All About Kids Dentistry

Staff Int & Date: _____

**** In order to setup new patients in our system and verify Insurance benefits, all forms must be completed, signed and returned to our office at least 48 hours before the first appointment.**

Patient (Child's) Name: _____ **Date of Birth**: _____

Parent/Legal Guardian Name: _____ **Date of Birth**: _____

Home Address: _____ **City:** _____ **Zip**: _____

Marital Status: Married___ Single___ Divorced___ Separated___ **Child resides with**: _____

Primary Email: _____ **Secondary Email**: _____

Primary Cell Num: _____ **Secondary Cell Num**: _____

Primary Employer: _____ **Emp Address:** _____

Emp City: _____ Emp St: _____ Emp Zip: _____ _

Second Employer: _____ Sec Emp Address: _____

Sec Emp City: _____ Sec Emp St: _____ Sec Emp Zip: _____ _____

Referred by or how you found us: _____

Health Provider Information

Pediatrician/Physician: _____ **Phone#**: _____

Previous Dentist's Name: _____ **Phone#**: _____

Medical History

Patients last dental visit:_____ **Date of last X-Rays**:_____

Patients last PCP visit:_____ **Does the patient get vaccinated**?: _____

Has the patient had any recent hospitalizations or surgeries?

If so, when:_____ Procedure:_____

Have you ever been told your child needs to take Antibiotics before a dental treatment?: _____

Patients oral habits:

Pacifier use____ Thumb Sucker____ Nail biting____ Chews on toys/blankets____ Nursing/Bottle Habits_____

Allergies:

___ Seasonal/Environmental ___ Latex ___Dogs ___ Cats
___ Fish ___ Dairy ___Milk ___ Peanuts ___ Tree Nuts
___Gluten ___Eggs ___Soy
___ Antibiotics: ___ Other:_____
Describe:_____
_____

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Check all the apply:

___ADHD
___AIDS/HIV Positive
___Anemia
___Asperger Syndrome
___Asthma
___Autism
___Bi-polar
___Cancer
___Cerebral Palsy
___Epilepsy/Seizures
___Chronic Bronchitis
___Diabetic
___Down Syndrome
___Fainting/Vertigo
___Headaches
___Hearing Impaired
___Hemophilia/Abnormal Bleeding
___Kidney Disease or Malfunction
___Liver Disease
___Respiratory Disease
___Skin rash/Eczema
___Thyroid Disease or Malfunction
___Heart Murmur (innocent or not)
___ Other: _____
_____
___ Tuberculosis
___ Speech Impairment/Disorder
___ Apraxia
___Tonsillitis
___ Sleep Apnea
___ Other Heart Conditions

Therapies:
___ Occupational
___ Speech
___ Behavior
___ Other
Describe:_____
_____

Diagnosed with:
___ Anxiety
___ Sensory Disorder or Sensory Issues
___ Depression
___ Other
Describe:_____
_____

Mental Development: _____ Normal ____ 1-2 years behind ____ More than 2 years behind

Medications the patient is currently taking:

1._____ Reason:_____
2._____ Reason:_____
3._____ Reason:_____
4._____ Reason:_____

***I understand the information given is correct to the best of my knowledge and it is my responsibility to inform the office of any changes to patients medical history.**

Parent/Guardians Signature:_____ Date:_____

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Insurance Information and Financial Policy

1. Primary Insurance Co: _____

Who holds this dental insurance?: Mom____ Dad____ ***Soc Sec #** _____-_____-_____

Employer's Name: _____

Ins ID#:_____ **Group#**:_____

*** Soc Sec number required for Met Life and most Delta Dental plans**

2. **Secondary Insurance Name**: _____**Number:** _____

Who holds this dental insurance? Mom____ Dad____ ***Soc Sec #** _____-_____-_____

Employer's Name: _____

Ins ID#:_____ **Group#:**_____

*** Soc Sec number is required to file claims with Met Life and most Delta Dental plans**

Financial Policy and Insurance:

Our practice is "**out of network**" with all insurance companies and we have no contract with your insurance provider. Your insurance coverage is a contract between you and your insurance company. As a courtesy to our patients we will attempt to estimate your insurance benefits based on the information we attain from your insurance company as accurately as possible. ***We may accept assignment of insurance benefits (submit claim and await payment from insurer); however, we require the patients estimated portion for all treatment appointments to be paid at time of service***. ***If your insurance company does not pay claims to out-of-network providers, payment is due at the time of treatment*****.** *For patients without dental insurance, payment is due at the time of treatment.* For larger treatment plans or when insurance is not available, we accept CareCredit as a convenient and timely payment method. Please visit **carecredit.com** to learn about different treatment financing options and to complete an application.

I understand I am responsible for any outstanding balance on my account not covered by insurance including the full balance in the event that; my insurance does not cover the entire cost of the treatment; my insurance has denied submitted claims; my insurance coverage was terminated or otherwise not in effect at time of treatment; the insurance info provided was incorrect or expired; or if plan benefits had already been exhausted for coverage period. I understand I am responsible for providing updated insurance information when coverage changes occur, when requested by the practice or on day of the patient's appointment.
I hereby agree to the above statements of financial obligation, insurance and payment for services provided. I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL POLICY.

Insurance Holder or Responsible Party Signatures:

Name:_____**Date**:_____**Signature**:_____
parent or guardian

Name:_____**Date**:_____**Signature**:_____
parent or guardian

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Because my child is a minor, I understand that a signed permission and authorization must be obtained from a parent or guardian before dental services for the child can be started and completed. I hereby grant my authorization for dental treatment to be performed on my child. Furthermore, I will be responsible for any bill incurred for services provided to this child for dental treatment.

DATE_____ **SIGNATURE**_____

parent or guardian

Late Appointments: If you arrive to your scheduled appointment more than 10 minutes late, we reserve the right to reschedule your appointment. **Initial**_____

Missed Appointments: We require a 48 hour notice if you need to cancel/miss your appointment. Otherwise we reserve the right to charge an amount of $50.00 for the canceled or missed appointment. **Initial**_____

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HIPAA 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 THIS FORM CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment of health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your right to access and control your protected health information. "Protected heal information" if information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. **Uses and Disclosures of Protected Health Information** Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment:
We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment:
Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations:
We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you.

We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases; Health Oversight, Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroner, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures; Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will Be Made with Your Consent, Authorization or Opportunity to Object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

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Your Rights

Following is a stamen of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint**.

This notice was published and becomes effective on/ or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Person(s) Responsible for the account and Insurance Holder(s)

Name:_____**Date**:_____**Signature**:_____

Name:_____**Date**:_____**Signature**:_____