Stanley H. Kessler, DDS
14 Elizabeth Street, Bethel, CT 06801
(203) 797-8070 – www.dockessler.com

Child Registration

Child's Name ______________________________ Nickname __________ Male __ Female __ Date of Birth ____________

Home Address ____

Home Phone ( ) _____________________________________School & Grade ______________________________

Father's Name __________________________________ Employer/Address__________________________

Home Address (if different from above) ____

Home Phone ( ) ______________ Cell Phone ( ) ______________ Work Phone ( ) ___________

Email ____May we call you at work? Yes ___ No ____

Mother's Name _________________________________

Employer/Address___________________________

Home Address (if different from above) ____

Home Phone ( ) ______________ Cell Phone ( ) ______________ Work Phone ( ) ___________

Email ____May we call you at work? Yes ___ No ____

Name/Address of Person Responsible for Payment ____

Whom may we thank for referring you to our office? ____

Dental Insurance

Primary Carrier (if applicable)	Secondary Carrier (if applicable)
Insurance Carrier ________________________	Insurance Carrier ________________________
Employee ______________________________	Employee ______________________________
Date of Birth ___________________________	Date of Birth ___________________________
Group No. ______________________________	Group No. ______________________________
Employer or Union _______________________	Employer or Union _______________________
Date Employed __________________________	Date Employed __________________________
Employee Ins. ID Number ________________	Employee Ins. ID Number ________________
Employee Soc. Sec. Num. (if required): _________	Employee Soc. Sec. Num. (if required):________

Name, Address and Telephone Number (include area code) of closest relative/friend not living with you:
____

Permission is hereby granted to Stanley H. Kessler, DDS, and such assistants as he may designate to perform routine dental services, diagnostic procedures and dental treatment, all as deemed necessary by Dr. Kessler and approved by me. I understand all services to be performed will be explained to me as well as alternative treatments when appropriate and treatment risks.

Signature ____ **Date** ____________________

 Please read and complete all pages where necessary.

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Child's Medical Health History

Child's Name ____ Date of Birth ____________________________

Child's Medical Doctor ____

1. Does your child have a health problem? Yes _____ No _____
   If yes, please specify: ____

2. Is your child currently under the care of a physician? Yes _____ No _____
   If yes, please specify: ____

3. Is your child taking any medication/s now? Yes _____ No _____
   If yes, please specify: ____

4. Has your child ever had a serious illness or operation? Yes _____ No _____
   If yes, please specify: ____

5. Indicate which of the following your child has had in the past or has at the present time. Please circle YES or NO to each of the following:

Diabetes	Yes	No	Fainting spells or seizures	Yes	No
Heart Trouble	Yes	No	Blood transfusion	Yes	No
Asthma	Yes	No	AIDS/HIV Positive	Yes	No
Rheumatic Fever	Yes	No	Psychiatric treatment	Yes	No
Kidney Infection	Yes	No	Excessive bleeding	Yes	No
Ear Infection	Yes	No	Cleft lip or palate	Yes	No
Cerebral Palsy	Yes	No	Hepatitis or Jaundice	Yes	No
Hearing disability	Yes	No	Development disability	Yes	No

6. Does your child have any allergies to any medications or drugs such as penicillin? Yes _____ No _____
   If yes, please specify: ____

7. Does your child have an allergy to latex rubber? Yes _____ No _____

Stanley H. Kessler, DDS complies with applicable Federal civil rights laws
and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
Stanley H. Kessler, DDS does not exclude people or treat them differently
because of race, color, national origin, age, disability, or sex.

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Child’s Oral Health History

Child’s Name ____ Date of Birth _____________________________

1. Is this your child’s first visit to the dentist? Yes _____ No _____

   If no, date of last visit ____

2. What is your child’s attitude towards this visit? ____

3. What concerns you most about your child’s oral health? ____

4. Is there currently a dental problem or oral pain? Yes _____ No _____

   If yes, please specify ____

5. Has your child ever had orthodontic treatment? Yes _____ No _____

6. Has your child ever been treated for any gum disease? Yes _____ No _____

7. Do your child’s gums bleed when brushing teeth? Yes _____ No _____

8. Does your child grind or clench teeth? Yes _____ No _____

9. Has your child ever had a toothache? Yes _____ No _____

10. Are there any sore or swollen areas in your child’s mouth? Yes _____ No _____

11. Have there been any injuries to your child’s mouth? Yes _____ No _____

12. Does your child have any habits such as

    Thumb sucking Yes _____ No _____

    Bottle nursing Yes _____ No _____

    Other (specify) ____

13. Is fluoride taken in any form at home? Yes _____ No _____

    If yes, please specify: Toothpaste _____ Drops _____ Tablets _____ City water _____ Rinses _____

14. Are you satisfied with your child’s previous oral health care? Yes _____ No _____

    If no, please specify ____

15. Are you satisfied with the appearance of your child’s teeth? Yes _____ No _____

    If no, please specify ____

16. Is there anything else you would like us to know about your child? Yes _____ No _____

To the best of my knowledge, all of the preceding answers are true and correct. If my child ever has any change in his/her health, or if any of his/her medicines change, I will inform Dr. Kessler’s office at the next appointment without fail.

Date: ___________________ Parent’s Signature: ____

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Financial Policy

Thank you for choosing Stanley H. Kessler, DDS. Our primary mission is to deliver the best and most comprehensive oral health care available. An important part of our mission is making the cost of optimal care as easy and manageable to our patients as possible by offering several payment options.

I understand that dental treatment is an agreement between Stanley H. Kessler, DDS, and myself, and that payment is due as services are rendered. I understand that a dental benefit plan is a contract between my employer and the insurance carrier, and I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the office of Stanley H. Kessler, DDS.

Payment Options

1. Cash, Check, Visa, MasterCard, American Express or Discover Card
    a. We offer a 10% courtesy to our Senior Citizens who pay prior to or at the time of treatment on all non-laboratory-involved treatment; and a 5% discount on laboratory-involved procedures.
    b. A fee of $25 will be charged for returned checks.
2. We accept payment at the appointment time. For treatment plans requiring multiple appointments, payment arrangements will be provided.
3. NO INTEREST[1] Payment Plans[2] from CareCredit
    a. Allow you to pay over time with NO INTEREST
    b. Convenient, low monthly payment plans available
    c. No annual fees or pre-payment penalties
4. We are network providers for many dental plans; please call us or contact your benefit provider.
    a. For all insurance plans, we are happy to work with your carrier to maximize your benefits and directly bill them for reimbursement for your treatment.[3]

If you have any questions, please ask. We are here to help you get the dentistry you want and need.

Appointment Times

Appointments are reserved exclusively for individual patients. As a courtesy, we try to confirm appointments a day or two before a scheduled appointment via phone, email or text message. Occasionally, we are unable to do so. All appointments are considered confirmed at the time they are made.

There is a charge for broken appointments not cancelled within 24-hours' notice. Ongoing appointments (i.e., crown and bridge) may require a deposit in order to schedule the extended appointment times.

Patient/Parent/Guardian Signature ____ Date __________________

Patient Name (Please print) ____

[1] If paid within the promotional period. Otherwise, interest assesses from purchase date. Minimum monthly payment required.
[2] Subject to credit approval.
[3] However, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

Stanley H. Kessler, DDS

HIPAA Privacy Form

Acknowledgment of Receipt of Notice of Privacy Practices
(pages 6-8 below)

Purpose: This form is used to obtain acknowledgment of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

I, ___________________________________, have received a copy of this office's Notice of Privacy Practices.

Please Print Name ____

Signature ____

Date ____

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

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify) ____

Acknowledgment of Receipt of
Notice of Privacy Practices

* You may refuse to sign this acknowledgement *

NOTICE OF PRIVACY PRACTICES

Stanley H. Kessler, DDS
14 Elizabeth Street, Bethel, CT 06801
phone: 203-797-8070 fax: 203-743-1321
office@dockessler.com
www.dockessler.com

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.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth, mouth, and oral health; prescribing medications and faxing them to be filled; prescribing dental appliances and dental prostheses; showing you treatment options; referring you to another dentist for specialty care; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your dental or medical care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

We will ask for special written permission in the following situations: anything related to HIV/AIDS status, any sale of information, any use of information for marketing or fundraising purposes.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;

- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
  disclosures of a "limited data set" for research, public health, or health care operations;
  incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
  disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. We must honor a restriction not to send information to a health care plan regarding any service for which you have already made full payment. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown
  at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 10 days of asking us. You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in

writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
  be notified by us in a timely manner of any breach of the privacy and confidentiality of your unsecured protected health information, which we will provide to you in accordance with law and take all appropriate measures to address.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office at the address or phone number shown at the beginning of this Notice.