Dental Smiles for Kids

Welcome

Astoria Office Phone: 718-278-1700	**Centereach Office** Phone: 631-585-6600	**North Babylon Office** Phone: 631-893-7000
Riverhead Office Phone: 631-727-8585	**Ronkonkoma Office** Phone: 631-451-7700	**Whitestone Office** Phone: 718-746-1230

Health History Form

Today's Date: ______________

NOTE: The parent or Guardian who accompanies the child is responsible for payment at the time of service.

1. Tell Us About Your Child

Child's Name ____
Last First MI

Goes by: ______________________ ☐ Male ☐ Female

Siblings that we treat __________________________________

Child's Birthdate _____/_____/_____ Child's Age ___________

School____________________________Grade__________

Child's Home # (__________)________________________

SS#____

Child's Home Address:_____________________________

____
City State Zip

Email Address:_____________________________________

2. Who may we thank for referring you to our office?

____

3. Mother's Information

Name ____

Mother Stepmother Guardian Birthdate _____/_____/_____

Employer ____

Work # (_________)___________________ Ext. __________

Home # (_________)_________________________________

Cellular Phone # (_________)_________________________

SS # _____________________ DL# ____________________

4. Father's Information

Name ____

Father Stepfather Guardian Birthdate _____/_____/_____

Employer ____

Work # (_________)___________________ Ext. __________

Home # (_________)_________________________________

Cellular Phone # (_________)_________________________

SS # _____________________ DL# ____________________

5. Who is Accompanying the Child Today?

Name ____

Relationship_______________________________________

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

6. Person Responsible for Account

Name____

Relationship_______________________________________

Billing Address _____________________________________

____
City State Zip

Home # (___________)_______________________________

Work # (___________)_______________________________

Cellular # (___________)____________________________

E-mail ____

7. Primary Dental Insurance

Insurance Co. Name _________________________________

Insurance Co. Address _______________________________

____

Insurance Co. Phone # (___________)__________________

Group # (Plan, Local, or Policy #) ____________________

Policy Owner's Name _________________________________

Relationship to Patient_______________________________

Policy Owner's Birthdate ______/ ______/ ______

Social Security # ___________________________________

Policy Owner's Employer ______________________________

8. Secondary Dental Insurance

Insurance Co. Name _________________________________

Insurance Co. Address _______________________________

____

Insurance Co. Phone # (___________)__________________

Group # (Plan, Local, or Policy #) ____________________

Policy Owner's Name _________________________________

Relationship to Patient_______________________________

Policy Owner's Birthdate ______/ ______/ ______

Social Security # ___________________________________

Policy Owner's Employer ______________________________

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9. Dental History

Is this your child's first visit to the dentist? ________________

If not, how long since the last visit to the dentist? ___________

Previous Dentist's Name_____________________________

Were any x-rays taken at previous dental visits? ___________

Have there been any injuries to the teeth, face or mouth? _____

If yes, please explain________________________________

____

____

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

____

____

Does the child have any of the following habits?

Y N Lip Sucking / Biting Y N Nail Biting

Y N Nursing / Bottle Habits Y N Thumb / Finger Sucking

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

If yes, please explain ________________________________

____

Is the child's water fluoridated? Yes No

Is the child taking fluoride supplements? Yes No

Has the child ever had any pain or 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

10. Health History

Has the child ever had any of the following conditions?

Y N Abnormal Bleeding

Y N Allergies to any Drugs

Y N Any Hospital Stays

Y N Any Operations

Y N Asthma

Y N Cancer

Y N Congenital Birth Defects

Y N Convulsions/Epilepsy

Y N Pregnancy

Y N Tuberculosis

Y N ADD/ADHD

Y N Disabilities/Special Needs

Y N Hearing Impairment

Y N Heart Disease/Murmur

Y N Hemophilia/Blood Disorders

Y N Hepatitis

Y N HIV + / AIDS

Y N Kidney/Liver Conditions

Y N Rheumatic/Scarlet Fever

Y N Allergies to Latex Product

Y N Diabetes

Y N Autism

Please discuss any serious medical conditions the child has had

____

____

Please list all drugs the child is currently taking______________

____

Please list all allergies________________________________

____

Child's Physician ____________________________________

Phone (____________)_______________________________

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

Please describe the child's current physical health...

Good **Fair** **Poor**

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA the CDC, and the ADA.

11.

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of 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 Relationship to Patient

For Office Use Only

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

Initials ____________ Date ______________

Doctor's Comments ________________________________

____

____

____

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Dental Smiles for Kids

Dr. Tsivas Kourtsounis, DDS

Financial Agreement

We appreciate you choosing our office for your child's dental care. In order to build a trustworthy relationship for years to come we want to clarify and agree on methods of payment. The person accompanying the patient is responsible for the account regardless of who carries the dental insurance. We ask that the person accompanying the child not leave the premises during the appointment in the event that a question arises regarding treatment. Payment for professional services is due at the time dental treatment is provided. Every effort will be made to provide a treatment plan, which gives your child the best possible care and fits your timetable and budget.

PLEASE UNDERSTAND that we file dental insurance claims as a courtesy to our patients. We do not have a contract with your insurance company, only you do. We work very hard to assist you in receiving maximum benefits available under your policy, but we are not responsible for how your insurance company handles its claims or for what benefits they pay on a claim. WE at no time guarantee what your insurance will or will not do with each claim.

MOST IMPORTANTLY, please keep us informed of any insurance changes such as policy name, insurance company address, or a change of employment.

Payments can be made by, credit card, ATM debit card, cash, personal check, money order or cashier's check.

On the day services are rendered, we will collect any; co-pay, coinsurance, deductible or any estimated patient portion responsibility. We will submit to your insurance company and once insurance payment is received if your insurance company deems necessary we will adjust your account accordingly or bill you for any unpaid services.

I have read and agree to the terms outline in this policy. I understand my financial responsibility to this office. I understand this office cannot guarantee my insurance status and any information given to me is an "estimate" not a guarantee of actual insurance payment.

Name of Patient ______________________________ Date: ____________________

Signature of Responsible Party: ____

Paraskevis Kourtsounis, DDS
DENTAL SMILES FOR KIDS
PEDIATRIC DENTISTRY CONSENT FORM

Dear Parent of legal guardian,

Since my child ___________________________ is a minor, it becomes necessary that a signed permission is obtained from a parent or legal guardian before any dental services can begin and/ or end by either Dr. Kourtsounis and/ or any Doctor associated with Dental Smiles for Kids, PLLC.

Authorization is hereby granted to perform an examination, take x-rays, clean the teeth, provide fluoride treatment, as well as give any oral hygiene instructions if deemed necessary. Following a consultation, authorization is hereby granted to administer any treatment, anesthetics, extractions, and perform such procedures or otherwise treat my child as it may be deemed necessary and/ or advisable. I also give permission to provide my child with emergency care if needed.

I authorize my pediatrician and/or other physician(s)/ medial facilities to release any, and all pertinent medical information regarding my child. I further understand that this consent will remain in effect until such time that I choose to terminate such options.

I understand that I accept responsibility for payment of services rendered. I certify the truth of the information provided. I also authorize the release of pertinent information to those persons requiring it for treatment of my child or for the purpose of payment of the account or credit references.

I certify the truth of the information given. I also authorize the release of pertinent information to those persons requiring it for the treatment of my child or for the purpose of payment of the account or credit references.

_________________________________ _________________________

Signature Date

Dental Smiles for Kids
Appointment Policy

NO SHOW AND CANCELLATION POLICY

Please be advised that we require at least 48 hours or (2)business days notice whenever an appointment needs to be changed. One of the reasons that we consistently run on time in our office is that we do NOT double or over book our schedule. This allows us to give you the personalized high quality attention that you deserve. To cancel an appointment without proper notice prevents us from being able to offer this time to other patients. In addition, minimizing schedule changes also allows us to not have to raise our fees.
You will be billed for NO SHOW appointments/appointments cancelled less than two(2) business days ahead($50 for Each dental visit Per Child). *In the event that you realize that you won't be able to keep an appointment over a weekend, the 48 hour policy will still apply so please leave a message on our voicemail. Our goal is to give the highest quality care to you and all our patients.*

We thank you in advance for your cooperation

Please acknowledge this policy by signing below.

____
(Please Print your name)

___________________________________ ______________
(Signature of Patient) ***(Date)***

NOTICE OF PRIVACY ACKNOWLEDGEMENT

DENTAL SMILES FOR KIDS, PLLC

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

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

I have received, read and understand your Notice of Privacy Practices containing a more complete description of 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 Private 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

____
Relationship to patient

____
Signature

____
Date

Staff Initials: __________

OFFICE USE ONLY

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

Date: ____________ Initials: ____________ Reason: __________________________