INFORMATION UPDATE FORM

Are you filling this form out for yourself or someone else?

○ Myself ○ Someone Else

What is your name? ______________________

First name ______________________ Last name ______________________

What is your relationship to the patient?

____

Patient information

First name ______________________ Last name ______________________

Preferred name ______________ DOB ______________ Gender ○ M ○ F ○ Non-Binary

Social Security Number or Tax ID (if you don't have one, put 000-00-0000) ______________________

Has your address changed in the last 6 months? ○ Yes ○ No

Home Address ______________________

Home Phone ______________________ Mobile Phone ______________________

Email (if you don't have an email, please write none@none.com) ______________________

Do you have an emergency contact? ○ Yes ○ No

Emergency Contact Name ______________________

Emergency Contact Number ______________________

How did you hear about us?

○ Professional/Doctor Referral
○ Drove by/Walked by
○ Billboard
○ Internet Search/Google
○ Website
○ Community Event
○ School Program/Presentation
○ Insurance Company Directory
○ Social Media
○ Sibling Referral
○ Existing Patient Referral

Do any of the following conditions apply to you?
Please check all that apply we need this information to keep you healthy and safe.

Heart or Circulatory

- ○ Angina
- ○ Artificial Heart Valve
- ○ Arteriosclerosis
- ○ Cardiovascular disease
- ○ Congenital heart valves
- ○ Damaged heart valves
- ○ Heart transplant
- ○ High blood pressure
- ○ Low blood pressure
- ○ Heart attack
- ○ Heart murmur
- ○ Infective endocarditis
- ○ Mitral valve prolapse
- ○ Pacemaker
- ○ Pulmonary embolism
- ○ Rheumatic heart disease

Lung or Breathing

- ○ Asthma
- ○ Bronchitis
- ○ COPD
- ○ Cystic Fibrosis
- ○ Emphysema
- ○ Tuberculosis

Digestive or Dietary

- ○ Acid reflux/persistent heartburn
- ○ Excessive urination
- ○ Gastrointestinal disease
- ○ Malnutrition
- ○ Eating disorder
- ○ Severe or rapid weight loss
- ○ Special diet
- ○ Pulmonary embolism

Neurological

- ○ Autism
- ○ Brain aneurysm
- ○ Brain injury
- ○ Epilepsy
- ○ Fainting
- ○ Migraines/severe headaches
- ○ Seizures
- ○ Stroke

Autoimmune

- ○ Ankylosing spondylitis
- ○ Celiac disease
- ○ HIV or AIDS
- ○ Immune deficiency
- ○ Lupus
- ○ Multiple sclerosis
- ○ Rhematoid arthritis
- ○ High blood pressure

Other Conditions

- ○ Anemia
- ○ Cancer
- ○ Diabetes
- ○ Glaucoma
- ○ Bleeding disorder/Hemophilia
- ○ Hepatitis
- ○ Jaundice or Liver Disease
- ○ Osteoporosis
- ○ Renal/Kidney problems
- ○ Sleep Apnea
- ○ Sexually transmitted disease
- ○ Total joint replacement

Comments or additional information regarding your medical history ______________________

____

Have you had any hospital stays or any operations recently? ○ Yes ○ No

Comments or additional information regarding the patient's hospital stays and operations with dates included:

____

Would you be interested in a consult with our Orthodontist to evaluate the possibility of braces or another appliance?

○ Yes ○ No

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Please carefully read and check all that apply regarding any medications you may be taking or allergies you have. We need this information to keep you healthy and safe.

Are you currently taking any medications or supplemnts?

Diabetes, Cholesterol, Blood Pressure, or Metabolic

- Avapro (Irbesartan)
- Coreg (Carvedilol)
- Coumadin (Warfarin)
- Crestor (Rosuvastatin)
- Klor-Con (Potassium Chloride)
- Lasix (Furosemide)
- Lipitor (Atorvastatin Calcium)
- Lopressor (Metoprolol)
- Losartan (Cozaar)
- Metformin (Glucophage)
- Microzide (Hydrochlorothiazide)
- Norvasc (Amlodipine)
- Plavix (Clopidogrel)
- Pravachol (Pravastatin)
- Prinivil (Lisinopril)
- Tenormin (Atenolol)
- Toprol XL (Metoprolol)
- Tricor (Fenofibrate)
- Zocor (Simvastatin)
- Zestoretic (Lisinopril)

Pain

- Aspirin
- Codeine
- Demerol (Meperidine)
- Hydrocodone (Vicodin/Lortan/Norco)
- Ibuprofen
- Percocet (Oxycodone)

Antibiotics

- Amoxicillin
- Clindamycin
- Ciprofloxacin
- Doxycycline
- Tetracycline
- Zithromax (Azithromycin)

Allergy, Asthma, or Breathing

- Claritin (Loratadine)
- Flonase (Fluticasone)
- Singulair (Montelukast)
- Ventolin (Albuterol Inhaler)
- Zyrtec (Cetirizine)

Antidepressants, Anxiety, or Behavioral

- Adderall
- Ambien (Zolpidem)
- Celexa (Citalopram)
- Cymbalta (Duloxetine)
- Effexor (Venlafaxine)
- Lexapro (Escitalopram)
- Neurontin (Gabapentin)
- Oleptro (Trazodone)
- Prozac (Fluoxetine)
- Xanax (Alprazolam)
- Wellbutrin (Buproprion)
- Zoloft (Sertraline)

Other

- Aclasta/Reclast (Zoledronic Acid)
- Boniva (Ibandronate)
- Cialis (Tadalafil)
- Cyclobenzaprine (Flexeril)
- Fosamax (Alendronate)
- Pantoprazole (Protonix)
- Prednisone
- Medrol (Methylprednisolone)
- Meloxicam (Mobic)
- Prilosec (Omeprazole)
- Synthroid (Levothyroxi)

What is the current weight (in lbs.) of the patient? ______________________

What is the reason for your appointment?

- Exam
- Cleaning
- Pain
- Cosmetic
- Second Opinion or Consult
- Other

Can you provide more detail? ______________________

Do you have any allergies? Please check all that apply we need this information to keep you healthy and safe.

Do you have any allergies you are aware of? (e.g. drug or latex allergies) ○ Yes ○ No

Do you have any of the following allergies?

- ○ AMOXICILLIN
- ○ PENICILLIN
- ○ LATEX
- ○ ASPIRIN
- ○ FOOD
- ○ TETRACYLLN
- ○ ANESTHSIA
- ○ POLLEN
- ○ ANIMALS
- ○ FENTANYL
- ○ VANZOMYCIN
- ○ PRILOSEC
- ○ ORAL BIRTH CONTROL
- ○ MEDICATIONS
- ○ NONE
- ○ OTHER
- ○ GRAPE EXTRACT
- ○ CODEINE
- ○ NO KNOWN DRUG ALLERGIES
- ○ ANIMALS
- ○ OTHER
- ○ BARBITURATES OR SEDATIVES
- ○ IODINE
- ○ METALS
- ○ SEASONAL
- ○ SULFA DRUGS

Are you pregnant or think you might be pregnant? ○ Yes ○ No

Are you currently breastfeeding? ○ Yes ○ No

Do you use any recreational drugs? ○ Yes ○ No

Do you smoke? ○ Yes ○ No

Approximately how much per day do you smoke? ______________________________

Are there any developmental disorders? (mental or physical) ○ Yes ○ No

Were there any complications during birth (e.g. preterm birth) or problems with physical growth? ○ Yes ○ No

Do you have a primary care physician? ○ Yes ○ No

Physician's Name ______________________________

Physician's Number ______________________________

What is the name of your preferred pharmacy? ______________________________

What is the address of your preferred pharmacy? ______________________________

What is the phone number of your preferred pharmacy? ______________________________

Patient or Guardian Signature ______________________________

Do you have dental insurance? ○ Yes ○ No

Can you provide a photo of your dental insurance card? ○ Yes ○ No

On this dental insurance, is the patient the subscriber? ○ Yes ○ No

Subscriber's Name ______________________________

Subscriber's Social Security Number or Tax ID (if you don't have one put xxxxxxxxx) ______________________________

Subscriber's Date of Birth ______________________________

Name of Insurance Company ______________________________

Subscriber ID ______________________________

Subscriber's Employer ______________________________

Insurance Group Number ______________________________

Is there a second dental insurance policy? ○ Yes ○ No

Can you provide a photo of your dental insurance card? ○ Yes ○ No

On this dental insurance, is the patient the subscriber? ○ Yes ○ No

Subscriber's Name ______________________________

Subscriber's Social Security Number or Tax ID (if you don't have one put xxxxxxxxx) ______________________________

Subscriber's Date of Birth ______________________________

Name of Insurance Company ______________________________

Subscriber ID ______________________________

Subscriber's Employer ______________________________

Insurance Group Number ______________________________

I understand that I am financially responsible for any charges not covered by my benefits. It is my responsibility to notify the office of any changes to my benefits. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for products and services received. I authorize this office to submit insurance claims on my behalf and to release information necessary to my insurance company for the processing of those claims. I assign all dental benefits for services rendered and authorize and direct my insurance carrier(s) to issue payment directly to you. I certify that the information I have provided is accurate to the best of my knowledge.

Patient or Guardian Signature ______________________________

Cancellations and Missed Appointments

Your appointment time is reserved specifically for you and for you only. Because of this, missed appointments or late cancellations are extremely detrimental to our day. As a result, we request at least 48 hours advanced notice if you will not be able to make your appointment. Repeated missed appointments or late cancellations may result in fees or dismissal as a patient.

Payment

Payment in full for your treatment is due no later than when services are rendered. Acceptable forms of payment include cash, Visa, Master Card, American Express, Discover, and assigned insurance benefits. In the event there is a shortage due to insurance underpayment, it is our policy to charge finance fees at 1.5% for outstanding patient balances after the balance has been outstanding for more than 30 days after you have been notified of a balance due. Payments returned due to non-sufficient funds will be subject to a NSF fee of $25.00.

Patient or Guardian Signature ____

Privacy Practices
YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

You have the right to:

- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we have shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated.
  To file a complaint, please contact:

  The ChildSmiles Group, LLC Attn: Privacy Officer
  103 Eisenhower Parkway, Suite 102
  Roseland, NJ 07068
  (973) 536-0607)

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, by home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information above.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference for example, if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

Treat you
We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization
We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

Bill for your services
We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests
We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director
We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Organized Health Care Arrangement
We are a member of an integrated family health care system known as the ChildSmiles Group and consisting of ChildSmiles-FamilySmiles, Pearly Whites, the Children's Ambulatory Surgery Center of New Jersey, Kids Care, Washington Park Pediatrics, Abra Health, Abra Dental and Smiles 4 Keeps. In the event that we need to refer you to another provider within the ChildSmiles Group and you agree to the referral, we will transfer your patient records to facilitate your referral. Any such transfer of records will be performed free of charge. This is done as a convenience for you, and to ensure that you receive the best care possible.

Effective Date: November 19, 2021

Patient or Guardian Signature ______________________________

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GENERAL INFORMED CONSENT

Smiles 4 Keeps wants your visit to be both educational and enjoyable. Therefore, we request that you read this consent and notice form carefully. This form is meant to provide information on some of the routine procedures we may perform during your initial and continuous visits. If you do not have any questions or concerns, we ask that you complete the form and sign at the bottom of the page giving us your consent to perform the listed procedures as deemed necessary.

Consent to receive dental treatment: I consent and authorize the doctor and his/her staff to examine, clean, and provide dental treatment. I further consent and authorize the taking of dental x-rays, as may be considered necessary by the doctor to diagnose and/or provide treatment. I will allow photographs to be taken for diagnostic or educational purposes. I consent to the application of fluoride varnish to prevent tooth decay and reduce tooth sensitivity. I also consent to the use of topical and local anesthetics during the treatment. I understand that although their occurrence is extremely rare, some risks are known to be associated with the anesthetics. These risks include, but are not limited to; swelling, bruising, nausea, breathing problems, allergic reactions, or brain damage. I further understand and accept that, though unlikely, complications may arise which may require hospitalization.

I hereby state that I have read and understand this consent and that all questions about the procedures have been answered in a satisfactory manner.

Patient or Guardian Signature ______________________________