Ruby Gelman dmd
dental care for kids

Child's Information

Patient ID#

Today's Date:

Welcome to our practice!

We strive to make your child's visit pleasant and comfortable. Our goal is to teach your child oral habits which will help maintain a beautiful smile for a lifetime.

Your Child

Child's Name _____ Nick Name _____

Sex: ☐ Male ☐ Female Birthdate _____ Age _____

SS#/SIN _____ School _____ Grade _____

Child's Home Address _____

City _____ State _____ Zip _____ Phone _____

1st Parent

Name _____ E-mail _____

Phone: (Home) _____ (Work) _____ (Cell) _____

SS#/SIN _____ Employer _____ Occupation _____

2nd Parent

Name _____ E-mail _____

Phone: (Home) _____ (Work) _____ (Cell) _____

SS#/SIN _____ Employer _____ Occupation _____

Parent's Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Who is responsible for making appointments?

Name _____

Phone: (Home) _____ (Work) _____ (Cell) _____

At which number shall we contact you? _____

Best time to call: (Date) _____ (Time) _____ Email _____

Primary Dental Insurance

Insured's Name _____ Relationship _____

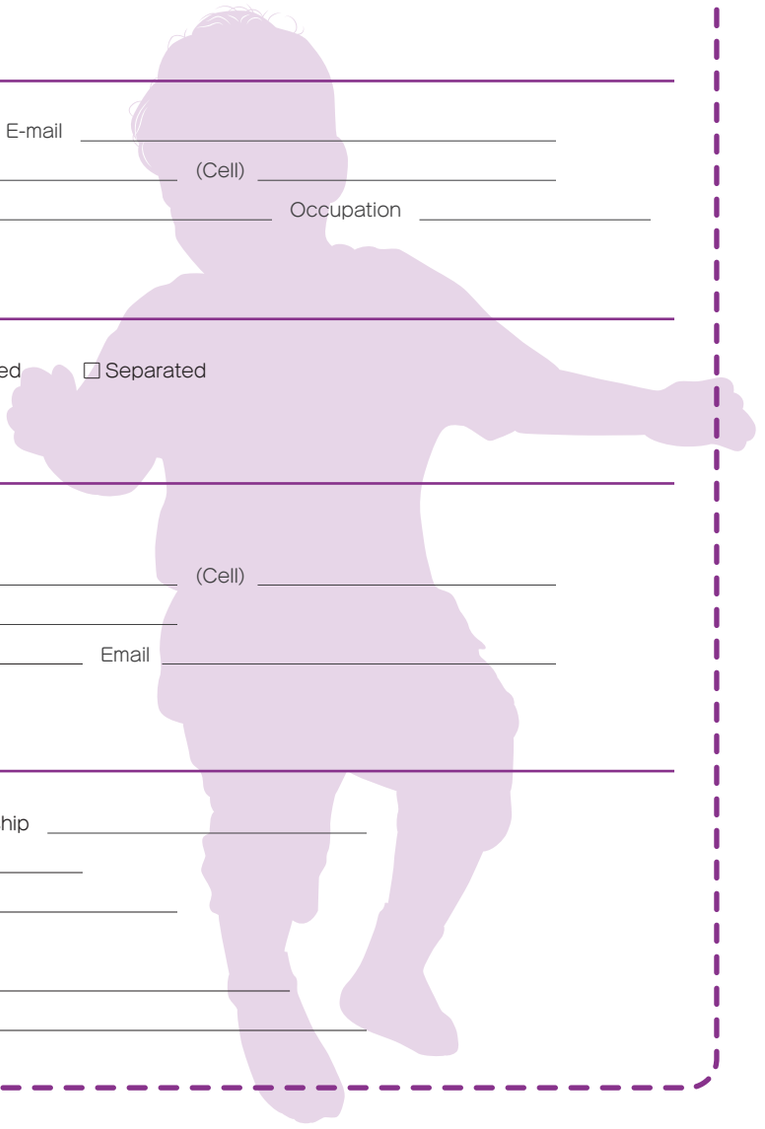
Birthdate _____ SS#/SiN _____

Employer _____ Date Emp. _____

Ins. Company _____

Policy # _____ Group # _____

Ins. Company Address _____



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Health History

Your child's overall health as well as any medications which your child takes could have an important inter-relationship with the dental care your child receives. Please answer each of the following questions completely.

Health History

Has your child had difficulty with previous visits? _____

Does your child have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks) ? _____

Is your child taking any medication? If so please list: _____

Has your child ever had any of the following:

Asthma	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Congenital Heart Defect	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No	Handicaps/Disablities	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No	Convulsions/Epilepsy	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Abnormal Bleeding	☐ Yes	☐ No
Allergies	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No

Please explain any medical problems that your child has:

_____

_____

Child's Habits

How often does your child brush? _____ How often does your child floss? _____

Date of last dental visit _____ Previous Dentist _____

Child's Physician _____ Physician's Phone Number _____

Child's Birthdate _____

Is your child's water fluoridated? ☐ Yes ☐ No Does your child take fluoride supplements? ☐ Yes ☐ No

Does your child:

Suck thumb/finger	☐ Yes	☐ No	Suck/Bite lips	☐ Yes	☐ No
Chew hard objects(Pencils, etc.)	☐ Yes	☐ No	Grind Teeth	☐ Yes	☐ No
Clench jaws	☐ Yes	☐ No			

Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. 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 authorize the dentist to release any information including the diagnosis and the record of any treatment or examination rendered to my child during the period of such Dental care to third party payors and/or other health practitioners. I hereby authorize the office of Dr. Ruby Gelman to perform the examination and after explanation, any and all treatment for the above named child including radiographs if indicated and consent to such methods, drugs and agents that may be indicated in connection with his/her dental care. This consent shall remain in effect until cancelled. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient or parent/guardian if minor _____ Date _____

Dentist Review

_____

_____

Date _____

Signed Dr. _____

Health History Update

Date _____

Comments _____

_____

Signature _____

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

TO THE PATIENT - 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 whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, healthcare operations, 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 Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Dr. Ruby Gelman

Telephone: 212-682-9555

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 to continue treating you if you revoke this Consent.

SIGNATURE

I, _____ , have had full opportunity to
(Parent / Legal guardian)

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 protected health information to carry out treatment, payment activities and healthcare operations.

Signature: _____

Date: _____

Patient's Name: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

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 me after I have revoked my Consent.

Signature: _____ Date: _____