Suni Bolar D.D.S

33 Clyde Road, Suite 104
Somerset, NJ 08873

CONSENT FOR TREATMENT

I am the (parent or guardian) of_____
-(name of child) who is a minor child, and I authorize examination and treatment as necessary by or under the supervision of Dr. Suni Bolar. This includes exposure of radiographs as necessary, use of local anesthetic, reasonable restraint as needed, and use of appropriate medicaments and materials for such treatment.

I READ AND UNDERSTAND THE ABOVE INFORMATION AND THE INFORMATION GIVEN ME VERBALLY.

BY MY SIGNATURE BELOW I CONSENT TO THE TREATMENT DESCRIBED IN THIS PAPER.

Parent Signature_____ Date_____

Witness _____ Date_____

Suni Bolar DDS

Acquaintance Form

Information about your child

Today's Date:_____
Child's First Name:_____
Child's Last Name:_____
Preferred Name: _____ ■ Male □ Female
Birthdate: _____ Child's Age:_____
Child's Home #:_____
Child's Home Address:_____
_____
_____

Who is accompanying the child today?

Last Name:_____First Name_____
Relationship to child:_____
Do you have legal custody of this Child? ■ Yes □ No
Is the child adopted? (If yes please provide proof of guardianship) □ Yes ■ No
Is the child in a foster home? (If yes please provide proof of guardianship) □ Yes ■ No
Whom may we thank for referring you?_____
_____
Previous Dentist:_____
Last Visit Date:_____Were X-rays taken: □ Yes ■ No

Parent/Guardian Information

■ Mother □ Step Mother □ Guardian
Name:_____
Birthdate:_____ Soc. Sec # : _____
Home #:_____Work # : _____
Cell #:_____ Accept Texts : □ Yes □ No
Occupation:_____
E-mail:_____

□ Father □ Step Father □ Guardian
Name:_____
Birthdate:_____ Soc. Sec # : _____
Home #:_____ Work # :_____
Cell #:_____ Accept Texts : □ Yes □ No
Occupation:_____
E-mail:_____

Parent's Marital Status: □ Single ■ Married □ Divorced □ Widowed □ Partnered □ Separated

Primary Dental Insurance Information:

Policy Owner's Name:_____
Relationship to Patient:_____
Policyholder's Birthdate: _____
Policyholder's Soc. Sec. #: _____
Policyholder's Employer: _____
Insurance Co. Name:_____
Insurance Policy ID #:_____
Insurance Co. Address:_____
_____
Insurance Co. Phone #:_____
Insurance Co. Group #:_____

Secondary Dental Insurance Information:

Policy Owner's Name:_____
Relationship to Patient:_____
Policyholder's Birthdate: _____
Policyholder's Soc. Sec. #: _____
Policyholder's Employer: _____
Insurance Co. Name:_____
Insurance Policy ID #:_____
Insurance Co. Address:_____
_____
Insurance Co. Phone # :_____
Insurance Co. Group #:_____

I certify that my child is covered by the above Insurance Co. and I assign to Suni Bolar DDS all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, manual or electronic.

_____ _____
Signature of parent or guardian Date

Your reason for this visit to the Pediatric Dentist?

_____

_____

Has your child ever had any unpleasant experiences associated with previous dental work? ☐ Yes ■ No

If yes, Please Explain:_____

_____

Is the child's water fluoridated? ☐ Yes ■ No

Is the child taking fluoridated supplements? ☐ Yes ■ No

Has child had pain in jaw joint (TMJ/TMD)? ☐ Yes ■ No

Does child brush teeth daily? ☐ Yes ■ No

Does child floss teeth daily? ☐ Yes ■ No

Has child ever taken Fosamax, Actonel, Boniva or any other Bisphosphonate? ☐ Yes ■ No

Child's Physician's name: _____

Phone # : _____ Last Visit Date: _____

Please describe your child's current physical health:

■ Good ☐ Fair ☐ Poor

Please list all medications the child is currently taking:

_____

_____

Please list below all medications and things child is allergic to:

_____

_____

_____

Has your child ever had any of the following conditions?

Abnormal Bleeding	☐ Yes ■ No	*Epilepsy*	☐ Yes ■ No
ADD/ ADHD	☐ Yes ■ No	*Exposed to HIV, but Neg.*	☐ Yes ■ No
Anemia	☐ Yes ■ No	*Handicaps/Disabilities*	☐ Yes ■ No
Any Hospitalizations	☐ Yes ■ No	*Hearing / Vision Loss*	☐ Yes ■ No
Any Operations	☐ Yes ■ No	*Heart Murmur*	☐ Yes ■ No
Artificial bones/Joints/Valves	☐ Yes ■ No	*Hemophilia*	☐ Yes ■ No
Asthma	☐ Yes ■ No	*Hepatitis*	☐ Yes ■ No
Autism/Asperger's/PDD	☐ Yes ■ No	*HIV+/AIDS*	☐ Yes ■ No
Blood Pressure	☐ Yes ■ No	*Kidney/ Liver Problems*	☐ Yes ■ No
Cancer	☐ Yes ■ No	*Measles*	☐ Yes ■ No
Chicken Pox	☐ Yes ■ No	*Rheumatic/ Scarlet Fever*	☐ Yes ■ No
Congenital Heart Defect	☐ Yes ■ No	*Sensory Issues*	☐ Yes ■ No
Convulsions	☐ Yes ■ No	*Sickle cell Disease/Traits*	☐ Yes ■ No
Diabetes	☐ Yes ■ No	*Tuberculosis (TB)*	☐ Yes ■ No
Downs Syndrome	☐ Yes ■ No	*Other*_____	

Are you Childs immunizations current: ■ Yes ☐ No

Anything you would like to discuss with the Doctor in private? ☐ Yes ■ No

Please discuss any serious medical problems child has had:_____

_____

_____

Did/ Does the child have any of the following habits?

Lip Sucking/ Biting	☐ Yes ■ No	*Nursing Bottle Habits*	☐ Yes ■ No
Nail Biting	☐ Yes ■ No	*Thumb/ Finger Sucking*	☐ Yes ■ No
Was the child breast fed?			☐ Yes ■ No

I understand that the information that I have given is correct to the best of my knowledge, and that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

_____ _____

Signature of parent or guardian Date

ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

*** You may refuse to sign this Acknowledgement***

I, _____, (Parents Name) have received a copy of this office's Notice of Privacy Practices.

_____ _____

Signature of parent or guardian Date

____ Individual refused to sign

Suni Bolar D.D.S
33 Clyde Road, Suite 104
Somerset, NJ 08873

OFFICE POLICY REGARDING BROKEN APPOINTMENTS / CANCELLATIONS WITHOUT 48 HOUR NOTICE

The office reserves the right to charge a broken appointment/Cancellation fee of $ 30.00 for every broken appointment / cancellation without 48 hour notice.

I am the (Parent or guardian) of _____-(name of child) who is a minor child.

I READ AND UNDERSTAND THE ABOVE INFORMATION. BY MY SIGNATURE BELOW I GIVE MY CONSENT.

Parent Signature_____ **Date**_____

Witness_____ **Date**_____

DIRECTIONS TO THE OFFICE

PLEASE NOTE: INTERNET & NAVIGATOR DIRECTIONS SEND YOU TO THE OLD COMPLEX. ONCE YOU COME ON TO CLYDE ROAD PLEASE FOLLOW OUR DIRECTIONS

From Route 287 South or 287 North :
Take Exit 10 for Easton Ave/New Brunswick. Follow Easton Ave. approximately 2 miles through 5 traffic lights. After the fifth traffic light, look for a sign for JFK Blvd. Turn right onto JFK Blvd. After 3 lights JFK Blvd becomes Clyde Road. Take the SECOND LEFT on to Churchill Ave (If you went over the railroad tracks, you went too far). Make a right into the complex (Towne Professional Park at Somerset). We are at 33 Clyde Road, Suite 104.

From Route 27 South: Take left on Bennett Lane. If you stay straight you are on Clyde Road (Bennett lane goes left). Right after the railroad tracks you make a right on Churchill Ave, then make another right into the complex. We are at 33 Clyde Road, Suite 104.

SUNI BOLAR DDS
SOMERSET PEDIATRIC DENTAL ASSOCIATES L.L.C,
33 Clyde Road, Suite 104, Somerset, NJ 08873

Suni Bolar, D.D.S.
Pediatric Dentist

Spec #5120
Diplomate and Fellow of the American Board of Pediatric Dentistry
www.sunibolardds.com

Dr. Suni Bolar received her D.D.S. degree from the New York University College of Dentistry.

She received her specialty training in Pediatric Dentistry from New York University College of Dentistry, graduating at the top of her class.

She is Board Certified in Pediatric Dentistry.

She has held prominent teaching positions at New York University College of Dentistry for 5 years, serving as Assistant Clinical Professor, Pediatric Clinic Chief and Clinical Fellow in the Pediatric Dentistry Department.

She is a member of the American Academy of Pediatric Dentistry, the New Jersey Academy of Pediatric Dentists and the American Dental Association.

Dr. Suni Bolar is married and has two children. Her hobbies include gardening, bird watching and hiking. Her gentle manner and genuine concern for her patients add a special dimension to her 30 years of practical experience.

Our Office

We start seeing children by age 1 as recommended by the American Academy of Pediatrics and the American Academy of Pediatric Dentistry.

We provide a full range of Pediatric dental services for children in our child friendly, state-of- the-art office. We are conveniently located in Somerset, NJ.

Dr. Suni Bolar and her staff are dedicated to quality patient care.

Suni Bolar, DDS
Dentistry for Children and Adolescents
Towne Professional Park at Somerset
33 Clyde Road, Suite 104
Somerset, NJ 08873
(732) 568-0233

PARENTS' GUIDE TO GOOD DENTAL HEALTH

AGE	PROCEDURE
6 Months – 1 year	Begin systemic fluoride therapy, as directed by your physician or dentist Do not allow child to go to bed with a bottle Begin brushing teeth with a soft nylon brush and Baby Orajel Tooth and Gum Cleanser
1 year	First visit to dentist
2 1/2 - 3 years	Continue oral hygiene Diet counseling – hygiene instruction
3 years	Continue dental examination, cleaning and topical fluoride treatment every 6 months verify change in systemic fluoride dosage
5 1/2 - 6 years	Seal permanent first molars
6 years	Verify change in systemic fluoride dosage
7 - 8 years	Ask for orthodontic evaluation
10 - 11 years	Seal all premolars Evaluate appearance of teeth Confirm orthodontic evaluation
12 years	Seal permanent second molars
12 years and up	Discontinue systemic fluoride therapy Continue check-up visits every six months

The above procedures are in addition to periodic check-up exams every six months.

SUNI BOLAR, DDS

Dentistry for Infants, Children and Adolescents

Towne Professional Park at Somerset
33 Clyde Road, Suite 104,
Somerset, NJ 08873
(732) 568-0233

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 3/1/2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.50 for each page, $ 10.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Dr. Suni Bolar

Telephone: (732) 568 0233 Fax: (732) 568 0213

E-mail:

Address: 33 Clyde Road, Suite 104, Somerset, NJ 08873