Sweet Tooth
PEDIATRIC DENTISTRY

Do Any of Your Other Children Attend Sweet Tooth? : Yes_____ No_____

If Yes, What Are Their Names? : _____

_____

PATIENT INFORMATION

1st Child	2nd Child
Child's Name:_____	Child's Name:_____
Nickname: _____Hobbies:_____	Nickname: _____Hobbies:_____
Birth Date: _____Age:_____	Birth Date: _____Age:_____
Male: _____ Female:_____	Male: _____ Female:_____
Insurance Plan Name:_____	Insurance Plan Name:_____
ID#:_____	ID#:_____
Physician's Name: _____	Physician's Name: _____
3rd Child	**4th Child**
Child's Name:_____	Child's Name:_____
Nickname: _____Hobbies:_____	Nickname: _____Hobbies:_____
Birth Date: _____Age:_____	Birth Date: _____Age:_____
Male: _____ Female:_____	Male: _____ Female:_____
Insurance Plan Name:_____	Insurance Plan Name:_____
ID#:_____	ID#:_____
Physician's Name: _____	Physician's Name: _____

PARENT/LEGAL GUARDIAN INFORMATION

Child's Name: _____	Child's Name: _____
Child's Name: _____	Child's Name: _____

Please circle who will be responsible for the account. **Mom** **Dad**

☐ Mother ☐ Stepmother ☐ Legal Guardian	☐ Father ☐ Stepfather ☐ Legal Guardian
Name: _____DOB:_____ Address:_____ City:_____State:_____Zip:_____ Employer:_____ Home #: _____ Cell #:_____ Email Address:_____ Social Security #:_____ Driver's License # and State:_____	Name: _____DOB:_____ Address:_____ City:_____State:_____Zip:_____ Employer:_____ Home #: _____ Cell #:_____ Email Address:_____ Social Security #:_____ Driver's License # and State:_____

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

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 Code

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 Code

EMERGENCY CONTACT INFORMATION

Relative or friend not living with you:

Name:_____ Phone #:_____

Address:_____

Street City State Zip Code

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:_____

Patient Name:_____DOB:_____

Health History Information

				Doctor's Notes
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? ----------			
	If yes, please list. _____	□Yes	□No	
8.	Does the child have any problems with □ penicillin, □ antibiotics, □ local anesthetics (Novocaine)	□Yes	□No	
	or □ other types or medications? List others: _____			
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? _____			

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, D.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: _____

FINANCIAL POLICY

Please initial and sign in the blank spaces below.

_____We are dedicated to providing our patients with the very best treatment available and base our treatment recommendation on what will best benefit your child's dental health needs. These recommendations are only estimates and we cannot guarantee what your insurance provider will or will not pay.

_____Coverage percentages vary based on the contract that your dental insurance provider has between you and your employer. You are ultimately responsible for your dental insurance coverage and you are responsible for paying any portion of treatment that your dental insurance provider does not cover or pay.

_____All quoted fees for procedures will be estimates based solely on your primary dental insurance. If your secondary dental insurance allows an additional payment, they may reimburse you a portion of the treatment costs to you.

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

_____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 dental 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, Visa, Mastercard and Care Credit. 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 date of service, the parent or legal guardian responsible for the account will be sent directly to the credit bureau to settle the financial obligation. By signing this document, you agree to pay all finance charges, collection costs, attorney fees, and all other costs associated with collection of your outstanding accounts as allowed by law.

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

Signature of Parent or Legal Guardian: _____Date:_____

LEGAL CONSENT TO MAKE DECISIONS

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. As a general rule of thumb, please only provide the names of individuals that you trust to make these important decisions.

LEGAL CONSENT: VISITS
With this list, the individual(s) that you list will have the authority to accompany your child to dental appointments. Unless specifically listed on this form, then a patient must always be accompanied by a parent or legal guardian.

LEGAL CONSENT: DECISION-MAKING
The individual(s) you list will also be given the ability to make decisions on your behalf without the need of any additional written or oral consent that include, but are not limited to decisions regarding: treatment changes, making payments and discussing medical and financial information. Please remember that you will be financially responsible for any charges that are incurred—including, but not limited to change in treatment—by any individual you authorize below.

HIPAA:
We are a HIPAA compliant healthcare facility and cannot release personal, medical or other information pertaining to a patient unless a release of information is first authorized by a parent or legal guardian. By signing below, you agree to authorize the release of personal, medical and other information to any individuals you list below.

Please identify such individuals and sign your decision to allow them to provide consent regarding personal, medical and financial decisions. By signing, you also agree that you will be responsible for any additional charges incurred during a particular visit in which they have accompanied your child.

As the parent or legal guardian of: Name:_____ SS#:_____ DOB:_____, I do hereby provide the individual(s) listed below 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 individual(s) listed below.

Individual's Name:	
Individual's Name:	
Individual's Name:	
Individual's Name:	
Individual's Name:	

Parent or Legal Guardian:_____ Date:_____

Sweet Tooth
PEDIATRIC DENTISTRY

Appointments

When appointments are scheduled, we will work with you to find a time and date that is convenient for both you and your family. Appointments are often scheduled several months in advance.

Confirming Appointments:

In order to ensure efficiency of appointments for all our patients, our office requires a call of confirmation 1 week prior to your child or children's appointment. Failing to confirm appointments by 12 noon the business day before the reserved appointment, may result in your child's appointment being given to another child on our waiting list.

Re-scheduling/Cancellations:

We understand that sometimes life and schedule can get hectic and change. If there is a change in yours or your children's schedules, please make sure to contact our office at least 48 business hours in advance to make any changes. This will help you to avoid any late cancellation fees and will help your children to establish and maintain good dental health.

Fee Assessment:

Late re-schedule and cancellation fees (*) will be assessed for each patient that no-shows or cancels an appointment without notifying our office at least 48 business hours prior to their scheduled appointment.

(*) A $50.00 cancellation fee will be assessed for each continuing care or new patient appointment and a $100.00 cancellation fee will be assessed for each treatment appointment.

Thank you for helping to assist us in making appointments accessible to all children. I have read and understand the preceding information.

Signature of Parent or Legal Guardian:_____Date:_____