A New Smile Dental Center

Patient Information For your Child

Today's Date: _____________________

Child's Name: ___________________ Birthdate: ________SS#__________
Address: ________________City: __________ST______Zip______
Phone: _______________

Whom May we thank for referring you? ___________________
Person to contact in case of emergency ____________Phone: ___________
Reason for your visit today? ______________________________

Responsible Party

Name: ________________________ SS #: ___________
Birthdate: _______________
Relationship: _____________________
Address: __________________ City: ______________
State: ____________Zip: _________
Email: ______________________

A fee of $25 will be charged for cancelled appts. Without 24 hour notice.

*Please sign X*____________________________________

Patient Dental and Medical History

*Previous Dentist*___________________ *Office #*________________ *Date of last exam*____________

How often does your child brush? ______________ How often does your child floss? ________________
Is your child's water fluoridated? Yes [ ] No [ ] Does your child take fluoride supplements? ________

Does your child:

Suck thumb/finger	Yes [ ] No [ ]	Bite/Chew nails	Yes [ ] No [ ]
Suck/Bite lip	Yes [ ] No [ ]	Chew hard objects	Yes [ ] No [ ]
Grind Teeth	Yes [ ] No [ ]	Clench Jaws	Yes [ ] No [ ]

Is your child taking any medication? Yes [ ] No [ ]
- If yes what medications ____________________________________

Does your child have a history of allergies/ sensitive/ adverse reactions to any drugs or medications?
(Penicillin Novocaine, etc.) Yes [ ] No [ ]
If yes please describe ____

Does your child have a history of allergies to any other substances (latex, environmental, etc.) ?

Has your child ever had any of the following?

- Rheumatic Fever	Yes [ ] No [ ]	- Heart Murmur	Yes [ ] No [ ]	- Tuberculosis	Yes[ ] No [ ]
- Seizures	Yes [ ] No [ ]	- Asthma	Yes [ ] No [ ]	- Anemia	Yes[ ] No [ ]
- Epilepsy/ Convulsion	Yes [ ] No [ ]	- Cancer	Yes [ ] No [ ]	-Liver Disease	Yes [ ] No [ ]
- Leukemia	Yes [ ] No [ ]	- Arthritis	Yes [ ] No [ ]	- Heart Trouble	Yes [ ] No [ ]
- Diabetes	Yes [ ] No [ ]	- Joint Replacement	Yes [ ] No [ ]	- Respiratory Problem	Yes [ ] No [ ]
- Kidney Disease	Yes [ ] No [ ]	- Jaundice/ Hepatitis	Yes [ ] No [ ]	- Mitral Valve Prolapse	Yes [ ] No [ ]
- Aids or HIV	Yes [ ] No [ ]	- Other	Yes [ ] No [ ]		

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I agree to be responsible for payment of all services rendered on my behalf of my dependants.

*X*___________________________ *Date*__________
Signature of Parent/ guardian of minor

*X*____________________________ *Date*________
Doctor's Signature

A New Smile Dental Center

Suzanne Abergel-Nahon D.D.S, P.A.
14050 S.W. 84th St Miami, FL 33183

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I HAVE THE RIGHT TO REVIEW THE NOTICE OF PRIVACY PRACTICES BEFORE SIGNING THIS CONSENT. I HAVE BEEN GIVEN THE OPPORTUNITY TO READ AND RECEIVE A COPY OF SUZANNE ABERGEL-NAHON D.D.S PA NOTICE OF PRIVACY PRACTICES.

With my consent **Suzanne Abergel-Nahon D.D.S, P.A.** may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to **Suzanne Abergel-Nahon D.D.S, P.A.** Notice of Privacy Practices for a more complete description of such uses and disclosures.

Suzanne Abergel-Nahon D.D.S, P.A. reserves the right to revise its Notice of Privacy Practices anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Privacy Officer at **Suzanne Abergel-Nahon D.D.S, P.A. 14050 S.W. 84th Street, Miami, FL 33183.**

With my consent **Suzanne Abergel-Nahon D.D.S, P.A.** may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent **Suzanne Abergel-Nahon D.D.S, P.A.** may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked personal and confidential.

With my consent **Suzanne Abergel-Nahon D.D.S, P.A.** may disclose my information for purposes of internal staff training or for external educational uses. For example, the doctor may use my health information as part of an academic seminar to demonstrate treatment techniques.

With my consent **Suzanne Abergel-Nahon D.D.S, P.A.** may email to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **Suzanne Abergel-Nahon D.D.S, P.A.** restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to **Suzanne Abergel-Nahon D.D.S, P.A.** to use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, **Suzanne Abergel-Nahon D.D.S, P.A.** may decline to provide treatment to me.

Please turn over -→

____

Signature of Patient or Legal Guardian

Patient's Name

____

Print Name of Patient or Legal Guardian

____

Date

Good faith attempts to obtain the signature from the patient; describe the reason why patient did not sign the form:

____

____

____

____

____

Signature of the Staff Member

____

Name of the Staff Member

____

Date