NEW PATIENT FORMS

PATIENT

Date ____

Patient's Last Name ________________________________ First Name ____________________________ Middle Initial _______
Prefers to be called _________________________________ Hobbies, activities ______________________________________

Birth date __________________ Sex ☐Male ☐Female Social Security # ____
School _______________________________ Grade ______ Email address ____
Home address ______________________________________ City, State, Zip ____
Home phone (_______)________-__________ Cell phone (_______)________-_____________

PARENT/GUARDIAN

Custodial parent(s) name(s) ____

Patient lives with (check all that apply) ☐Mother ☐Father ☐Stepmother ☐Stepfather ☐Grandparents ☐Other __________

Father's full name ____ Title: ☐Mr. ☐Dr. ☐Other ________________
Occupation ____ Email address ____
Address (if different than patient) ____
Home phone (_______) ________-__________ Cell phone (_______) ________-_____________

Mother's full name ____ Title: ☐Mrs. ☐Ms. ☐Dr. ☐Other ___________
Occupation ____ Email address ____
Address (if different than patient) ____
Home phone (_______) ________-__________ Cell phone (_______) ________-_____________

Parent's Marital Status

☐Married ☐Divorced ☐Separated ☐Widowed ☐Single

Brother/sister name ___________________________________ DOB __________________________
Brother/sister name ___________________________________ DOB __________________________
Brother/sister name ___________________________________ DOB __________________________
Brother/sister name ___________________________________ DOB __________________________
Brother/sister name ___________________________________ DOB __________________________

EMERGENCY CONTACT

Name ____ Relationship _________________________________
Address ____
Home phone (_______) ________-__________ Cell phone (_______) ________-_____________

FINANCIAL RESPONSIBILITY

Who is financially responsible for this account? ____________________
Address (if different than page 1)____________________
Home phone (_________) __________-____________ Cell phone (________) __________-______________
Email address ____________________ Social Security # ____________________
Who will be responsible for bringing the patient to appointments? ____________________

DENTAL INSURANCE

Primary policy holder's full name ____________________ DOB ____________________
Social Security # ____________________ Relationship to patient ____________________
Address and phone (if not listed above) ____________________
Employer ____________________ Address ____________________
Insurance Company ____________________ ID # ____________________ Group # ____________________

Secondary policy holder's full name ____________________ DOB ____________________
Social Security # ____________________ Relationship to patient ____________________
Address and phone (if not listed above) ____________________
Employer ____________________ Address ____________________
Insurance Company ____________________ ID # ____________________ Group # ____________________

MEDICAL INSURANCE

Policy holder's full name ____________________ Insurance Company ____________________

PHYSICIAN

Patient's primary care physician ____________________ City, State ____________________
Last seen ____________________ Reason ____________________ Next appt ____________________
Most recent physical exam ____________________

Please list any specialists your child has seen (i.e. cardiologist, ENT, etc.)
Name ____________________ City, State ____________________
Reason ____________________
Name ____________________ City, State ____________________
Reason ____________________
Name ____________________ City, State ____________________
Reason ____________________

DENTAL HISTORY

Reason for today's visit ____________________
Do you have any concerns about your child's teeth? ____________________

Is this your child's first visit to the dentist? ☐YES ☐NO
If no, when was the last visit and what was done? ____________________

Do you expect your child to be a cooperative patient? ☐YES ☐NO
If no, please explain: ____________________

Has your child bumped any teeth? ☐YES ☐NO
If so, when? ____________________

Has your child has a history of headaches, pain, popping or clicking of the jaws? ☐YES ☐NO

Does your child have a nighttime bottle? ☐YES ☐NO

Does your child have a toothache? ☐YES ☐NO

Does your child have or has he/she had any of the following problems/habits?

- ☐Thumb Sucking   How long? ________   Still active?   ☐YES   ☐NO
- ☐Finger Habit   How long? ________   Still active?   ☐YES   ☐NO
- ☐Pacifier   How long? ________   Still active?   ☐YES   ☐NO

How often does your child brush? ____________________________

Is tooth brushing supervised?   ☐YES   ☐NO

Is dental floss used?   ☐YES   ☐NO

Does your child receive: ☐Fluoride tablets/drops   ☐Bottled water
☐Fluoridated water (tap water)   ☐Well water
☐Fluoride in vitamins

MEDICAL HISTORY

Is your child presently under the care of your family physician for any medical reason?   ☐YES   ☐NO
If yes, please explain: ____

Family Physician Name: ____
Address: ____________________________________   Phone # ____________________________

Is your child in good health?   ☐YES   ☐NO
If no, please explain: ____

Does your child have any drug allergies?   ☐YES   ☐NO
If yes, please explain: ____

Does your child have any allergies?   ☐YES   ☐NO
If yes, please explain: ____

Is your child taking any medications at this time? ☐YES   ☐NO
If yes, list: ____

Has your child ever been hospitalized or treated in an emergency room for any particular trauma?   ☐YES   ☐NO
If yes, please explain: ____

Have your child's tonsils and/or adenoids been removed?   ☐YES   ☐NO

Does your child breathe through the mouth?   ☐YES   ☐NO   If yes,   ☐Seldom   ☐Often

Does your child snore?   ☐YES   ☐NO

Please indicate if your child has had any of the following:

☐Anemia	☐Asthma	☐Autism/Asperger's Syndrome
☐Bleeding Disorder	☐Bone Disorder	☐Cleft Palate
☐Diabetes	☐Endocrine Disorder	☐Epilepsy/Seizures
☐Hyperactivity/ADD/ADHD	☐Heart Ailment or Murmur	☐Intellectual Disability
☐Latex Allergy/Sensitivity	☐Liver Problems/Hepatitis	☐Malignancies/Leukemia
☐Physical Handicap	☐Positive for HIV	☐Radiation Treatment
☐Rheumatic Fever	☐Speech Problem	

Please comment on any problems that were checked in the above areas:

____

____

____

RELEASE AND WAIVER

I authorize release of any information regarding my child's dental treatment to my dental and/or medical insurance company.

Parent/Guardian Signature ____ **Date** ______________

I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my dentist/staff of any changes in my child's medical or dental health.

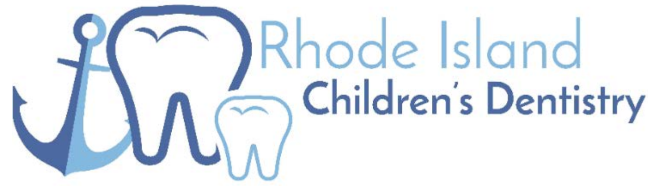
Parent/Guardian Signature ____ **Date** ______________

In an effort to improve communications with our patients, Rhode Island Children's Dentistry will be emailing and/or texting appointment reminders. If you are interested in being part of this service, please enter your information below. Please be aware that this email address may also be used to email you personal information (i.e.. Receipts, Invoices, Letters) relating to your dental care. Your information is only used for communications with you and other dental professionals. We do NOT share or sell personal information.

Parent/Guardian Signature ____ **Date** ______________

I hereby authorize the dentists and staff at Rhode Island Children's Dentistry to perform diagnostic aids including an examination, x-rays, photographs, models, cleaning and fluoride treatment, when necessary, as the standard of care to properly diagnose and record any and all dental conditions. I authorize my insurance company to pay Rhode Island Children's Dentistry all insurance benefits otherwise payable to me for services rendered. I also authorize the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges for services rendered whether or not it is covered by my insurance, all broken appointment fees and all late payment services charges. I also understand that obtaining insurance coverage and benefit information is my responsibility and not the responsibility of Rhode Island Children's Dentistry's. This consent is to remain in effect from the date indicated until canceled in writing.

Parent/Guardian Signature ____ **Date** ______________



General Consent

I attest that the information I have provided on this form is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status.
I understand that by signing below I authorize the following procedures to be performed as deemed necessary by the dentist and have read and understand the possible risks and complications of each procedure.

X-Rays & Examination
I understand that my child will be receiving a dental examination from a state licensed pediatric dentist. I understand that x-rays may be taken of my child's teeth as part of the necessary requirements to complete a thorough and comprehensive examination.

Medical Photography Consent
I consent to digital photographs and x-ray images of my child to be used exclusively within their medical record for the purposes of identification and dental treatment.

Dental Cleaning and Fluoride Treatment
I authorize Dr. Paquin and/or his staff members to clean my child's teeth today. I understand that the application of fluoride is part of the standard of care for children and helps prevents cavities.

Dental Sealants and Restorations

I authorize Dr. Paquin and/or his staff members to perform sealants and restorations including composite fillings, amalgam fillings, stainless steel crowns and space maintainers as part of comprehensive dental care. Any invasive procedures will obtain a separate consent.

Drugs and Medication
I understand that antibiotics, analgesics and topical compounds can cause allergic reactions even with no prior known history. Allergic reactions can cause redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock. I have informed the dentist, to the best of my knowledge, of any adverse reactions my child has had.

I understand that all of the above treatments are the standard of care in pediatric dentistry. It is my responsibility to inform the staff during the registration process if I choose to decline any of the above treatments.

Authorization and Release
I authorize Dr. Paquin and/or his staff to release any information including the diagnosis and the records of any treatment or exam rendered to my child during the period of such dental care to third party payors, health practitioners and as required by law.

____
Child's Name

______________________________ ______________________________
Responsible Party's Name | Relationship to Child

______________________________ ______________________________
Signature | Date

Nitrous Oxide Consent

We may recommend nitrous oxide in order to make your child more comfortable and increase our likelihood of successfully completing treatment. Nitrous oxide, more commonly known as laughing gas, will make your child more relaxed and somewhat less aware of his/her surroundings which can help ease minor discomfort. Nitrous oxide does not eliminate the need for local anesthesia, which produces a numb feeling in the area being treated.

Nitrous oxide is breathed in through a nasal mask and is easily titrated to a desired level.

- Nitrous oxide will only provide relaxation; the patient is still awake and fully conscious, able to respond to questions and direction.
- The purpose is to make the patient more comfortable to receive the necessary dental care with less anxiety.
- Side effects of nitrous include, but are not limited to excessive perspiration, increased saliva production, behavioral changes, shivering, nausea and vomiting, and "light headed" feeling.
- Alternatives to nitrous oxide are: No nitrous oxide, conscious oral sedation or general anesthesia.

I consent to the use of nitrous oxide to supplement local anesthesia for the planned procedure.

______________________________ ______________________________

Responsible Party's Name Relationship to Child

______________________________ ______________________________

Signature Date

Optional Photography Consent

I consent to having my child's photo taken and displayed in the office as part of contests or bulletin boards. I consent to having my child's photo taken and posted as part of online social media including, but not limited to: the office website and blog; Facebook and Instagram.

Check one: ☐ I Consent ☐ I Do Not Consent

FINANCIAL POLICY

I assume financial responsibility for all dental treatment and medications provided for my child. I understand that payment is expected on the date services are provided. Although our office will gladly e-file dental insurance claims as a courtesy to you, any and all account balances are ultimately your responsibility. Insurance plans can vary greatly and some companies arbitrarily select certain services that they will not cover. Please contact us if you make any changes to your dental coverage, so that we may keep accurate and current records of your account. Sixty days is the most we can wait for your insurance company to pay your account balances. After this time, we will need you to pay any remaining balances. We will gladly refund you for any overpayments that occur after you have paid your bill. The parent or guardian who brings the child is responsible for payment, regardless of what a divorce decree may state. Reimbursements must be made amongst the divorced parties and cannot involve the office.

HIPAA ACKNOWLEDGMENT

I acknowledge that I have received a copy of Rhode Island Children's Dentistry's HIPAA Notice of Privacy Practices.

PARENT/GUARDIAN POLICY

I acknowledge that the policy of Rhode Island Children's Dentistry is for a legally responsible parent or guardian to be present for all dental appointments. If someone other than the parent or legal guardian accompanies your child to their visit we reserve the right to reschedule the appointment. If advance notice is given (at least 48 hours) and we can obtain the necessary paperwork prior to the scheduled visit, we may accommodate your needs on a case by case basis. Certain types of treatment visits (including sedation) always require a parent or legal guardian to be present for the entirety of the visit. Please see additional information on our policies in the additional forms section.

CANCELLATIONS AND NO-SHOWS

In order to be respectful of other patients' needs, please be courteous and call our office promptly if you are unable to make your appointment. This will allow us to offer your reserved appointment to a patient in urgent need of treatment and promptly reschedule your child for another appointment date. Any appointment(s) not cancelled at least 24 hours in advance is subject to a $50 cancellation fee. We cannot reschedule your appointment until the fee is paid. Continued cancellations and no-shows can result in dismissal from the practice.

____
Child's Name

______________________________ ______________________________
Responsible Party's Name | Relationship to Child

______________________________ ______________________________
Signature | Date

840 Tiogue Avenue
Coventry, RI 02816
phone 401-828-1171

2358 South County Trail
East Greenwich, RI 02818
fax 401-828-4704

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.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on March 1, 2003 and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

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. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, text messages, emails, postcards or letters.

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phone 401-828-1171

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East Greenwich, RI 02818
fax 401-828-4704

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Office Manager for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Duplications of records, if requested, will be $100.00. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons *other than* treatment, payment or healthcare operations.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies.) Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Office Manager. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us. In writing. Request a Complaint Form from our Office Manager. We support your right to the privacy of your information and 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.