** that usual risks or complications may occur with the planned treatment and procedures. These risk include, but are not limited to, the possibility of pain or discomfort during the treatment, swelling, infections, bleeding, injury to adjacent teeth and surrounding tissue, development of a temporomandibular joint disorder, temporary or permanent numbness, and allergic reactions.

4. I **understand** that during the course of the patient's treatment, something unexpected may arise that might necessitate procedures in addition to or different from those listed on the patient's TREATMENT PLAN, and that I will be consulted *prior to initiation of treatment procedures* not listed. I am aware that the practice of dentistry is not an exact science and acknowledge that no guarantees have been made to me concerning the results of the dental treatment that the patient receives at **Astoria Smiles.**

5. I **understand** that treatment for children include efforts to guide their behavior by helping them to understand the treatment in terms that are appropriate for their age. Behavior will be guided using praise, explanation, demonstration of procedures and instruments, and using variable voice tones.

6. I **understand** that if the patient becomes uncooperative during dental procedures with movement of the head, arms and/ or legs, dental treatment cannot be **safely** provided. During such disruptive behavior, it may be necessary for the assistant(s) to hold the patient hands, stabilize the head, and control leg movements.

7. For the purpose of advancing medical-dental education, I give permission to the use of clinical dental photographs of the patient for diagnostic, scientific, and educational purposes.

8. I **understand** that I may revoke this consent to treatment at any time and that no further action based on this consent will be initiated, except to the extent that treatment and procedures have already been performed or initiated.

9. I **confirm** that I have read(or read to me) and understood this form, and that all blanks were filled in and all inapplicable paragraphs, if any, were stricken before I have signed below.

Parent/Guard Signature_____ Date_____

Witness Signature_____ Date_____

ASTORIA SMILES
PEDIATRIC DENTISTRY

Rashmi Ambewadikar, DDS

FINANCIAL POLICY

1. Full payment is due at the time of service. All methods of payment are accepted, **excluding personal checks.**

2. I authorize payment of dental benefits directly to the dentist. I further authorize the release of any information necessary to process these dental claims. I understand that I am financially responsible for all deductibles, co-payments, and non-covered services that have not been paid by my dental insurance plan. I am aware that eligibility is not a guarantee of coverage, as actual benefit payments are determined only when a claim is received and finalized.

3. It is the policy of this office to bill for any missed appointments unless given a 48 hour notice. Cancellations with less than a 48 hour notice are considered missed appointments. Appointment changes must be made directly through the office. I understand that unless I give such notice, I will be charged **$25.00 fee for general appointments** and **$50.00 for Operative Treatment appointments**. Providing advance notice allows other children who may have been waiting for an appointment the opportunity to be seen.

4. Please be advised that it is your responsibility to know your eligibility and coverage status with your dental insurance. It is your responsibility to notify our office if there has been any change to your dental insurance. Non payments due to inactive status will result in full responsibility of payments(s) due by your behalf.

Patient/Guardian Signature_____ Date _____

Witness Signature_____ Date_____

ASTORIA SMILES
PEDIATRIC DENTISTRY

Rashmi Ambewadikar, DDS

SOCIAL MEDIA CONSENT

I consent that **ASTORIA SMILE PEDIATRIC DENTISTRY** may use photographs or videos of me or my child on their social media tools which include, but not limited to, Facebook, Twitter, Yelp, and Instagram pages. I understand that these images and/ or videos will not be used for any other commercial purpose. I can revoke this permission at any time and request to have any photo/video that was posted to be removed at any time.

☐ I give consent for my child's photographs or videos to be posted on Astoria Smiles social media only.

☐ I do not give consent for my child's photographs or videos to be posted on Astoria Smiles social media.

Patient/Guardian Signature_____ Date _____

Witness Signature_____ Date_____

HIPAA 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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care options (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is –information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information 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, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law. **Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. **Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected information be disclosed to the health plan to obtain approval for the hospital admission. **Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. Fro example, we may disclose your protected health information to medical school students that see patient at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of an appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners: Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosure: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with requirements of Section 164.500. **Other Permitted and Required** Uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law. **You may revoke this authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Signature_____**Date**_____