OCEAN PEDIATRIC DENTAL ASSOCIATES

ELISA J. VELAZQUEZ, D.M.D., M.S.D.
BOARD CERTIFIED SPECIALIST
AND ASSOCIATES

Dentistry and Orthodontics for Infants and Children

We would like to welcome you and your family to our office. We are happy that you chose us as your child's dental home and we will do our best to assure that your child's dental experience will be an enjoyable and pleasant one.

Your child's first visit will be approximately 30 minutes and will include:

- Meeting the staff and becoming familiar with the office
- A thorough oral examination, orthodontic evaluation, soft tissue analysis, oral hygiene instruction, fluoride and dietary counseling
- Any necessary x-rays and a discussion regarding their interpretation
- A diagnosis concerning your child's dental care, a treatment plan and consultation
- A chance for you to ask questions
- A cleaning and fluoride treatment

You are welcome to be present in the room while your child receives their dental care. One parent must be present at the initial visit.

We are available by telephone through our office staff or answering service 24 hours a day and will respond to emergency calls promptly. Your child's needs and care are our ultimate concern and we would like to be contacted in the event of pain or injury.

Methods of payment include: Cash, Visa, Mastercard, American Express, Discover, Debit Cards & we also offer Care Credit.

If you need to change your appointment, please give the office 24 hours notice.

Enclosed you will find a medical /dental history form. Please fill it out and bring it with you. If you have dental insurance, please bring your insurance ID card and any necessary forms.

We want to help give your children the best possible chance to grow up with healthy teeth and beautiful smiles. With your understanding and cooperation, we hope to achieve this goal!

Once again, we thank you for choosing our office and we look forward to meeting you and your family.

Elisa Velazquez D.M.D., Matthew Sones D.M.D, and Staff

1301 Route 72, Suite 305
Manahawkin, NJ 08050
609-597-9195
Fax 609-597-9165

368 Lakehurst Road • Suite 305
Toms River, NJ 08755
732-473-1123
Fax 732-473-1133

211 W Millstream Road
Cream Ridge, NJ 08514
609-758-9595
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www.oceanpediatricdental.com

HIPAA Notice of Privacy Practices

368 Lakehurst Road, Suite 305
Toms River, NJ 08755
(732) 473-1123

1301 Route 72, Suite 305.
Manahawkin, NJ 08050
(609) 597-9195

211 W. Millstream Road
Cream Ridge, NJ 08514
(609) 758-9595

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) and for the purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your dental care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admissions.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. Mail personal office letters, review financial agreements, collect payment prior to treatment, to review hygiene instructions and dental treatment. We may send billing statements and contact you and your insurance carrier for insurance information.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Disease: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal proceedings: Law Enforcement: Coroners: Funeral Directors, Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in the care or for notification purposes as described in This Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

You physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice ad will inform you by mail of any changes. You than have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe you privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filling a complaint**

This notice was published and becomes effective on/or before **April 14, 2003.**

Contact Officer: **Marianne Patchett** Telephone: (732) 473-1123
Fax: (732) 473-1133

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of Privacy Practices:

Print Name:_____ Signature:_____ Date:_____

OCEAN PEDIATRIC DENTAL

Dr. Elisa Velazquez, Dr. Matthew Sones and Associates

MEDICAL HISTORY

Patient's name_____Age_____Date_____
Last First

Date of Birth_____Male_____Female_____Nickname_____Weight_____

Address_____
City State Zip

Home Phone_____Cell/Pager #_____

E-mail _____

Pediatrician_____
Name Address Phone

Other Health Care Providers_____

Whom may we thank for referring you?_____

1. General status of Health?_____Excellent_____Good_____Fair

2. Date and reason for child's last medical exam
   _____

3. Has your child ever been hospitalized or received sedation/anesthesia?
   Reason_____

4. Is your child allergic to any medicine, food or substance?
   List_____

5. Is your child taking any medications?
   List_____

6. Has your child ever had any of the following? Please Check

___Heart Murmur	___Asthma	___Chronic sinusitis	___Lung disease
___Heart Disease	___Anemia	___Cerebral Palsy	___Seizures
___Hepatitis	___Bronchitis	___Bleeding Problems	___Epilepsy
___Diabetes	___Tuberculosis	___Blood Transfusion	___Other
___HIV(+)or AIDS	___Thyroid	___Hearing Difficulty	_____
___Kidney Disease	___Hemophilia	___Liver Disease	

7. Has your child's physical development been normal?____Yes ____No
   If no, please explain:_____

8. Does your child have any Psychological/Emotional /Behavioral concerns? ____Yes ____No
   If yes, please explain:_____

9. Has your child been diagnosed with the following: ADD__ ADHD __ SPD__ AUTISM__NONE__

(Over Please)

Dental History

1. Is this your child's first visit to the dentist? ____Yes____No
2. Name, Date and Address of previous dentist_____
   _____
   Reason for the visit?_____
   Were any x-rays taken? ____Yes ____No
   Was visit pleasant? ____Yes ____No
   If no, please explain_____
   _____
3. Has your child ever had any of the following? Please check:
   ____Dental fillings ____Local anesthesia (Novocain) ____Sealants
   ____Orthodontics ____Nitrous oxide (Laughing gas) ____Extraction
   ____Injury to teeth, jaw or face ____Nerve treatment
4. Does your child have any oral habits? Please check:
   ____Pacifier ____Finger/Thumb sucking ____Breastfeeding
   ____Nail biting ____Tongue thrusting ____Bottle nursing
   ____Grinding teeth
5. Are you happy with the appearance of your child's teeth? ____Yes____No
   If no, please explain_____
6. What concerns you most about your child's teeth?_____
   _____
7. Does your child take fluoride in any form? Explain_____
8. Child's interests, hobbies, pets, etc:_____
9. Please list any questions you would like to have answered_____
   _____

PARENT/GUARDIAN INFORMATION

Parent#1 name_____ Parent #2 name_____

Occupation_____ _____

Soc. Sec. #_____ _____

Birth Date_____ _____

Employer_____ _____

Address_____ _____

Bus phone_____ _____

Cell Phone_____ _____

Dental Ins. Carrier_____ _____

Policy #_____ _____

Consent

Because _____is a minor, it is necessary that signed Permission be obtained from a parent or guardian before dental treatment is initiated. Therefore, I authorize the doctor and the dental staff to perform the necessary dental services my child may require. Furthermore, I will be responsible for any fee incurred on the above-named child for dental services rendered.

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash, check or credit card at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of $40.00 will be charged to your account if referred to our collection agency.
A service charge of $40.00 will be charged to your account for any checks(s) returned for insufficient funds.
The parent that accompanies the child for their dental visit is responsible for payment for services rendered.

I grant my permission to you or your assignee, to telephone me at home, work, or cell phone to discuss matters related to this form.

There will be a $25.00 fee (for each ½ hour of time set a side for the appointment) for any broken appointment unless 24 hour notice is given.

I have read the above conditions of treatment and payment and agree to their content.

X_____

PRINTED NAME Signature of parent or guardian Date

Fluoride Notification

Please be advised as of January 1, 2007 most Insurance Companies will only pay for Fluoride Treatments once (1) a year. Our office focuses on prevention and fluoride will be applied every 6 months.

Fluoride is naturally occurring element that helps prevent tooth decay by strengthening teeth. The ADA & the American Academy of Pediatric Dentistry recommend that topical fluoride be professionally applied at least 2 times a year.

I understand that any treatment not covered by insurance will be my financial responsibility

Signature **Date**

Please feel free to discuss fluoride with hygienist and the doctor.

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Authorization to Release Information:

I hereby authorize the above named dentists to provide any insurance companies, claim administrators, and consulting health care professionals information concerning health care, advice, treatment, or supplies provided. This information will be used exclusively for the purpose of evaluating and administering claims for benefits.

_____ ____/____/____

Patient or Authorized Guardian's Signature **Date**

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