KIDS DENTAL

4864 Arthur Kill Rd.
Staten Island, NY
(718) 356-5437

1. Tell Us About Your Child

Child's Name _____
First Middle Last

Nickname _____ Male Female

Siblings that we have treated _____

Child's Birth date ____/____/____ Child's Age _____

Child's Home # (____) _____

Child's Home Address _____

_____
City State Zip

Parent's Email _____

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

_____

3. Mother's/Parent 1 Information

Name _____
Mother Stepmother Guardian

Home # & Address, if different (____) _____

_____
City State Zip

Cell Phone # (____) _____

Employer _____

Work Phone# (____) _____

SS # _____ Birth date ____/____/____

4. Father's/Parent 2 Information

Name _____
Father Stepfather Guardian

Home # & Address, if different (____) _____

_____
City State Zip

Cell Phone # (____) _____

Employer _____

Work Phone# (____) _____

SS # _____ Birth date ____/____/____

5. Who Is Accompanying the Child Today? X_____

List all names of who can bring your child to the office and

relationship _____

_____Do you have legal custody? YES NO

6. Dental History

Is this your child's first visit to a dentist? YES NO

If not, when was last visit to dentist? _____

Were any x-rays taken at last dental visit? YES NO

Previous Dentist's Name _____

Have there been any injuries to face, mouth, or teeth? YES NO

If yes, please explain _____

_____

Why did you bring your child to the dentist today?

_____

Has your child ever had a serious or difficult problem associated with previous dental work? YES NO

If yes, please explain _____

HABITS: Does your child do any of the following?

Y N Lip Sucking/Biting/Nails **Y N** Pacifier/Thumb/Finger

Y N Spitting out Toothpaste **Y N** Grinding

Y N TOOTHPASTE: Fluoride or Non-Fluoride **Y N** Parents assist with Brushing / Flossing

Y N Nursing / Bottle / Sippy Cup -- Contains: Milk / Juice / Water
If Yes, WHEN? Only Mealtime/ Just before Bed/ All Night/ All Day

Anyone in family congenitally MISSING teeth? YES NO

7. Medical History Has the child ever had?

Y N Any Hospital Stays/Surgery:_____

Y N Congenital Birth Defects:_____

Y N ADHD/ADD/PDD/AUTISM/NOS/Spectrum _____

Y N Learning/Behavioral Disabilities _____

Y N Abnormal Bleeding **Y N** Asthma/Reactive Airway

Y N Cancer **Y N** Hearing Impairments

Y N Epilepsy/Seizures **Y N** Heart Murmur/Defect/PreMed

Y N Diabetes **Y N** Hemophilia/Blood Disorders

Y N Hepatitis **Y N** Kidney/Liver Conditions

Y N HIV+/AIDS **Y N** Rheumatic/Scarlet Fever

Y N **Allergy** to Latex/Peanuts/Walnuts/Medication_____

ALLERGIC to: _____

Please discuss any serious medical conditions _____

_____

Please list all drugs your child is currently taking _____

_____

Child's Physician _____Phone _____

Pharmacy Name _____ Number_____

8. 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

Office Use: Scan ____ TU ____
Email Fin ____ RR ____
Ins _____ _____

INFANT/PARENT INTAKE INFORMATION FORM

PATIENT'S NAME _____ BIRTHDATE: _____

MALE FEMALE Birth Weight _____ Present weight _____ # delivered this birth: Twin / Triplet / Quad

Birth history (circle) Home Hospital Vaginal C section Any complications _____

Did baby receive Hepatitis B vaccine? ___ Yes ___ No

Did baby receive Vitamin K shot? ___ Yes ___ No

Was your infant premature? ___ Yes ___ No If yes, how many weeks? _____

Are you presently breastfeeding? ___ Yes ___ No If no, how long since you stopped? _____

Are you presently using a nipple shield? ___ Yes ___ No

Are you choosing NOT to breastfeed? ___ Yes ___ No

Are you pumping breast milk? ___ Yes ___ No

Are you supplementing using a bottle? ___ Yes ___ No

Are you using SNS device (Supplemental Nursing System)? ___ Yes ___ No

MOTHER'S SYMPTOMS

____ Creased, cracked or blanching of nipples

____ Gumming or chewing of the nipples

____ Bleeding, cracked or cut nipples

____ Poor or incomplete breast drainage

____ Infected nipples or breasts

____ Abraded nipples

____ Painful latching of infant onto the breast Scale 1-10 _____

____ Plugged ducts

____ Mastitis

____ Nipple thrush

____ Feelings of depression

____ Oversupply of breast milk

____ Undersupply of breast milk

INFANT'S SYMPTOMS

____ Difficulty in achieving a good latch to breast/bottle

____ Slides off the breast when attempting to latch

____ Milk leaking out the sides of mouth during feedings

____ Falls to sleep while feeding

____ Clicking, swallowing air during nursing

____ Gumming or chewing of nipple

____ Lip curls under when feeding/crease mark around baby's upper lip/nose after nursing

____ Gagging, choking, coughing when feeding

____ Spits up often Amount/frequency? _____

____ Hiccups often

____ Reflux symptoms

____ Colic symptoms/cries a lot

____ Gassy often/Distended or bloated belly (circle)

____ Signs of discomfort such as arching of the back or clenching of the hands

____ Waking up congested in the morning/naptime

____ Posture or shoulder tension or head position favoritism (sleeps with head arched back)

____ Only sleeping when held upright position/car seat

____ Short sleep episodes (feeding every 1-2 hours)

____ Snoring, heavy noisy breathing/mouth breathing

____ Unable to keep pacifier in the infant's mouth

____ Gagging when attempting to introduce solid foods

____ Poor weight gain

Family History of Tongue Tie or Lip Tie _____

SPECIALISTS (IBCLC, OT, PT, SLP, MYO) indicate each _____

_____ Parent Signature: _____ Date: _____

_____ Doctor Signature: _____

INFANT CONSENT AND FINANCIAL AGREEMENT

We are delighted that you chose Dr. Lazzara for your child's tongue-tie or lip-tie procedure. A tongue or lip-tie is a relatively common condition in infants and children and can be diagnosed at any age. Restricted oral tissues can affect breastfeeding, bottle feeding, sleep, solid feeding, speech, and other important functions now and in the future. Dr. Lazzara will evaluate your infant or child for any oral restrictions. When the type of treatment has been decided, we can either complete the treatment at the same visit or at a later date. All financial arrangements will be discussed with you before treatment begins. We aim to offer the highest level of customer service and clinical excellence. We do not charge for follow-up visits or if the procedure needs to be redone in the first year, so this investment in your child's health is all-inclusive.

LASER CONSENT FORM

DIAGNOSIS: After through oral examination, Dr. Lazzara has advised me that the revision of the frenum(s) in my mouth or my child's mouth may help to restore anatomy, function, and/or possibly prevent commonly associated future problems.

RECOMMENDED TREATMENT: In order to treat this condition, Dr. Lazzara has recommended that a frenectomy be performed at the selected site(s). An FDA soft tissue laser will be utilized, that is approved for this soft tissue surgery and is an excellent tool to optimize treatment and recovery. Nitrous oxide and local anesthesia ("novacaine") may be utilized.

CONSIDERATIONS: I understand that a smooth recovery is expected, however, there are always associated risks that cannot be eliminated and may occur in a minority of cases. These complications include but are not limited to post-surgical bleeding, infection, swelling, fever and pain. A more common complication is reattachment of the frenum. Genetics also play a strong role in healing, such as formation of scar or fibrous tissue formation. The expectation is that by removing the frenulum there will be the establishment of a more normal lip and/or tongue posture and movement. The presence of the frenulum in this case is most likely one of the causes for the latching problems during breastfeeding. It is understood that thought the intent is to alleviate the problem by the frenectomy, there is no guarantee that this will cure the problem. I understand that the frenulum is likely a contributing cause to feeding difficulty.

FOLLOW-UP: I am advised that 1 week and 2 week follow up on the proposed care is needed, and an important part of success. I also am aware of the need for home care, stretching exercises, and additional therapies to include IBCLC, SLP, OMT, OT, and PT.

ALTERNATIVES TO SUGGESTED TREATMENT: I understand that alternatives to a frenectomy include: no frenectomy, with the expectation that the frenum does not normally improve with age but may aggravate the surrounding tissues including gums, jaws, teeth, airway, and breathing.

NO WARRANTY OR GUARANTEE: I hereby acknowledge that no guarantee, warranty, or assurance has been given to me that the proposed treatment will be successful. I do expect, however, that the doctor will perform the surgery to the best of her ability.

LASER FINANCIAL AGREEMENT FORM

We will provide you with a statement for you to submit to your dental/medical insurance on your own to try and receive reimbursement. As a dental office, we are unfortunately considered out of network for medical insurance; however you can also try to submit through dental insurance. Unfortunately, some insurance plans do not cover the procedure or have a high deductible, so there is no guarantee that filing a claim will result in reimbursement.

By signing below, I agree to be responsible for payment of services rendered by Dr. Lazzara and understand that payment is due in full at the time of service for the procedure. I also certify that I have read and fully understand this document and that all my questions were answered.

CHILD'S NAME: _____ DATE: _____

Parent's Name (Print): _____ SIGNATURE: _____

AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT PHOTOGRAPHIC AND/OR VIDEO IMAGES

AUTHORIZATION: I authorize the use and disclosure of photographic/video images by Kids Dental, P.C., for insurance and marketing purposes by this office. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

PURPOSE: The photographic/video images will be used for Social Media, Advertising, and/or Teaching

REVOCABILITY: I understand that I may revoke tis authorization at any time, but such revocation must be in writing and received by the practice via registered mail. Revocation affects disclosure moving forward and is not retroactive. This authorization expires 99 years from date signed.

NO TREATMENT CONDITIONS: I understand that the practice cannot condition treatment on whether or not I sign this authorization.

Practice Name: KIDS DENTAL, P.C. Please state if you want a copy of this form: YES NO

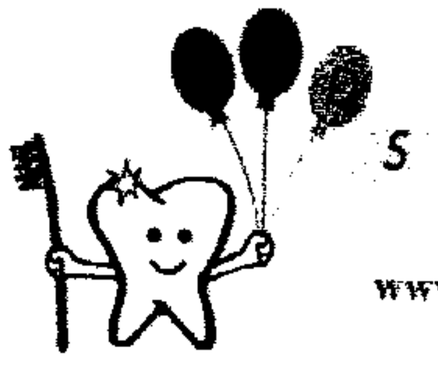
Patient's Name: _____ Date: _____

Signature: _____ Parent/Guardian's Name: _____

KIDS DENTAL

BOARD CERTIFIED PEDIATRIC DENTISTRY

Helping infants, children of all ages, teens, and those with special needs



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Staten Island, NY 10309
Phone: 718-356-KIDS (5437)
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www.sikidsdental.com

PARENTAL CONSENT FOR BEHAVIOR MANAGEMENT

Children are often nervous or scared when experiencing something new. Our goal as trained pediatric specialists is to make your child's visit as comfortable as possible. We start with "**baby steps**" to help your child learn how to overcome any fears of going to the dentist. We explain every step in "**kid friendly**" language and most children begin to understand after their first visit, that visiting the dentist can be **FUN**. Our caring, understanding, humor and fun approaches can be used to eliminate and minimize fearful/avoidance behavior. Some children need a little bit more help to overcome their fear of the dentist. We used scientifically proven and approved techniques by the American Academy of Pediatric Dentistry, which include:

(1) Tell Show Do: the dentist or staff tells the child what is to be done, shows an example on a tooth model or on the child's finger, then the procedure is done on the child's tooth

(2) Positive Reinforcement: rewards a child who displays cooperative behavior with compliments, praise, encouragement, or a small prize/token

(3) Voice Control: a change in the tone and volume or the dentist's voice to gain the attention of an uncooperative child to help them modify their behavior

(4) Non-verbal Communication: reinforce a desired by facial expression and posture/body language

(5) Distraction: diverting patient's attention from what may be perceived as an unpleasant procedure

(6) Solo Communication/ Parental Absence: parent may be asked to be a silent observer in the room, or even asked to step out of the room; the objective is to gain the child's attention, establish communication, and avoid negative behavior. Parents can always verify their child's safety, by observing near the doorway, without the patient viewing their presence

(7) Mouth Prop: a soft rubber device placed in your child's mouth to prevent accidental closure during treatment

(8) Hand/Head Holding: an adult assists child's body to remain still so child cannot grab the dentist's/hygienist's hand or sharp tools

(9) Nitrous Oxide (Laughing Gas): a safe and effective inhalation technique that can be used to help reduce anxiety, help decrease pain and reduce a child's gag reflex. It allows the child to relax without being asleep. It is completely safe and is eliminated from the body within 5 minutes

(10) Protective Stabilization/Wrap (Papoose): on rare occasions, this fabric mesh wrap with velcro is used to limit potentially injurious movements. This technique is first discussed with parent, at the point when every effort has been utilized to complete treatment and verbal consent is obtained.

(11) Sedation/General Anesthesia: for some children with medical complications or in instances where other behavior modification techniques are ineffective; a child's dental treatment can be accomplished under general anesthesia. Additional information will be provided to parents if this is recommended for your child.

I hereby acknowledge that I have read and understand this consent form, and this consent shall remain in effect for my child/children until I choose to terminate it and I will give written notification to reverse this document.

PATIENT NAME x_____ Relationship to Patient x_____

_____ _____

Signature (Parent/Guardian) Date

CONSENT FOR TREATMENT at Kids Dental, P.C.

We would like to welcome you and your child to our office. It is important that we inform you about the various procedures provided in Pediatric Dentistry. Informed consent is necessary before starting your child's treatment. Please take a moment to carefully read this form. Since, patient is a minor, it is necessary that signed permission be obtained from parent or legal guardian before any dental services can be started and accomplished by Dr. Lisa Lazzara or any other doctors, hygienists, assistants, or staff associated with Kids Dental, P.C.

Authorization is hereby granted to perform examinations, take x-rays and/or photographs, clean teeth, administer fluoride treatments, and provide oral hygiene instruction if deemed necessary.

After thorough examination, if further treatment is necessary, authorization is hereby granted to administer local anesthetics and/or nitrous oxide analgesia and perform any treatment (i.e. x-rays, photographs, cleaning, sealants, white or silver fillings, pulp therapy, composite crowns, stainless steel crowns, extractions, space maintenance, tooth movement) and/or such operations, or treat my child/children as it may be deemed necessary or advisable by Dr. Lisa Lazzara or any other doctors, hygienists, assistants, or staff associated with Kids Dental, P.C. I also give permission to provide my child/children with emergency care if needed. I have had the treatment plan(s) for my child/children explained to me. The risks involved with those procedures, alternatives to those procedures, risks therein involved, and the risks of no treatment at all have also been explained to me, and I understand the explanations. I have been given the opportunity to ask questions and have those questions answered.

Unless otherwise requested below, we will use white/composite fillings. In some cases, the co-pay may be slightly higher for white/composite fillings than the silver/amalgam fillings.

_____ I request **WHITE**/composite fillings for my child/children

_____ I request **SILVER**/amalgam fillings for my child/children

_____ I request **WHITE**/composite fillings for **adult** (permanent) teeth
and **SILVER**/amalgam fillings for **baby** (primary) teeth for my child/children

I hereby acknowledge that I have read and understand this consent form, and this consent shall remain in effect for my child/children until I choose to terminate it and I will give written notification to reverse this document.

Patient Name _____ Relationship to Patient _____

Signed Name (Parent/Legal Guardian) _____ Date: _____

NOTICE OF PRIVACY ACKNOWLEDGEMENT KIDS DENTAL, P.C.

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("**HIPAA**") 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 whom may be involved in the treatment directly or indirectly
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications
- Confirm or verify appointment information when messages may be left on answering machines or cellular telephones

I authorize my child's/children's pediatrician or other physician(s)/medical facilities to release any and all pertinent medical information regarding my child/children, I also authorize the release of pertinent information to those persons requiring it for treatment of my child/children or for the purpose of payment of the account or credit references. I authorize transmission, electronically or other means of data for payment/communication purposes including, but not limited to, insurance companies.

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 to obtain a current copy of the Notice of Privacy Practices

PATIENT NAME _____ Relationship Patient _____

Signature of Parent/Guardian _____ Date _____

FINANCIALS AND OFFICE POLICIES

PLEASE READ - Most insurance companies pay on a percentage basis, such as 100% for preventive, 80% for basic, and 50% for major services. Some insurance have various frequencies for procedures, and some are **not** covered by insurance. **NOT ALL SERVICES ARE A COVERED BENEFIT**. Any services **not** covered will be the **patient's/parent's responsibility**. You, the member, need to fully understand these terms and agreements with your own dental insurance company. **YOU, THE MEMBER, WILL THEN BE RESPONSIBLE FOR ANY DEDUCTIBLE AND/OR COPAYMENTS** up to 100% of the maximum allowable fee set by your insurance at the time treatment is rendered. We must emphasize that as dental care providers, our relationship is with you and not your insurance company. If you have any questions about the above information, or any uncertainty regarding your insurance coverage, please do not hesitate to ask - we are here to help you. **Please look at your EOB (explanation of benefits) that is mailed to you.**

****DUAL INSURANCE COVERAGE** - **MUST provide the EOB of the primary insurance within 30 days** of receipt, or you will be responsible for any remaining balance on the account. **INITIALS: _____**

CHARGES MAY ALSO BE INCURRED FOR BROKEN OR CANCELLED APPOINTMENTS: Kids Dental, P.C. is committed to providing quality specialized dental care. We ask that you please be respectful of the time that is scheduled for your appointment(s). Our policy requires that you give us, at minimum **24 hours** notice (not including weekends and holidays) if you need to cancel or reschedule your appointment. Failure to do so will result in a **$30.00** fee for HYGIENE appointments and **$50.00** fee for your DOCTOR appointments. If you arrive 15 minutes, or more, late for your appointment, your appointment may have to be rescheduled. **INITIALS**: _____

CREDIT CARD AUTHORIZATION: It is our OFFICE POLICY to obtain your credit card information and authorization to process a claim for payment should your dental health insurance not honor the claim submitted or you have a remainder out of pocket. In providing credit card information below, you **authorize payment by credit card** for services in the absence of coverage by your dental insurance (including, but not limited to, **copayments, deductibles, and/or not covered services), missed appointment fee, and/or bounced checks that cannot be redeposited, and associated bank fees.**

Name on Credit Card _____ Billing Zip Code _____

Credit Card Number (Visa/MC) _____ CVV/CID _____ Exp. Date _____

Signature _____ Today's Date _____ **STAFF** ONLY ____