PATIENT REGISTRATION

ABOUT YOUR CHILD

Child's Full Name: _____ Nickname: _____
Birthdate: _____ Sex: __M __F
Child's Home Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____
How did you hear about us? _____
Siblings seen in our office: _____

RESPONSIBLE PARTY

Name: _____
Relationship to Patient: _____
Birthdate: _____ Sex: __M __F
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Social Security #: _____

MATERNAL INFORMATION

☐ Mother ☐ Stepmother ☐ Guardian
Name: _____ Birth date: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Home #: _____ Work #: _____
Beeper #: _____ Cell #: _____
E-mail Address: _____
Occupation: _____
Social Security #: _____
Dental Insurance? ☐ No ☐ Yes (if yes, please continue)
Employer's Name (Company) _____
Insurance Co. Name: _____
Insurance Phone #: _____ Policy #: _____

PATERNAL INFORMATION

☐ Father ☐ Stepfather ☐ Guardian
Name: _____ Birth date: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Home #: _____ Work #: _____
Beeper #: _____ Cell #: _____
E-mail Address: _____
Occupation: _____ Social Security #: _____
Dental Insurance? ☐ No ☐ Yes (if yes, please continue)
Employer's Name (Company) _____
Insurance Co. Name: _____
Insurance Phone #: _____ Policy #: _____

Parents Marital Status:
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

HOW CAN WE REACH YOU?

Who is responsible for making your child's appointment?
_____
Can we contact you at work if need be? ☐ Yes ☐ No
Could we please have your permission to contact you at:
☐ Home ☐ Beeper ☐ Cellular ☐ E-mail
Emergency Contact Name: _____
Relationship: _____
Emergency Contact Phone: _____

AUTHORIZATION

I understand that I am responsible for all charges incurred by me or my family regardless of insurance coverage and *PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED*. If my account requires servicing by a collections agency or by an attorney, I understand that I will be liable for the collection fees, attorney fees and applicable court costs, in addition to my outstanding balance. I also request that payment under my dental insurance program be made directly to Small World Dental, PLLC on any unpaid bills for services furnished me or my family. I authorize the release of any dental information necessary to process this claim and all future claims. The policy in our office is such that the parent or guardian who requests treatment for a child is responsible for all fees for services rendered. Failure to cancel an appointment with at least *24 hours* notice will result in a *$25 cancellation fee*. I give the doctor permission to use such measures as deemed necessary in his professional judgment to render a diagnosis for my child. This would include an oral examination, radiographs, prophylaxis, fluoride treatment and other diagnostic aids. I have given an accurate report of my child's physical and mental health history. I have reported any prior allergic/unusual reactions, abnormal bleeding & other conditions related to my child's health or any other physical conditions that my child's medical doctor has advised me should be reported to a dental surgeon.

_____
Signature **Date**

SMALL WORLD DENTAL, PLLC
6795 HYLAN BLVD.
STATEN ISLAND, NY 10309
(718) 967-2412

CONSENT FOR TREATMENT

We are here to provide dental service to you and your child in the most beneficial way possible. This requires mutual understanding. Please read this form carefully. Should you have any questions, our business coordinators will be delighted to help you.

1. I hereby authorize and direct Dr. Abhinav Sinha, and/or any of his dental associates and/or dental auxiliaries to perform dental treatment with the use of any necessary or advisable radiographs and/or any other diagnostic aids in order to complete a thorough diagnosis and treatment plan.

2. I understand certain parts of the treatment may be performed by paraprofessionals (dental assistants/hygienists) rather than the doctor.

3. I also authorize Dr. Abhinav Sinha, and/or any of his dental associates and/or dental auxiliaries to take and to use photographs, radiographs, other diagnostic materials, and treatment records for the purposes of teaching, research, and scientific publication. The photographs shall be used for dental records and if in the judgment of Dr. Sinha and/or any of his dental associates, dental research, education, or science will be benefited by their use, such photographs and information relating to my child's case may be published and republished, either separately or in connection with each other, in professional journals or medical books, or used for any other purpose which s/he may deem proper in the interest of medical education, knowledge, or research; provided, however, that it is specifically understood that in any such publication or use my name or my child's name not be identified by name. The aforementioned photographs may be modified or retouched in any way that my doctor, in his/her discretion, may consider desirable.

4. I understand radiographs, photographs, models of the mouth, and/or any other diagnostic aid used for an accurate diagnosis and treatment planning are the property of the doctor but copies are available upon request for a fee.

5. In general terms, the dental procedure(s) can include but not be limited to:
   A. Comprehensive oral examination, radiographs, prophylaxis, and the application of topical fluoride.
   B. Application of sealants to the grooves of teeth.
   C. Treatment of diseased or injured teeth with dental restorations (fillings), stainless steel or composite crowns, and/or root canal treatment.
   D. Oral surgery: Extraction of one or more teeth, excision of hyper plastic and/or pericoronal tissue, frenectomy, exposure of unerupted tooth.
   E. Placement of space maintainers and/or replacement of missing teeth with dental prosthesis.
   F. Treatment of diseased or injured oral tissues secondary to traumatic injuries and/or accidents and/or infection.
   G. Treatment of habits, misaligned (crooked) teeth, orthodontia and/or oral, dental developmental or growth abnormalities.
   H. Recommendation for treatment to be completed using conscious sedation or general anesthesia in a hospital setting.

6. I understand that the doctor is not responsible for previous dental treatment. I understand that, in the course of treatment, this previously existing dentistry may need adjustment and/or replacement.

7. I realize that guarantees of results or absolute satisfaction are not possible in pediatric dental health service.

8. I have answered all the questions about my or my dependent's medical history and present health condition fully and truthfully. I have told the dentist or other office personnel about all conditions, including allergies, which might indicate that my child should not receive oral medications and/or antianxiety agents. I also understand if I or my dependent ever had any changes in health status or any changes in medication(s), I will inform the doctor at the next appointment.

9. I authorize Dr. Abhinav Sinha and/or any of his dental associates to forward a review of findings and/or any other dental information to the referring doctor (if such has been the referral source) or any other health care giver for his/her records, as well as any third parties such as insurance companies who may request information.

I hereby acknowledge that I have read and understand this consent and the meaning of its contents. All questions have been answered in a satisfactory manner and I believe I have sufficient information to give this informed consent. I further understand that this consent shall remain in effect until terminated by me.

Patient Name	Person Authorized to Consent	Relationship To Patient	Date

SMALL WORLD DENTAL, PLLC
6795 HYLAN BLVD.
STATEN ISLAND, NY 10309
(718) 967-2412

CONSENT TO DISCLOSE
PRIVATE HEALTHCARE INFORMATION
FOR TREATMENT, PAYMENT, AND/OR HEALTHCARE OPERATIONS

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your child's/dependent's 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 whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your child's/dependent's 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 Practices, which will contain the changes. Those changes may apply to any of your child's/dependent's protected health information that we maintain.

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 in the Notice of Privacy Practices. 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 or continue treating your child/dependent if you revoke this Consent.

I, _____, have had full opportunity to read and consider the contents of this Consent form and 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 child's/dependent's protected health information to carry out treatment, payment activities and health care operations.

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A copy of this authorization is agreed by the undersigned to have the same effect and force as an original.

Any person, firm, or entity that releases matters pursuant to this authorization is hereby absolved from any liability that might otherwise result from the release of those matters.

I further understand that I have the right to review Small World Dental, PLLC's Notice of Privacy Practices and to request restrictions. I further understand that I may revoke this consent in the future if I should so desire.

Signed this _____ day of _____,20____.

_____
Signature of Parent or Legal Guardian

_____
Printed Name of Parent or Legal Guardian

_____
Patient's Name (printed)

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. PLEASE ADVISE US IF YOU WANT A COPY.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat my child/dependent after I have revoked my Consent.

Signature: _____ **Date:** _____

PEDIATRIC DENTISTRY INFORMED CONSENT FOR PATIENT MANAGEMENT TECHNIQUES

ACKNOWLEDGMENT OF RECEIPT OF INFORMATION

ALL IN GOOD INTENTION

It is our intent that all professional care delivered in our dental office shall be of the best possible quality we can provide for each child. We believe that any dentist can get your child's work done – our mission is to do so in a manner which leaves your child with good positive feelings about going to the dentist. The entire focus is on your child, relating to them, fostering good dental health habits and instilling a healthy, positive attitude toward dentistry for life.

All efforts will be made to obtain the cooperation of child dental patients by the use of warmth, friendliness, persuasion, humor, charm, gentleness, kindness, and understanding. In some cases, further behavior management techniques are needed. There are several behavior management techniques that are used by pediatric dentists to gain the cooperation of child patients to eliminate disruptive behavior or prevent patients from causing injury to themselves due to uncontrollable movements. These techniques are **not** a form of punishment and are in no way used as a form of punishment. These techniques are simply used only when and, if necessary, to complete a dental procedure in the safest manner possible.

Please read this form carefully & ask about anything you do not understand. Please initial to identify you understand the techniques we use.

PEDIATRIC DENTISTRY BEHAVIOR MANAGEMENT TECHNIQUES

The more frequently used pediatric dentistry behavior management techniques are as follows:

_____**1. Tell-Show-Do:** The doctor or assistant explains to the child what is to be done using simple terminology and repetition and then shows the child what is to be done by demonstrating with instruments on a model or the child's or dentist's finger. Then the procedure is performed in the child's mouth as described. Praise is used to reinforce cooperative behavior.

_____**2. Positive reinforcement:** This technique rewards the child who displays any behavior which is desirable. Rewards include compliments, praise, pat on the back, a hug, or a prize.

_____**3. Voice control:** Is a controlled alteration of voice volume, tone, or pace to influence and direct the patient's behavior.

_____**4. Mouth props/Rubber dams:** A mouth prop or "tooth pillow" as we call it is used to help support your child in keeping his/her mouth open during an operative procedure. This allows him/her to relax and not worry about consciously keeping his/her mouth open for the procedure. A rubber dam is a "raincoat" placed on the area of work to be worked on to isolate the teeth and prevents any debris from being swallowed or going to the back of the throat.

_____**5. Immobilization by the doctor:** The doctor controls the child from movement by gently holding down the child's hands or upper body, stabilizing the child's head between the dentist's arm and body.

_____**6. Immobilization by the assistant:** The assistant controls the child from movement by gently holding the child's hands, stabilizing the head, and/or controlling leg movements.

_____**7. Immobilization by Papoose Wrap:** A passive restraint device, designed specifically for pediatric dental procedures, is used when complete immobilization is needed for the safety of the patient and the dental team. It is used during most, not all, sedation procedures.

_____**8. Relaxation Gas:** Nitrous oxide (laughing gas) and oxygen may be administered to relax the child and to raise his/her pain threshold. This allows the child to sit in chair longer and increases their attention span and allows for more work to be done without the child labeling something as painful. **Nitrous oxide and oxygen is not general anesthesia.** The child is not "put to sleep" and does not become unconscious, only relaxed.

_____**9. Conscious Sedation/General Anesthesia (Hospital Setting)** is recommended for apprehensive, very young children, and medically compromised patients. The majority of children respond very well for dental treatment. For various reasons, some children may be apprehensive about dental treatment and may require some form of sedation to allow treatment.

ACKNOWLEDGMENT OF RECEIPT OF INFORMATION

1. The listed pediatric dentistry management techniques have been explained to me.
2. I am clear and understand that none of the above techniques are used in any way as punishment. These procedures are standard of care in the pediatric dental community and are merely used only if necessary to provide the best dental care.
3. I have been encouraged to ask questions and all questions about the patient management techniques described have been answered in a satisfactory manner.
4. I hereby acknowledge that I have read and understand this consent.
5. I acknowledge that I have not been coerced/ forced to sign this consent and that I have been given the alternative to withdraw from it.
6. I hereby authorize and direct Dr. Sinha assisted by other doctors and/or dental auxiliaries of her/his choice, to utilize, if required, the necessary patient management techniques to assist in the provision of the required dental treatment for my child (or legal ward).
7. I understand that this consent shall remain in effect until terminated by me.

_____	_____	_____	_____
Patient Name	**Person Authorized to Consent**	**Relationship To Patient**	**Date**

SMALL WORLD DENTAL, PLLC
6795 HYLAN BLVD.
STATEN ISLAND, NY 10309

MEDICAL/DENTAL INFORMATION

Patient Name:_____
Date of Birth:_____

Reason for visit:_____

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_____
_____

Does the child brush his/her teeth daily? Yes No

Floss his/her teeth daily? Yes No

Has the child ever had any of the following conditions?

Y	N	Abnormal Bleeding	Y	N	Handicaps/Disabilities
Y	N	Allergies to any drugs	Y	N	Hearing Impairment
Y	N	Any hospital stays	Y	N	Heart disease/Murmur
Y	N	Any surgeries/operations	Y	N	Hemophilia/Blood disorders
Y	N	Asthma	Y	N	Behavioral Issues
Y	N	Autism	Y	N	Hepatitis
Y	N	Cancer	Y	N	HIV +/AIDS
Y	N	Congenital Birth Defects	Y	N	Kidney/Liver Conditions
Y	N	Convulsions/Epilepsy	Y	N	Rheumatic/Scarlet Fever
Y	N	Allergies to Latex Products	Y	N	Tuberculosis
Y	N	Diabetes	Y	N	Other _____

If yes, please explain_____
_____
_____
_____
_____

Please list all drugs the child is currently taking_____
_____
_____

Please list all drugs/foods the child is allergic to_____
_____
_____

Child's Primary Physician_____
Phone #_____

I understand that the information I have given is correct to the best of my knowledge. I authorize the dental staff to perform the necessary dental services my child may need.

_____ _____
Signature of Parent or Guardian **Date**

_____ _____
Print Name **Relationship to Patient**

Small World Dental, PLLC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOUCAN 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 September 1st, 2008, 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. You may request that we provide copies in a format other than photocopies. 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 $1.00 for each page, 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 performed starting September 1st, 2008. 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.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Dr. Abhinav N. Sinha (Founder and Owner, Small World Dental, PLLC)
Telephone: (718) 967-2412
Fax: (718) 554-4515
E-mail: smallworlddental@yahoo.com
Address: 6795 Hylan Blvd., Staten Island, New York 10309