Dear Parent,

WELCOME TO OUR PRACTICE! Your initial visit is an important one- a time for us to get to know each other. Your child's introduction to dentistry in our office will be done with a fun, positive approach.

You can help us make your child's first visit a successful experience. Please feel at ease and relaxed, as any anxiety on your part will be transferred to your child. Tell your child that we will count his/her teeth and show him/her how to brush. Please avoid any mention of fear-provoking terms such as hurt, shot, drill, and needle.

Parents will be asked to accompany children under 4 into the treatment area. If your child is older, we may request that your child come into the treatment area alone, or if you are present, we ask that you join your child as a "silent partner" and stand at the back of the treatment room. This allows us to establish a direct relationship with your child.

Enclosed you will find a registration form that we ask you to complete and bring with you for the first visit or return to us by mail. This information gives us a better understanding of your child's overall health.

Your aim as a parent, and ours as a pediatric dental team, is the same- to keep your child's teeth and mouth in good health and to make the process of doing so pleasant for all. We look forward to meeting you and your child, and welcome any comments or suggestions you may have.

Sincerely,

Dr. Kristine Grazioso and Staff

South Shore Children's Dentistry
Kristine A. Grazioso, D.M.D.
Mina M. Schafft, D.M.D.

Reviewed by:

Dr.
Date

PATIENT INFORMATION

Child's First and Last Name_____ Nickname_____
D.O.B._____ Sex: Male____ Female____ Telephone#: (____)_____
Mailing Address: Street_____
City_____ State_____ Zip Code_____

Mother's Name_____ D.O.B._____ S.S.#_____
Employed by_____ Occupation_____
Business #: (____)_____ Cell#: (____)_____
E-mail address_____

Father's Name_____ D.O.B._____ S.S.#_____
Employed by_____ Occupation_____
Business #: (____)_____ Cell#: (____)_____
E-mail address_____

Marital Status:____ Married ____ Single ____ Divorced ____ Widowed ____ Other
Child Lives With: ____ Both Parents____ Mother____ Father ____ Other
*All office correspondence will go to the address where the child resides.

Name and Age of Siblings:_____

Who may we thank for referring you?_____

Child's Pediatrician_____ Date of last visit_____
Address_____
Phone# (____)_____

Child's Previous Dentist_____ Date of last visit_____
Address_____
Phone# (____)_____

DENTAL INFORMATION

Reason(s) for seeking dental care:

_____First examination
_____Routine check-up
_____Toothache or swelling
_____Second Opinion
_____Accident
_____Other_____
_____Appearance of teeth
_____Consultation

Do you have any concerns or issues regarding your child's dental health that you would like addressed?

_____

Has your child had any negative dental experiences?_____ If yes, please explain_____

_____

How do you expect your child to react to the visit today?
_____Excellent _____Good _____Fair _____Poor _____Don't know

Please check any of the following that may describe your child: ___Outgoing ___Shy
___ Cooperative ___Anxious ___ Stubborn ___ Trusting ___ Friendly ___Moody

Does your child receive fluoride in any of the following forms?
___ In Vitamins ___In Water Supply ___ Drops/Tablets ___ Rinse/Gel

Does your child brush daily? ___ Yes ___ No
Does an adult assist with the brushing? ___ Yes ___ No
Does your child use dental floss? ___ Yes ___No

Does your child have any of the following habits?
___ pacifier ___ thumb sucking ___ finger sucking ___ bottle with milk or juice in bed
___ teeth grinding ___ mouth breathing

Have your child's teeth ever been injured? ___ Yes ___ No
If yes, at what age? _____ Which teeth? _____
Cause? _____ Treatment received? _____

MEDICAL INFORMATION

Is your child being treated for any condition presently? ___ Yes ___ No
If so, explain _____
Is your child taking any medications? ___ Yes ___ No

Drug	Reason

Has your child ever had an allergic or unusual reaction to a medication or drug? ___ Yes ___ No
If yes, explain _____
Does your child have any allergies to the following?
___ Latex ___ Foods ___ Food Dyes ___ Other

Has your child ever been hospitalized? ___ Yes ___ No
If so, explain _____
Has your child had any surgery? ___ Yes ___ No
If so, explain _____
Was general anesthesia used? ___ Yes ___ No
Were there any complications? _____

Are your child's immunizations current? ___ Yes ___ No

Has your child ever been diagnosed with a heart condition that requires antibiotics prior to dental treatment? ____ Yes ____ No

If yes, explain _____

Does your child have any history of the following diseases or conditions?

YES	NO	
☐	☐	Allergies to Medication/Food/Other
☐	☐	Anemia or Blood Disorder
☐	☐	Arthritis
☐	☐	Asthma
☐	☐	Attention Deficit Disorder
☐	☐	Autism
☐	☐	Behavioral Disorder
☐	☐	Bladder Conditions
☐	☐	Blood Transfusions
☐	☐	Birth Defects
☐	☐	Bone or Joint Problems
☐	☐	Brain Injury
☐	☐	Bruising Easily
☐	☐	Cancer or Malignancies
☐	☐	Cerebral Disorder
☐	☐	Child Abuse
☐	☐	Chronic Adenoid/Tonsil Infection

YES	NO	
☐	☐	Chronic Headaches
☐	☐	Chronic Ear Infections
☐	☐	Cleft Lip/Palate
☐	☐	Convulsions/Seizures
☐	☐	Diabetes
☐	☐	Downs Syndrome
☐	☐	Emotional Disturbance
☐	☐	Epilepsy
☐	☐	Excessive Bleeding Problem
☐	☐	Excessive Gagging
☐	☐	Fainting or Dizziness
☐	☐	Growth & Development Problems
☐	☐	Hearing/Speech Problems
☐	☐	Heart Disease
☐	☐	Heart Murmur
☐	☐	Hemophilia
☐	☐	Hepatitis or Liver Disease

YES	NO	
☐	☐	Hyperactivity
☐	☐	Immune Disorders (AIDS, ARC, HIV)
☐	☐	Kidney Disease
☐	☐	Leukemia
☐	☐	Mental Retardation
☐	☐	Neurological Problems
☐	☐	Nutritional Deficiency
☐	☐	Oral Ulcers
☐	☐	Orthopedic Problems
☐	☐	Premature Birth
☐	☐	Rheumatic Fever
☐	☐	Scoliosis
☐	☐	Sickle Cell Anemia
☐	☐	Spina Bifida
☐	☐	Syndrome _____
☐	☐	Tuberculosis
☐	☐	Visual Impairment
☐	☐	Other _____

MEDICAL HISTORY UPDATE

(For future health changes)

DATE	NO CHANGE	CHANGES	PARENT SIGNATURE

Insurance Information

For those patient covered by dental insurance

Subscriber's Name:_____ Subscriber ID#:_____

Subscriber's DOB: _____ Subscriber's Employer:_____

Insurance Co. Name:_____ Group #: _____

Insurance Address:_____

Insurance Phone #:_____

Financial Information, Terms and Conditions

This statement is to inform you of our financial policy. We are committed to providing your child with the highest quality dental care using only the best material available in dentistry today in a child-friendly environment. Our financial policy is intended to facilitate excellent service to you while minimizing our administrative costs.

As a condition of treatment by this office, fees must be paid at the time the service is performed. All charges you incur are your responsibility regardless of your insurance coverage. **We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company**. As a courtesy to you, we will help you process all your insurance claims. This office will accept assignment of benefits providing you pay all co-payments and patient deductibles at the time of the visit. Any insurance payment not received in 45 days from the date of service will be charged to your account. We accept no responsibility in collecting overdue insurance claims or negotiating settlement on disputed claims.

Payment of your portion of the charges, whether a part of or the total amount, is due on the date of service, unless other specific arrangements have been made prior to treatment. Our office accepts cash, personal checks, MasterCard, and Visa. Returned checks are subject to a $35.00 fee. Balances over 60 days old become the sole responsibility of the patient, even if insurance benefits are expected. Additionally, our office will charge you for broken appointments and appointments cancelled without 24-hour advance notice a fee of $50.00.

By signing below, I understand and agree to the terms described herein and agree to accept responsibility for the payment of services. I agree to pay all costs incurred by my failure to remit for services rendered, including fees charged by a collection agency. I grant my permission to you, or your assigns, to telephone me at home or at my work to discuss matters related to this form. Furthermore, I authorize the dental benefits otherwise payable to me to be paid directly to Dr. Kristine A. Grazioso. **I have read the above conditions of treatment and agree in content:**

_____ _____

Parent/Guardian Signature Date

Consent for Treatment

I hereby give my consent to Kristine A. Grazioso, DMD and Staff to treat my child which may include the following dental procedures: complete dental examination (check-up), prophylaxis (cleaning), fluoride treatment, radiographs (x-rays), sealants, study models, and other diagnostic/preventative aids deemed necessary by Dr. Grazioso or her staff to make a thorough diagnosis of my child's dental needs.

I authorize Dr. Kristine Grazioso and staff to provide any information to other Doctors (Physicians, Dentists, etc.) for the purpose of consultation. I understand that prior to providing any treatment I will be advised about such treatment, that I may ask questions concerning the treatment, and that I may revoke this consent BEFORE treatment is provided.

Parents/Guardians: For future appointments, if you are planning to send your child with someone other than a parent/legal guardian, please provide the following information:

Name of authorized person(s) to accompany my child for future treatment visits:

1. Name: _____ Relationship to Child:_____
2. Name: _____ Relationship to Child:_____
3. Name: _____ Relationship to Child:_____

_____ _____

Parent/Guardian Signature Date

Kristine A. Grazioso, DMD PC

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 April 14, 2003, 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.

Payment: We may use and disclose your health information to obtain payment for services 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 this 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 locating) 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 national 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. 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 $0.50 for each page, $75 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, dating back to October 6, 2000 or for the last 6 years whichever is the lesser time, 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 Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.