Pediatric Dentistry and Orthodontics

PATIENT INFORMATION

Last Name_____ First Name _____ DOB _____ Age_____ Sex ☐ M ☐ F

Additional Siblings Being Seen (If applicable)

Last Name_____ First Name _____ DOB _____ Age_____ Sex ☐ M ☐ F

Last Name_____ First Name _____ DOB _____ Age_____ Sex ☐ M ☐ F

Last Name_____ First Name _____ DOB _____ Age_____ Sex ☐ M ☐ F

PARENT/GUARDIAN INFORMATION

☐ **Mother** ☐ **Father** ☐ **Guardian**

Last Name_____ First Name _____ DOB _____ Sex ☐ M ☐ F

Home Address_____ City _____ State_____ Zip_____

Cell #_____ Alt Phone #_____ e-mail _____

☐ **Mother** ☐ **Father** ☐ **Guardian**

Last Name_____ First Name _____ DOB _____ Sex ☐ M ☐ F

Home Address_____ City _____ State_____ Zip_____

Cell #_____ Alt Phone #_____ e-mail _____

EMERGENCY CONTACT

In the event of an emergency, whom should we contact?

Name _____ Relationship _____ Phone _____

DELEGATION OF POWER BY PARENT/GUARDIAN

I give my consent to allow person(s) named below other than myself to accompany and oversee my child for appointments, to release healthcare information for the appointment or to secure payment for dental services. I understand I can revoke this consent at any time by providing written notice.Persons who have consent in my absence are:

l) _____ Relationship to patient _____

2)_____ Relationship to patient _____

☐ I do not wish to delegate power to any additional parties at this time.

Signature of Parent/Guardian_____ **Date**_____

MEDICAL HISTORY

Patient Name_____ **DOB**_____

Patient's Pediatrician: _____ Phone: _____

Is child under care of a physician now 7 ..... No_Yes(explain) _____

Receiving any medications or drugs? ..... No_Yes(explain) _____

Ever been hospitalized ? ..... No_Yes{explain) _____

Ever had surgery? ..... No_Yes{explain) _____

Are there any Drug/Food/Latex allergies ..... _No_Yes(explain) _____

HAS YOUR CHILD HAD ANY HISTORY OF:

☐ Anemia	☐ Cerebral Palsy	☐ Hearing Problems	☐ Prolonged bleeding when cut
☐ Asthma	☐ Convulsions	☐ Hepatitis/Liver Disease	☐ Rheumatic Fever
☐ Autism	☐ Developmental Delay	☐ High/Low Blood Pressure	☐ Seasonal Allergies
☐ ADHD	☐ Diabetes	☐ Kidney Disease	☐ Tuberculosis
☐ Birth Defect	☐ Down syndrome	☐ Lung Disease	☐ Thyroid Disease
☐ Blood Disorder	☐ Ear, Eye , Nose Trouble	☐ Premature Birth	
☐ Cancer	☐ Heart Disease	☐ Problems with anesthesia	
☐ Gastric Reflux	☐ Heart Murmur	☐ Other_____	

DENTAL HISTORY

Reason for this visit:

☐ Checkup/cleaning ☐ Dental Cavities ☐ Mouth injury ☐ Toothache ☐ Crooked teeth ☐ Oral Habits ☐ Other _____

Date of Last Dental Visit and Reason_____ Previous Dentist's name _____

Any unhappy dental experience? _____

How do you think your child will behave during the visit ?

☐ Friendly ☐ Happy ☐ Anxious ☐ Timid ☐ Afraid ☐ Resistant

ACKNOWLEDGMENT OF PATIENT INFORMATION/AUTHORIZATION FOR INITIAL EVALUATION

All of the Information I have given is correct to the best of my knowledge. I understand that all information is confidential, 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 necessary dental services to my child for an initial evaluation. Any other dental services required will be explained and authorized by me after the initial visit.

Signature of Parent/Guardian_____ **Date**_____

INSURANCE INFORMATION

Primary Dental Insurance

Name of Policy Holder_____ DOB_____ SSN _____

Insurance Name_____ Member ID #_____ Group #_____

Employer _____ Group Name_____ Insurance Phone #_____

Secondary Dental Insurance

Name of Policy Holder_____ DOB_____ SSN _____

Insurance Name_____ Member ID #_____ Group #_____

Employer _____ Group Name_____ Insurance Phone #_____

PRACTICE INSURANCE AND FINANCIAL POLICY

We are committed to providing your child with the best possible care and are pleased to discuss our professional tees with you at any time.Your clear understanding of our financial and insurance policies is important to our professional relationship.

I .-VERIFYING INSURANCE: As a convenience to you, we will verify your insurance for eligibility and benefits prior to your new patient appointment as well as any time that you notify us of a change in your coverage. The insurance companies do not guarantee payment based on the information that they provide us. You are ultimately responsible for knowing if there are any waiting periods for work to be performed. Any amounts on your treatment plans that are not covered by your insurance, arc your financial responsibility. Please keep your insurance information current by notifying us of any changes in employment, insurance coverage, etc.

2.-PAYMENT: Payment is due at the time of service. The adult accompanying a minor and/or the parent (or guardian of the minor) is responsible for payment at the time of appointment. Additionally, if you have a balance following an insurance payment from a previous visit, you will be expected to pay that amount as well.

3.-CHANGES IN PERSONAL INFORMATION: Changes in your address or telephone numbers should be kept current with our office.

4 .-INSURANCE:! certify that my child is covered by insurance and assign directly to this office for all insurance benefits, otherwise payable lo me for services rendered. I understand that I am financially responsible for all charges not covered by dental insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions

Signature of Parent/Guardian_____ **Date**_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of this office's Notice of Privacy Practices. (*You may refuse to sign this acknowledgment*)

Signature of Parent/Guardian_____**Date**_____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because due to the following Reason(s)_____

Print Name _____Signature _____ Date _____

Patient HIPAA Awareness

With my permission, Wayne Smiles Pediatric Dentistry and Orthodontics and/or Butler Smiles Pediatric Dentistry and Orthodontics may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Wayne / Butler Smiles Pediatric Dentistry and Orthodontics Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Wayne Smiles Pediatric Dentistry and Orthodontics / Butler Smiles Pediatric Dentistry and Orthodontics reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, Wayne Smiles Pediatric Dentistry and Orthodontics/Butler Smiles Pediatric Dentistry and Orthodontics may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TOP, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my permission, Wayne Smiles Pediatric Dentistry and Orthodontics/Butler Smiles Pediatric Dentistry and Orthodontics may mail to my home or other designated locations and items that assist the practice in carrying out TOP, such as appointment reminder cards and patient statements. This also includes texting appointment reminders.

With my permission, Wayne Smiles Pediatric Dentistry and Orthodontics/Butler Smiles Pediatric Dentistry and Orthodontics may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Wayne Smiles Pediatric Dentistry and Orthodontics restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement .

By signing this, I am allowing Wayne Smiles Pediatric Dentistry and Orthodontics/Butler Smiles Pediatric Dentistry and Orthodontics the use and disclosure by PHI for TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

_____

Print Name of Parent or Legal Guardian

_____

Signature of Parent or Legal Guardian

_____

Date

NOTICE OF PRIVACY PRACTICES

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 with your signature agreement, and will remain in effect until we replace it You may request a copy of our Notice at any time.

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.
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.
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, 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 the 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 inference of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms for 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 authorize federal officials health information required to 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 access to 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. You must make a request in writing to obtain access to your health information. If you prefer, we will prepare a summary or an explanation of your health information for a fee.
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. 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 of 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).

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, you may complain to us. 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.