PATIENT INFORMATION (CONFIDENTIAL)

NAME_____ DATE_____

FIRST MI LAST

ADDRESS_____ CITY_____ STATE/PROV._____ ZIP/P.C._____

E-MAIL_____CELLPHONE_____HOME PHONE_____

SS#/SIN_____BIRTHDATE_____

CIRCLE APPRORIATE: MINOR SINGLE MARRIED DIVORCED WIDOWED SEPARATED

IF COLLEGE STUDENT, F.T. / P.T., NAME OF SCHOOL_____CITY_____STATE_____

PATIENT'S OR PARENT'S/GUARDIAN'S EMPLOYER_____WORK PHONE_____

BUSINESS ADDRESS_____CITY_____STATE_____ZIP_____

SPOUSE OR PARENT'S/ GUARDIAN'S NAME_____EMPLOYER_____ WORK PHONE_____

WHOM MAY WE THANK FOR REFERRING YOU?_____

PERSON TO CONTACT IN CASE OF AN EMERGENCY_____PHONE_____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT_____RELATIONSHIP TO PATIENT_____

ADDRESS_____HOME PHONE_____

DRIVER'S LICENSE #_____BIRTHDATE___ _____SS#/SIN_____

EMPLOYER_____WORK PHONE_____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? (CIRCLE APPRORIATE) YES / NO

INSURANCE INFORMATION

NAME OF INSURED_____RELATIONSHIP TO PATIENT_____

BIRTHDATE_____SS#/SIN_____DATE EMPLOYED_____

NAME OF EMPLOYER_____UNION OR LOCAL #_____WORK PHONE_____

INSURANCE CO._____TEL. #_____GRP #_____POLICY/ I.D #_____

INS. CO. ADDRESS_____CITY_____STATE_____ZIP_____

HOW MUCH IS YOUR DEDUCTIBLE?_____HOW MUCH HAVE YOU USED?_____MAX ANNUAL BENEFIT?_____

DO YOU HAVE ANY ADDITIONAL INSURANCE? (CIRCLE APPRORIATE) YES / NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED_____RELATIONSHIP TO PATIENT_____

BIRTHDATE_____SS#/SIN_____DATE EMPLOYED_____

NAME OF EMPLOYER_____UNION OR LOCAL #_____WORK PHONE_____

INSURANCE CO._____TEL. #_____GRP #_____POLICY/ I.D #_____

INS. CO. ADDRESS_____CITY_____STATE_____ZIP_____

HOW MUCH IS YOUR DEDUCTIBLE?_____HOW MUCH HAVE YOU USED?_____MAX ANNUAL BENEFIT?_____

X_____ _____

SINGATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR PATIENT NUMBER

Child Health/Dental History Form

American Dental Association
www.ada.org

Patient's Name (LAST / FIRST / INITIAL)	Nickname	Date of Birth
Parent's/Guardian's Name	Relationship to Patient	
Address (PO OR MAILING ADDRESS / CITY / STATE / ZIP CODE)		
Phone (Home / Work)		Sex M ❑ F ❑

Have you (the parent/guardian) or the patient had any of the following diseases or problems? ❑ Yes ❑ No
1. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3.Cough that produces blood?
If you answer yes to any of the three items above, please stop and return this form to the receptionist.

Has the child had any history of, or conditions related to, any of the following:

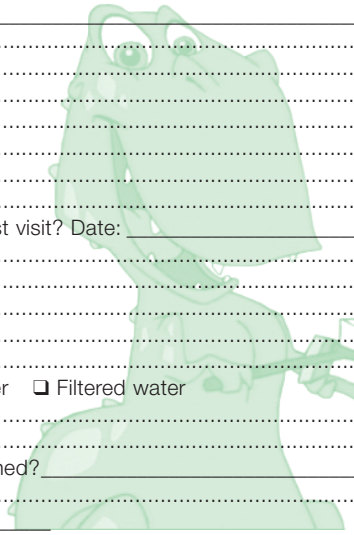
❑ Anemia	❑ Cancer	❑ Epilepsy	❑ HIV +/AIDS	❑ Mononucleosis	❑ Thyroid
❑ Arthritis	❑ Cerebral Palsy	❑ Fainting	❑ Immunizations	❑ Mumps	❑ Tobacco/Drug Use
❑ Asthma	❑ Chicken Pox	❑ Growth Problems	❑ Kidney	❑ Pregnancy (teens)	❑ Tuberculosis
❑ Bladder	❑ Chronic Sinusitis	❑ Hearing	❑ Latex allergy	❑ Rheumatic fever	❑ Venereal Disease
❑ Bleeding disorders	❑ Diabetes	❑ Heart	❑ Liver	❑ Seizures	❑ Other_____
❑ Bones/Joints	❑ Ear Aches	❑ Hepatitis	❑ Measles	❑ Sickle cell	

Please list the name and phone number of the child's physician:

Name of Physician _____ Phone _____

Child's History

		Yes	No
1.	Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? If yes, please list: _____	❑	❑
2.	Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____	❑	❑
3.	Is the child allergic to anything else, such as certain foods? If yes, please explain: _____	❑	❑
4.	How would you describe the child's eating habits? _____		
5.	Has the child ever had a serious illness? If yes, when: _____ Please describe: _____	❑	❑
6.	Has the child ever been hospitalized?	❑	❑
7.	Does the child have a history of any other illnesses? If yes, please list: _____	❑	❑
8.	Has the child ever received a general anesthetic?	❑	❑
9.	Does the child have any inherited problems?	❑	❑
10.	Does the child have any speech difficulties?	❑	❑
11.	Has the child ever had a blood transfusion?	❑	❑
12.	Is the child physically, mentally, or emotionally impaired?	❑	❑
13.	Does the child experience excessive bleeding when cut?	❑	❑
14.	Is the child currently being treated for any illnesses?	❑	❑
15.	Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: _____	❑	❑
16.	Has the child had any problem with dental treatment in the past?	❑	❑
17.	Has the child ever had dental radiographs (x-rays) exposed?	❑	❑
18.	Has the child ever suffered any injuries to the mouth, head or teeth?	❑	❑
19.	Has the child had any problems with the eruption or shedding of teeth?	❑	❑
20.	Has the child had any orthodontic treatment?	❑	❑
21.	**What type of water does your child drink?** ❑ City water ❑ Well water ❑ Bottled water ❑ Filtered water		
22.	**Does the child take fluoride supplements?**	❑	❑
23.	**Is fluoride toothpaste used?**	❑	❑
24.	How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____	❑	❑
25.	Does the child suck his/her thumb, fingers or pacifier?	❑	❑
26.	At what age did the child stop bottle feeding? Age _____ Breast feeding? Age _____		
27.	Does child participate in active recreational activities?	❑	❑



NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature _____ Date _____

For completion by dentist

Comments _____

For Office Use Only: ❑ Medical Alert ❑ Premedication ❑ Allergies ❑ Anesthesia Reviewed by _____

Date _____

Form S707

To Reorder call 1-800-947-4746
or go online at www.adacatalog.org

Delba J. Pena, D.D.S., P.C.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

_____, has received a copy of this office's notice if Privacy Practices.

_____

Please Print Name

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ○ **Individual refused to sign the acknowledgement of receipt.**
- ○ **Communications barriers prohibited obtaining the acknowledgement.**
- ○ **An emergency situation prevented us from obtaining acknowledgement.**
- ○ **Other (Please Specify Below)**

_____

_____

_____

Delba J Pena D.D.S., P.C.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: PATIENT GIVING CONSENT.

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Social Security #: _____

Section B: PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.
Notice of Privacy Practices: you have the right to read our Notice of Privacy Practices before you decide to sign this consent. Our Notice provides a description of our treatment, payment activities and healthcare options of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.
We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our Privacy Practices, we will issue a revised Notice of Privacy practice, which will contain the changes.
Those changes may apply to any of your protected health information that we maintain.
You may obtain obtain a copy of our our Notice of Privacy practices, including any revisions of our Notice, at anytime by contacting:

Contact Person: Delba J. Pena D.D.S., P.C.
186 Clinton Street Hempstead, NY 11550
Tel (516) 483-8136
Fax (516) 483-8134

Right to revoke: you will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this consent.

I, _____have had full opportunity to read and consider the form: I am giving my consent to your Notice of Privacy practices. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment.

Signature:_____Date: _____
If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's name: _____

Relationship to the patient: _____

DENTAL TREATMENT CONSENT

Please read and initial the items checked below and read and sign the section at the bottom of this form.

Patient name: _____

1. WORK TO BE DONE

I understand that I am having the fallowing work done: Fillings___ Bridges___ Crowns ___ Extractions___
Impacted teeth removed ___General Anesthesia ___ Root Canals ___others_____

Initials_____

2. DRUGS AND MEDICATIONS

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting and/or anaphylactic shock (severe allergic reaction).

Initials_____

3. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.

Initials _____

4. REMOVAL OF TEETH

Alternatives to removal have been explained to me (root canal therapy, crowns, periodontal surgery, etc.) and I authorized the dentist to remove the following teeth_____ and any other necessary for reason in paragraph #3. I understand removing teeth does not always remove all the infection, if present and it may be necessary to have further treatment. I understand the risk involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling my teeth, lips, tongue and surrounding tissue (paresthesia) that can last for indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

Initials_____

5. CROWN, BRIDGES AND CAPS

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they pre kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown; bridge or cap (including shape, fit, size and color) will be before cementation.

Initials_____

6. DENTURES, COMPLETE OR PARTIAL

I realize that full or partial dentures are artificially, constructed of plastic, metal and/or porcelain. The problem of wearing these appliances has been explained to me including looseness, soreness and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, placement and color) will be the teeth in wax try in. I understand that must dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included on the initial denture fee.

Initials_____

7. ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth and that complications can occur from the treatment (apicoectomy)

Initials_____

8. PERIODONTAL LOSS (TISSUE & BONE)

I understand that I have a serious condition causing gum and bone inflammation loss and that it can lead to the loss of my teeth. The alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.

Initials_____

I understand that dentistry in not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I have the knowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and questions have been to my satisfaction. I agree to the proposed treatment.

Signature of patient/or patient guardian _____ Date _____