Name: _____

Date: _____

Please tell us how you learned about our practice. (Select **ALL** that apply)

_____ Friend/Family Name: _____

_____ Sibling is a current patient Name: _____

_____ Current patient Name: _____

_____ Staff member Name: _____

_____ Other dentist/doctor Name: _____

_____ School Name: _____

_____ Insurance company Name:_____

_____ Our website www.ryesmiles.com

_____ Internet search

_____ Facebook

_____ Twitter

_____ Google

_____ Yelp

_____ Instagram

_____ Community service outreach/booth

_____ Flyer

_____ Postcard

Patient Information

Today's Date: _____

Child's Name: _____ _____
(First) (Last)

Nickname: _____ M / F Age:_____ DOB: __/__/____

Siblings seen in this office?: (Names)_____

Home Address:_____

City:_____ State:_____ Zip code:_____

PARENT INFORMATION

Name:_____

Mother/Father Step-parent Guardian Birth date: ___/___/____

Address (if different than child's):_____

Home phone #:_____ Cell #: _____

Employer:_____ Occupation:_____

Work #:_____ Ext._____

SS#:_____ E-mail:_____

PARENT INFORMATION

Name:_____

Mother/Father Step-parent Guardian Birth date: ___/___/____

Address: (if different than child's)_____

Home phone #:_____ Cell#:_____

Employer:_____ Occupation:_____

Work #:_____ Ext._____

SS#:_____ E-mail:_____

Marital Status: Single Married Separated Widowed Divorced

Who is accompanying your child today?_____

Relationship:_____

IN CASE OF EMERGENCY CONTACT

Name:_____ Phone #:_____

PERSON RESPONSIBLE FOR THE ACCOUNT

Name:_____ Relationship:_____

Billing address:_____

City:_____ State:_____ Zip code:_____

Office: (914) 967-5735
Fax: (914)967-6638

16 School Street, Second floor
Rye, NY 10580

www.ryesmiles.com
ask@RyeSmiles.com

RYE SMILES
PEDIATRIC DENTISTRY

YOUR CHILD'S DENTAL HISTORY

Is this your child's first visit to the dentist?_____
If not, how long has it been since your last visit?_____
Was the child's past visit(s) positive? ☐Yes ☐No
If not, please explain why_____

Were there any X-rays previously taken?_____Date:_____

Name of previous dentist:_____
Location:_____

Have there been any injuries to the face, teeth or mouth?_____
If yes, please explain_____

Why did you bring your child to the dentist today?_____

Does your child have any of the following habits?

- ☐ Thumb/finger sucking?
- ☐ Nursing bottle habits
- ☐ Nail biting
- ☐ Grinding

Has your child ever had a serious or difficult problem associated with previous dental work?

Is your child's water fluoridated? ☐ Yes ☐ No
Is your child taking fluoride supplements? ☐ Yes ☐ No
Does your child drink bottled water? ☐ Yes ☐ No
Does your child brush their teeth daily? ☐ Yes ☐ No
Floss daily? ☐ Yes ☐ No
Does your child have pain in his/her teeth today? ☐ Yes ☐ No
Has your child ever had any pain or tenderness in their jaw (TMJ/TMD)? ☐ Yes ☐No

Is there any information you could share with us that might make your child feel more comfortable during his/her visit(s)? (hobbies, interests, etc.)?_____

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YOUR CHILD'S HEALTH HISTORY

Has your child had any of the following conditions?

☐Yes ☐No	ADD/ADHD	☐Yes ☐No	Sensory Issues
☐Yes ☐No	Abnormal bleeding/Hemophilia	☐Yes ☐No	Handicaps/disabilities
☐Yes ☐No	Allergies to any drugs/meds	☐Yes ☐No	Hearing/sight impairment
☐Yes ☐No	Any hospital stays/Operations	☐Yes ☐No	Glandular/Hormone Disease
☐Yes ☐No	Eating disorder/Stomach problems	☐Yes ☐No	Diabetes
☐Yes ☐No	Asthma/Reactive Airway Disease	☐Yes ☐No	Hepatitis
☐Yes ☐No	Cancer/Tumors	☐Yes ☐No	Exposure to HIV/AIDS
☐Yes ☐No	Abnormal heart condition/Murmur	☐Yes ☐No	Kidney/Liver Condition
☐Yes ☐No	Convulsions/Epilepsy	☐Yes ☐No	Rheumatic/Scarlet Fever
☐Yes ☐No	Mental/Nervous Disorder	☐Yes ☐No	Allergies to latex products
☐Yes ☐No	Speech problems/impairments	☐Yes ☐No	Congenital birth defects

Please explain or list any serious medical conditions your child has had:

_____

Please list all medications your child is currently taking:

_____

Please list ANY allergies your child may have (including foods):

_____

Child's Physician: _____ Date of last well visit: _____

Location: _____ Phone#: _____

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

If yes, for what? _____

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.

As the parent/guardian of _____, I authorize the dental staff to perform the necessary dental services my child may need.

NO TREATMENT, ANESTHESIA OR X-RAYS WILL BE PERFORMED WITHOUT YOUR PRIOR KNOWLEDGE.

I also acknowledge that I am responsible for all charges incurred in the rendering of dental services at the time or treatment.

Signature:_____ Date:_____ Relation to patient_____

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RyeSmiles Pediatric Dentistry
16 School St.
Rye, NY 10580

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I, _____have received a copy of Dr. Deborah Troy's Notice of Privacy Practice.

_____
Please print patient's name.

_____
Please print your name.

_____
Relation to patient.

Your Signature._____

Date._____

********** For Office Use Only **********

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

- ☐ Individual refused to sign
- ☐ Communication barrier prevented obtaining acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (please specify) _____

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PEDIATRIC DENTISTRY

HIPAA Communications Consent

HIPAA stands for the Health Insurance Portability and Accountability Act. HIPAA was passed by the U.S. government in 1996 in order to establish privacy and security protections for health information. Information stored on our computers is encrypted. The email guidelines are available (page 5634) on the U.S. Department of Health and Human Services – http://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf

Please complete this form by indicating a check mark in each section that would be an acceptable manner in which our practice can contact you.

Contact via phone:

- ○ Provider can leave their name and phone number **only** when they call
- ○ Provider can leave a detailed message when they call

Contact via text:

- ○ Provider can text appointment reminders to a mobile phone
- ○ Decline to allow text appointment reminders to a mobile phone

Contact via email at _____

- ○ Provider may send me appointment reminders or protected health information (PHI) using encrypted email messages. Once the email is received by you, someone may be able to access your email account and read it. In cases of emergency, email is not suitable; for a prompt response, please contact our on call service at 914-967-5735.
- ○ Decline to allow encrypted emails for communication

_____ _____ _____

Patient's Name (Please print) Signature of Patient, Parent, or Legal Guardian Date

RYE SMILES
PEDIATRIC DENTISTRY

Dr. Deborah Troy, D.D.S., P.C.
Dr. Charles Yau, D.D.S.

WELCOME TO OUR OFFICE

Our regular office hours are every Monday - Friday 9-6pm
& Some Saturdays 9-3pm
24 hour emergency service is available

Please take a moment to look over the following information and sign the form at the bottom.
A copy will be provided to you upon request. Thank You.

OUR POLICIES

- **APPOINTMENTS**
  Due to the large volume of patients we see, 24 hour notice must be given for any cancellations. Missed or broken appointments without notice are subject to a $65.00 charge. As a courtesy, we attempt to reach all patients 1-3 days in advance for confirmation. However, the final responsibility for all appointments lies with the parent/guardian.

- **PAYMENT**
  Payment is due upon completion of treatment (at each visit) unless specific financial arrangements have been made. If such arrangements are needed, we will be glad to assist you. It is the responsibility of the parent/guardian who signs below for all fees incurred. We accept cash, personal checks, VISA, MasterCard, Discover, and American Express.

  Late or missed payments will be subject to a finance charge of 1.5%. Outstanding balances of more than 60 days are automatically assigned finance charges which will continue to accrue until the balance is fully paid.

- **INSURANCE**
  We will electronically submit to your insurance company as a courtesy to you. However, our professional services are rendered to your child and not the insurance company. Therefore, you are responsible for payment of your child's treatment at the time services are rendered as well as following up with submitted claims.

I, hereby, certify that I have read the above information on _____
(DATE)

_____ _____

(SIGNATURE) (RELATIONSHIP TO PATIENT)

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