



PLEASE PRINT

Patient Information

Child's Name: _____ Male Female

Last

First

Middle

Nickname: _____ School: _____ Grade: _____

Siblings Names and Ages: _____

Address: _____

Street

City

State

Zip

Home Phone: _____ Birth date: ___/___/___ Age: _____ Child's Social Security #: _____

Name of child's pediatrician: _____ Phone #: _____

Name of child's previous dentist: _____ Phone #: _____

Date of last dental visit: _____

Parents' or guardians' name: _____

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

Child's Hobbies/Sports: _____

Parent/Legal Guardian Information

Who is responsible for account? _____ Parent's Marital Status: Single Married Divorced Other

Father Stepfather Legal Guardian

Name: _____

Birth date: ___/___/___

Mailing Address: (If different than Child's)

Street City State Zip

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Employer: _____

Email Address: _____

Social Security #: _____

Driver License # and State: _____

Mother Stepmother Legal Guardian

Name: _____

Birth date: ___/___/___

Mailing Address: (If different than Child's)

Street City State Zip

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Employer: _____

Email Address: _____

Social Security #: _____

Driver License # and State: _____

Insurance Information

Primary Insurance Information:

Subscriber's Name: _____ Subscriber's Birth date: ____/____/____

Subscriber's Social Security #: _____ Subscriber's ID#: _____

Subscriber's Employer: _____ Group/Plan #: _____

Insurance Company Name: _____ Insurance Company Phone #: _____

Insurance Company Address: _____

Street

City

State

Zip

Do you have secondary insurance coverage? Yes No

Secondary Insurance Information:

Subscriber's Name: _____ Subscriber's Birth date: ____/____/____

Subscriber's Social Security #: _____ Subscriber's ID#: _____

Subscriber's Employer: _____ Group/Plan #: _____

Insurance Company Name: _____ Insurance Company Phone #: _____

Insurance Company Address: _____

Street

City

State

Zip

Emergency Contact Information

Relative or friend not living with you:

Name: _____ Phone #: _____

Address: _____

Street

City

State

Zip

Relationship to child: _____

Authorization

I hereby authorize this office to release all information necessary to secure the payment of benefits, and I assign directly to this office 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 deductibles that my insurance does not cover, including services that were previously considered to be covered.

I understand that where appropriate, credit bureau reports may be obtained.

I certify that the information I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence and that it is my responsibility to inform this office of any changes to my account.

I will be informed of any treatment my child may need prior to services rendered. I authorize the dental staff to perform all necessary dental services that pertain to the dental care of my child.

Signature of Parent or Legal Guardian: _____ Date: _____

Health History Information

1. Does your child have previous dental experience? ----- Yes No
2. If yes, was it pleasant? ----- Yes No
3. Has your physician ever told you that your child needs an antibiotic before having any dental work? Yes No
4. Is the child under a physician's care? ----- Yes No
If yes, why? _____
5. When was the child's last physical exam? _____
6. Is the child taking any medications or substances? ----- Yes No
If yes, please list. _____
7. Is the child allergic to any medication or substances? ----- Yes No
If yes, please list. _____
8. Does the child have any problems with penicillin, antibiotics, local anesthetics (Novocaine) or other types or medications? List others: _____ Yes No
9. Is the child sensitive to any metals or latex? ----- Yes No
If yes, what types? _____
10. Has the child ever been treated for heart disease? ----- Yes No
11. Does the child have a heart murmur? ----- Yes No
12. Does the child have a pacemaker or an artificial heart valve implant? ----- Yes No
13. Has the child ever had rheumatic fever? ----- Yes No
14. Is the child pregnant or suspect that the child is pregnant? ----- Yes No
15. Does the child take birth control medications? ----- Yes No
16. Does the child have high blood pressure? ----- Yes No
17. Has the child ever had a serious illness or surgery? ----- Yes No
If yes, what? _____
18. Has the child ever had radiation treatment or chemotherapy? ----- Yes No
19. Does the child have soreness, clicking, or popping in the jaw joint? ----- Yes No
20. Does the child have any blood disorders, such as anemia, leukemia, hemophilia, etc? ----- Yes No
21. Does the child have any artificial joints/prosthesis? ----- Yes No
22. Has the child ever bled excessively after being cut or injured? ----- Yes No
23. Has the child ever received a blood transfusion? ----- Yes No
24. Does the child have any kidney, stomach, or liver problems? ----- Yes No
25. Does the child have autism or any type of syndrome? ----- Yes No
If any other syndrome, what type? _____
26. Is the child developmentally delayed? ----- Yes No
27. Is the child diabetic? ----- Yes No
28. Does the child have asthma? ----- Yes No
29. Is the child HIV positive or have AIDS? ----- Yes No
30. Does the child have epilepsy or seizure disorders? ----- Yes No
31. Has the child had or tested positive for hepatitis? ----- Yes No
32. Did you read this question? ----- Yes No
33. Does the child or has the child ever had tuberculosis? ----- Yes No
34. Does the child smoke, use any form of tobacco, or live with someone who smokes? ----- Yes No
35. Does the child consume alcoholic beverages or use controlled substances? ----- Yes No
36. Is there anything else we should know about the health of the child not yet covered? ----- Yes No
If yes, what? _____

**Doctor's
Notes**

I certify that I have read and understand the foregoing questions, and hereby certify that the information I have given is correct to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes in my child's medical status.

Initial Visit

Patient/Guardian Signature _____

Date _____ Reviewed by _____

First Update

Patient/Guardian Signature _____

Date _____ Reviewed by _____



NOTICE OF PRIVACY PRACTICES

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.

The Health Insurance Portability & Accountability Act of 1996 (“HIPAA”) is a federal program that requires that all Dental records and other individually identifiable health information used or disclosed by us in any form, whether electronically, paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. “HIPAA” provides penalties for covered entities that misuse personal health information.

As required by “HIPAA,” we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and healthcare operations.

- **Treatment** means providing, coordinating, or managing healthcare and related services by one or more healthcare providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Healthcare operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14th, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us at the above address for more information. For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, C.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775



PRIVACY PRACTICES CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change it's *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the above address to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Parent or Legal Guardian Signature: _____ Date: _____



CANCELLATION GUIDELINES

Due to the high demand for appointments and patient no-show rate in our office, we must attempt to maintain an efficient patient flow to accommodate our large patient population. To best accomplish this, we have implemented office guidelines to help regulate appointment scheduling, including no-show appointments.

Our office guidelines are as follows:

- Our office will call to confirm all appointments with you. We will begin confirming 72 business hours in advance. If we are unable to reach you, we ask that you call back and confirm that you are keeping your appointment. A confirmation call back is necessary to reserve the appointment. **Should we not be able to confirm appointments with you before 12 pm the business day before the reserved appointment, we may forfeit the appointment to another child on our waiting list.** You are responsible for informing our office of changes in your contact information.
- You may confirm appointments on our voicemail but cannot make any schedule changes. Please call back during normal business hours Monday-Friday between 8am-5pm in order to make changes to your appointment.
- It may be necessary for our office to dismiss patients that fail to keep appointments without notifying our office staff at least 48 hours prior to their scheduled appointment.
- A **\$50 cancellation fee** will be assessed for each patient that no-shows or cancels an appointment without notifying our office staff at least 48 hours prior to their scheduled appointment for a continuing care or new patient appointment.
- A **\$100 cancellation fee** will be assessed for each patient that no-shows or cancels an appointment without notifying our office staff at least 48 hours prior to their scheduled appointment for a treatment appointment.

Thank you for assisting us in making appointments accessible to all children.

I have read the preceding information:

Signature of Parent or Legal Guardian: _____ Date: _____



FINANCIAL POLICY

We are dedicated to providing our patients with the best treatment available and base our treatment recommendation on what will be best for your child and not what your insurance company does or does not pay for. As a courtesy, our office will be happy to submit any insurance claims for your child. Your dental insurance is a contract between you, your employer and your insurance company; therefore, you are ultimately responsible for your insurance coverage. Any co-pays, deductibles, or known percentages for your child's dental care must be paid prior to services being rendered. However, please remember that in most cases these figures are only estimates. We cannot guarantee what your insurance will pay. You will be responsible for any services not covered or paid by your insurance carrier.

If you have secondary insurance coverage, our office will be happy to submit a claim form to your secondary insurance. However, all quoted fees for procedures will be based solely on your primary insurance. If your secondary insurance allows an additional payment, they will reimburse you.

Prior to completing any treatment, we will provide you with a cost estimate indicating our total fee, what we expect your insurance coverage to be, and your estimated out-of-pocket portion. This is only an estimate based upon generalized information provided by your dental insurance.

We ask that you contact us immediately after making any changes to your dental coverage, so that we may keep accurate and current records of your account and to expedite reimbursement of your dental benefits.

We allow a maximum of 60 days for your insurance company to clear account balances. After 60 days, any unpaid portions will be due in full by you.

For your convenience, we accept cash, money orders, cashier's checks, personal checks, Visa, Mastercard, and CareCredit. All returned checks will be subject to a \$25.00 fine.

After attempts to collect outstanding funds and a grace period of 90 days from the day of service, the parent or legal guardian responsible for the account will be sent directly to the credit bureau to settle the financial obligation. I agree to pay all finance charges, collection costs, attorney fees, and all other costs associated with collection of my outstanding accounts as allowed by law.

I acknowledge that I have read, understand, and am willing to comply with the above financial policy.

Signature of Parent or Legal Guardian: _____ Date: _____



LEGAL CONSENT TO MAKE DECISIONS

Patient's Name: _____

As a convenience, we would like to offer you a chance to provide us with a list of individuals that may accompany your child to subsequent visits. Listing an individual will automatically provide them with your legal consent to make both treatment and financial decisions on your behalf.

With this list, a family member, step-parent, or good friend would have the authority to accompany your child to a dental appointment and make decisions without the need of any additional written or oral consents. If not listed, patients must always present with a parent or legal guardian. Please only provide the names of those individuals that you trust to make such decisions as treatment changes, to make payments, and to discuss medical and financial information. Please remember, individuals that are permitted to make treatment decisions will also be responsible for any incurred payment changes.

We, as a HIPAA compliant healthcare facility, will use our best discretion to maintain all personal information and will only provide the individuals listed below with information needed to make a specific decision on your behalf. Information will only be provided on a need-to-know basis and we will not allow these individuals to have or copy your child's dental chart. We simply want to make treating your child in our facility as convenient as possible for you.

Please identify such individuals and initial your decision to allow them to provide consent to treatment decisions, to make financial arrangements, or both. Please also remember any individuals accompanying your child to an appointment will also be responsible for additional charges incurred during that particular visit.

CONSENT TO MAKE DECISIONS

Individual's Name	Treatment	Financial

As the parent or legal guardian of the patient noted above, I do hereby provide the individuals listed beneath the chart entitled "Consent to Make Decisions," the legal authority to make decisions in my absence. I also understand that these decisions may change or alter previous treatment recommendations or charges that I have already agreed to and that I, as this child's parent or legal guardian, am ultimately responsible for any new charges incurred as a result of treatment decisions made by any individuals listed above.

Parent or Legal Guardian: _____ Date: _____