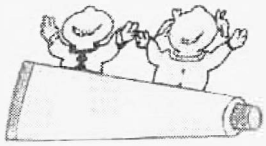
Renuka Rao Bijoor

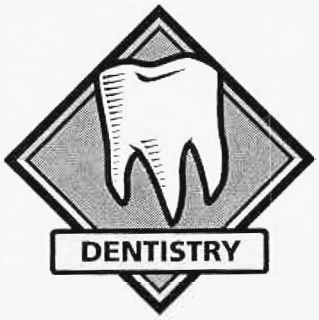
DDS, MDS (Oral Surgery)
FDSRCS (ENG), FFDRCS (IRE)
Board Certified Pediatric Dentist
Briarcliff Pediatric Dentistry



325 South Highland Ave.
Briarcliff Manor, NY 10510
914-762-4151
briarcliffpediatricdentistry.com

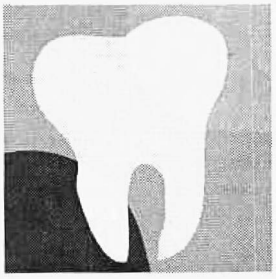
Patient and Family Information:

Child's Name _____ Birthdate _____ ☐ Male ☐ Female
Nickname/preferred to be called by _____
Social Security # _____ Home Phone _____
Home Address _____
School _____ Grade _____
Responsible Party _____
Relationship to Child _____
Name of Mother/Guardian _____ Birthdate _____
Social Security # _____ Home Phone _____
Address _____
City _____ State _____ Zip _____
Employer _____ Business Phone _____
Cell Phone _____ E-Mail _____
Name of Father/Gaurdian _____ Birthdate _____
Social Security # _____ Home Phone _____
Address _____
City _____ State _____ Zip _____
Employer _____ Business Phone _____
Cell Phone _____ E-Mail _____
Names and ages of brothers and sisters _____
Hobbies, pets, favorite TV shows, etc. _____
Whom may we thank for referring you? _____



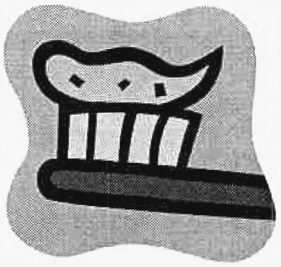
Child's Dental History:

Former Dentist _____ Office Phone _____
Address _____
City _____ State _____ Zip _____
Date of last dental visit _____
Is there anything we need to know about that visit? _____
_____
Reason for this visit (1st examination, check-up, toothache, etc.) _____
_____
Does your child use fluoride or toothpaste? No ☐ Yes Take Fluoride supplements? No ☐ Yes
Does your child use floss? No ☐ Yes
Please check all that apply to your child:
☐ Thumb/Finger Sucking ☐ Fingernail Biting ☐ Grinding Teeth
☐ Lip or Cheek Biting ☐ Jaw Difficulty: Clicking and/or Pain



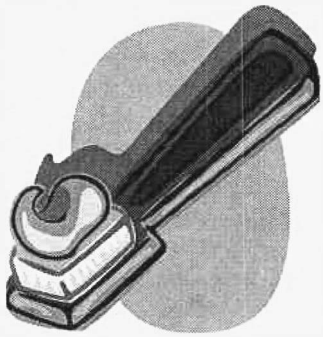
Child's Medical History:

Child's physician/pediatrician _____ City _____ Phone _____
Is your child in good health? _____ Is your child taking any medications? _____
Is your child allergic to any medications? If yes, please list: _____
Other Allergies: If yes, please explain _____
Does your child have a history of…
Cerebral palsy, seizures, fainting, or loss of consciousness? No ☐ Yes ☐
Sensory disorders? (Seeing, Hearing, Sensory Integration Disorder) No ☐ Yes ☐
Being diagnosed with PDD, autism, ADHD, or ADD? No ☐ Yes ☐



Congenital heart disease, heart murmur, or rheumatic fever? If yes, name details of cardiologist. No ☐ Yes ☐

Needing antibiotics prior to dental procedure? No ☐ Yes ☐
Heart surgery being done or recommended? No ☐ Yes ☐
Having a blood transfusion? No ☐ Yes ☐
Anemia or sickle cell disease? No ☐ Yes ☐
Bruising easily or bleeding excessively from small cuts? No ☐ Yes ☐
Pneumonia, cystic fibrosis, asthma, or difficulty breathing? No ☐ Yes ☐
Stomach, intestinal, kidney, or liver problems? No ☐ Yes ☐
Hepatitis? No ☐ Yes ☐
Asthma? If yes, is it under control? No ☐ Yes ☐
Diabetes? No ☐ Yes ☐
Thyroid disease or other glandular disorders? No ☐ Yes ☐
Being hospitalized? No ☐ Yes ☐
(If yes, please explain)_____
Is your child up to date with immunizations? (DPT, IPV, MMR, Hib, HepB) No ☐ Yes ☐
Any other information: _____
_____



Dental Insurance:
Person Responsible for Account_____
Relationship to Patient_____ Birthdate _____
Social Security #_____ Home Phone_____
Address_____
City_____ State_____ Zip_____
Employer_____ Business Phone_____
Business Address_____ Occupation_____
Insurance Company_____
Insurance Company Address_____
Insurance Company Phone Number_____
Subscriber I.D.#_____ Group #_____

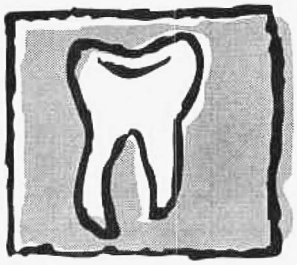
Office Insurance Policy:
The office will only bill to your primary insurance company that we are a participating network provider for. You are responsible for any balance and submitting to your secondary insurance company. All copayments and deductibles are due the day the services are rendered.

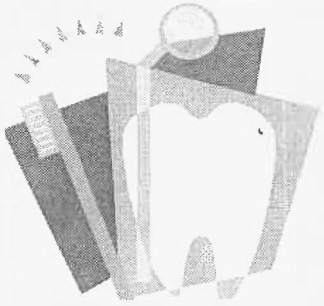
Assignment and Release:
I hereby authorize payment directly to _____
for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

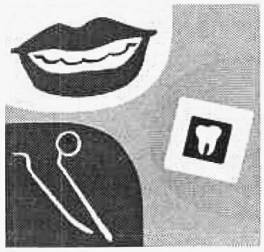
I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

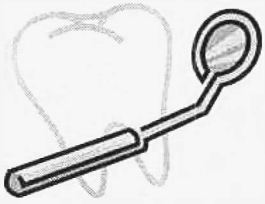
I understand that regardless of insurance coverage, all charges are due in full within 60 days from the date of service from the responsible party. For any unpaid balances, I understand that I am responsible for any legal recourse/fees that will be incurred if balance is not paid.

Signature Responsible Party_____ Date_____









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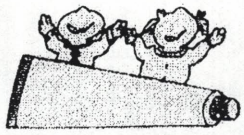

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E-Mail: drbijoor@yahoo.com

Thank you for choosing our office for your dental needs. Obtaining dental treatment is very important for your overall health, but using dental insurance can be confusing. Our financial policies are designed to help patients maximize their insurance plan benefits, and make filing claims easy.

All Patients must complete a patient registration form, a health history form and the HIPPA form before seeing the doctor or hygienist.

PAYMENTS

1. Full payment is due at the time of service for patients without a dental plan. If we accept assignment of insurance payment, the amount not covered by your insurance is due the day of treatment (your portion will be estimated). Total payment is due for first visits. You may find it more convenient to pay in full at the time of treatment, and we will direct your insurance company to pay you.

2. We ask you to provide us with all of your insurance information prior to your first appointment. Your dental plan may or may not include benefits for services rendered in this office. The benefits you receive are in accordance with your dental plan agreement, which is determined by either your employer or yourself. We are happy to help you by submitting insurance claims without charge for those insurance that we do not accept. However, our office does not guarantee payment or coverage by your insurance company. Dental insurance usually pays only a portion of your charges and we urge you to be fully aware of the provisions of your dental plan's policy. You are responsible for your estimated portion at the time of service. Claims uncollectible after five months will become the responsibility of the patient and payable in full. A late charge will be added to your account on any unpaid balance 60 days from the date of treatment on all unpaid balances including outstanding amounts to be paid by your insurance company(s). We will not accept responsibility for your insurance company's delay of payment on your claims.

3. Cash, Check, VISA, Mastercard, American Express, CareCredit are acceptable methods of payment.

4. Since our time with our patients is very precious to us and lost time is irretrievable, we must charge for broken appointments when we have not been notified at least 24 hours in advance. Our charge for broken appointments is $50.00 for every 30 minutes reserved time and $75.00 for Saturday appointments. Our desire is never to find it necessary to make this charge. Please Help us serve you better by keeping your scheduled appointments, we are waiting for you. To cancel or re-schedule, please call during our regular business hours. We will not take cancellations on our answering machine. Please Note: We require an adult to accompany all children under the age of 18.

Monthly payment plans: Care Credit or a similar lender has several NO interest financing options for approved applicants.

FINANCIAL

- An interest charge of 18% will be included on statements overdue by 30 days.
- Any expense incurred from returned checks is your responsibility and will be added to your account balance.
- You will be responsible for an additional 30% of your balance for collection fees incurred.

You will be asked to sign this policy signifying your acknowledgment of and agreement to our financial policies before dental services at Briarcliff Pediatric Dentistry are rendered.

I have read, understand and agree to the financial policy describe above.

_____ _____

Signature of Patient, Parent or Guardian *Date*

We look forward to caring for your dental needs.

AKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign this Acknowledgement *

1. _____, have been given the opportunity to review the copy of this Notice of Privacy Practices

_____
Please Print Name

_____
Signature

_____
Date

_____
For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the aknoledgement
- ☐ An emergency situation prevented us from obtaining aknowledgement
- ☐ Other (Please Specify)

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We are very committed to the philosophy of early intervention and prevention of problems that could impair correct oro-facial growth and development. Diagnosing and treating pediatric sleep disorded breathing is a huge focus in our practice. Please help us help your child best by answering the following.

Name: _____ Age: _____

*Depending on the age of your child, some questions may not be relevant.

Please circle/answer the following:

A. Does your child:

- Still breast-feed? Yes/No
- Still use the bottle? Yes/No
- Have any habits:
  - Pacifier? Yes/No
  - Chewing blanket/toy? Yes/No
  - Thumb? Yes/No
  - Other: _____
- Sleep well at night?
  - If not, why do you think?

    _____
  - How often does your child wake up? _____
- Wet the bed or have frequent urination? Yes/No
- Have difficulty waking up in the morning? Yes/No
- Have daytime drowsiness? Yes/No
- Snore? Yes/No
  - If yes, how often? _____

- Breathe through the mouth? Yes/No
    - During the day, at rest? Yes/No
    - At night? Yes/No
- Grind his/her teeth? Yes/No
    - During the day, at rest? Yes/No
    - At night? Yes/No
- Get frequent colds/upper respiratory/ear infections? Yes/No
- Have seasonal allergies? Yes/No
    - If yes, is he/she under the care of an allergist? Yes/No
    - Name of the allergist? _____
    - What triggers these allergies? _____

      _____
    - What treatment? _____
- Have asthma? Yes/No
- Show signs of hyperactivity? Yes/No
- Show overt irritability? Yes/No
- Show inability to sit still or focus in school? Yes/No
- Fall asleep in class—Has the teacher commented? Yes/No

B. Have you:

- Had your child evaluated by an ENT specialist or had treatment? If yes, who did you see? What was the diagnosis/treatment?

_____

C. Are you concerned/worried about:

- Your child's appearance? Yes/No
- Your child's teeth? Yes/No
    - Do you think they are crooked? Yes/No
    - Are they falling out too soon/too late? Yes/No

Anything else you need to let us know:

_____

Parent/Guardian Signature: _____

Patient Family Screening Form

Patient Name:

TEMPERATURE:

	PRE-APPOINTMENT	IN-OFFICE
	Date:	Date:
Have you, your child, or anyone in your family had a fever in the last two weeks?	Yes / No	Yes / No
Are you, your child, or anyone in your family having any breathing difficulties?	Yes / No	Yes / No
Do you, your child, or anyone in your family have a cough?	Yes / No	Yes / No
Do you, your child, or anyone in your family have any flu-like symptoms or upset stomach, headache, fatigue, rash, etc.?	Yes / No	Yes / No
Have you, your child, or anyone in your family lost taste or smell?	Yes / No	Yes / No
Have you, your child, or anyone in your family been sick or in contact with a person who is sick with COVID-19/Coronavirus?	Yes / No	Yes / No
Has your child been in the hospital or do they have medical problems, such as heart disease, rash, or lung disease?	Yes / No	Yes / No
Have you traveled outside of the Tristate Area in the last 2 weeks?	Yes / No	Yes / No

****IF THE RESPONSE TO ANY IN "PRE-APPOINTMENT" IS YES, NOTIFY DR. BIJOOR**

****IF THE RESPONSE TO ANY IN "IN-OFFICE" IS YES, SEND PATIENT AND FAMILY HOME: THEY NEED CLEARANCE FROM THEIR DOCTOR**