# Welcome

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

## 1 Tell Us About Your Child

Today's Date: _____

**Child's Name:** _____
Last First MI

Child's Birthdate: _____/_____/_____ Child's Age: _____

Nickname: _____ ☐ Male ☐ Female

School: _____ Grade: _____

Child's Home #: (_____)_____ SS #: _____

Child's Home Address: _____
Apt / Condo #

_____
City State Zip

E-mail Address: _____

## 2 Who Is Accompanying The Child Today?

Name: _____ Relation: _____

Do you have legal custody of this child? ☐ Yes ☐ No

Is child adopted? ☐ Yes ☐ No Is child in a foster home? ☐ Yes ☐ No

Whom may we thank for refering you? _____

Other siblings seen by us: _____

Previous / Present Dentist: _____
(Please Circle)

Last Visit Date: _____

Parent's Marital Status ☐ Single ☐ Widowed ☐ Partnered ☐ Married ☐ Divorced ☐ Separated

## 3 Parent's Information

☐ **Mother** ☐ Step Mother ☐ Guardian

Name: _____ Birthdate: ____/____/____

Wk #: (_____)_____ Ext: _____ Hm #: (_____)_____

Employer: _____

SS #: _____ DL #: _____

☐ **Father** ☐ Step Father ☐ Guardian

Name: _____ Birthdate: ____/____/____

Wk #: (_____)_____ Ext: _____ Hm #: (_____)_____

Employer: _____

SS #: _____ DL #: _____

Neighbor or Relative not living with you.

Name: _____ Phone: (_____)_____

Address: _____

_____
City State Zip

## 4 Person Responsible for Account

Name: _____

Child's Home Address: _____

_____
City State Zip

Wk #: (_____)_____ Ext: _____ Hm #: (_____)_____

Employer: _____

DL #: _____ SS #: _____

**Who is responsible for making appointments?**

Name: _____

Wk #: (_____)_____ Ext: _____ Hm #: (_____)_____

## 5 Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (_____)_____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ____/____/____ ID #: _____

Policy Owner's Employer: _____

Employer's Address: _____

Orthodontic Coverage: ☐ Yes ☐ No

## 6 Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (_____)_____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ____/____/____ ID #: _____

Policy Owner's Employer: _____

Employer's Address: _____

Orthodontic Coverage: ☐ Yes ☐ No

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## Why did you bring the child to the dentist today? _____

_____

_____

Has the child ever had a serious / difficult problem associated with previous dental work? ☐ Yes ☐ No

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

Is the child taking fluoridated supplements? ☐ Yes ☐ No

**Has the child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD)?** ☐ Yes ☐ No

Does the child brush his / her teeth daily? ☐ Yes ☐ No

Child's Physician: _____

Phone #: _____ Date of Last Visit: _____

Is the child currently under the care of a physician? ☐ Yes ☐ No

**Please describe the child's current physical health:**

☐ Good ☐ Fair ☐ Poor

Has the child ever taken Fosamax, Actonel, Boniva or any other bisphosphonate? ☐ Yes ☐ No

**Please list all drugs the child is currently taking:**

_____

_____

**Aside from items listed below, list all drugs/things the child is allergic to:**

_____

_____

Latex ☐ Yes ☐ No Metals/Nickel ☐ Yes ☐ No Plastic ☐ Yes ☐ No

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## Has the child ever had any of the following medical problems?

| | | | | | |
|---|---|---|---|---|---|
| Y | N | Abnormal Bleeding | Y | N | Handicaps / Disabilities |
| Y | N | ADD / ADHD | Y | N | Hearing Impairment |
| Y | N | Anemia | Y | N | Heart Murmur |
| Y | N | Any Hospital Stays | Y | N | Hemophilia |
| Y | N | Any Operations | Y | N | Hepatitis |
| Y | N | Artificial Bones / Joints / Valves | Y | N | Hives |
| Y | N | Asthma | Y | N | HIV+ / AIDS |
| Y | N | Cancer | Y | N | Kidney / Liver Problems |
| Y | N | Chicken Pox | Y | N | Measles |
| Y | N | Congenital Heart Defect | Y | N | Mononucleosis |
| Y | N | Convulsions | Y | N | Mitral Valve Prolapse |
| Y | N | Epilepsy | Y | N | Rheumatic / Scarlet Fever |
| Y | N | Diabetes | Y | N | Sickle Cell Disease / Traits |
| Y | N | Exposed to HIV, but Neg. | Y | N | Skin Rash |
| | | | Y | N | Tuberculosis (TB) |

Are the Child's Immunizations current? ☐ Yes ☐ No

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

**Please discuss any serious medical problems that the child has had:**

_____

_____

## Does / did the child have any of the following habits?

| | | | | | |
|---|---|---|---|---|---|
| Y | N | Lip Sucking / Biting | Y | N | Nursing Bottle Habits |
| Y | N | Nail Biting | Y | N | Thumb / Finger Sucking |

Was the child breastfed? ☐ Yes ☐ No

**Our office is HIPPA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.**

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

My method of payment will be: _____

_____

Signature of parent or guardian Date

I certify that my child is covered by _____ Insurance Co. and I assign directly to Dr. _____ 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, whether manual or electronic.

_____

Signature of parent or guardian Date

**The Parent or Guardian who accompanies the child is responsible for payment at times of service unless prior arrangements have been approved.**

**OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE**

I verbally reviewed the medical / dental information above with the parent / guardian named herein. Initials: _____ Date: _____

**Doctor's Comments:**

_____

_____

_____

_____

_____

### Medical History Update

1. Date: _____ Signature: _____

Comments: _____

_____

2. Date: _____ Signature: _____

Comments: _____

_____

Family Roots
DENTISTRY

# FINANCIAL POLICY

Thank you for choosing us for all of your dental needs. We are committed to providing you with the highest quality of care, and we offer a variety of convenient financial options to help you receive the dental care that you need and deserve. The following information is to inform you of our financial policy.

## PAYMENT OPTIONS

We accept the following methods of payment: cash, check, and credit card (VISA, MasterCard, and Discover). Please note: There is a $50 fee for all returned checks. We extend pre-payment courtesies as well as offer payment plans. We have also partnered with third-party financing companies for extended payment options.

Your expected payment is due in full at the time of service unless prior arrangements have been made. We communicate all recommended treatment options and associated fees prior to the start of treatment.

## INSURANCE

Dental insurance is incredibly complex, because each insurance policy has its own unique rules and stipulations that can vary greatly and can be hard to understand. If you have dental insurance, our knowledgeable team will help you understand your specific insurance plan in order to maximize your available benefits. We are also happy to file all paperwork and claims on your behalf.

Please keep in mind that your insurance policy is a specific contract between you and your insurance company. We are not a party to that contract and cannot guarantee coverage or benefits. We do our very best to collect all the information that we can from your insurance company prior to you receiving dental care so that we can provide you with the most accurate estimates of your coverage. We kindly request that you notify our office prior to your appointment with any changes in your dental insurance policy. If the information provided is incorrect, you will be responsible for payment.

## APPOINTMENTS

Your scheduled appointment is a time that we have reserved exclusively for you. We have various methods of reminding you of upcoming appointments. We understand that there may be times when you are unable to keep your scheduled appointment, and we request that you notify our office with at least 48 hours notice.

## MINORS

For parents or guardians of minors, the parent or guardian that accompanies the minor to their visit assumes financial responsibility for the minor's account.

I understand the above information and agree to its contents.

Signature: _____ DATE: _____

(Patient/responsible party)

Family Roots
DENTISTRY

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

*Please note: you may refuse to sign this acknowledgement.*

I have received, read, and understand this office's Notice of Privacy Practices.

Signature_____ Date: _____

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**FOR OFFICE USE ONLY**

We attempted to obtain acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communications barriers prevented obtaining acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other

If other, please specify:

_____

Date_____

Family Roots
DENTISTRY

**NOTICE OF PRIVACY PRACTICES**

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AN D HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect **9/23/2013** 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

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We may use and disclose your health information for different purposes, including treatment, payment and health care operations. For each of these categories, we have provided a description and an example. Some information, such as related to HIV, genetic, alcohol &/or substance abuse records and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

**Treatment.** We may use and disclose your health information for your treatment. For example, we may disclose your information to a specialist providing treatment to you.

**Payment.** We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involving your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company or another third party. For example, we may send claims to your dental health plan containing certain health information.

**Healthcare Operations.** We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs and licensing activities.

**Individuals Involved in Your Care or Payment for Your Care.** We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

**Disaster Relief.** We may use or disclose your health information to assist in disaster relief efforts.

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

**Public Health Activities.** We may disclose your health information for public health activities, including disclosures to:
-Prevent or control disease, injury or disability;
-Report child abuse or neglect;

-Report reactions to medications or problems with products or devices;
-Notify a person of a recall, repair or replacement of products or devices;
-Notify a person who may have been exposed to a disease or condition; or
-Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence.

**National Security.** We may disclose to military authorities the 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 the protected health information of an inmate or patient.

**Secretary of HHS.** We will disclose your health information to the Secretary of the U.S. Dept. of Health and Human Services when required to investigate or determine compliance with HIPAA.

**Worker's Compensation.** We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

**Law Enforcement.** We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to subpoena or court order.

**Health Oversight Activities.** We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs and compliance with civil rights.

**Judicial and Administrative Proceedings.** If you are involved in a lawsuit or dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose your health information in response to a subpoena, discovery request or other lawful process instituted by someone else in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

**Research.** We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

**Coroners, Medical Examiners and Funeral Directors.** We may release your PHI to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

**Fundraising.** We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out.

**Other Uses & Disclosures of PHI.**
Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided in this Notice (or as otherwise permitted by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

**YOUR HEALTH INFORMATION RIGHTS**
**Access.** You have the right to view or get copies of your PHI, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we

maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

**Disclosure Accounting.** With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your PHI, you must submit in writing to the Privacy Official. If you request this more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to additional requests.

**Right to Request a Restriction.** You have the right to request additional restriction on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

**Alternative Communication.** You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested, we may contact you using the information we have.

**Right to Notification of a Breach.** You will receive notifications of breaches of your unsecured protected health information as required by law.

**Electronic Notice.** You may receive a paper copy of this Notice upon request, even if you have agreed to receive this notice electronically on our Website or by e- mail.

**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, if you disagree with a decision we made about access to your PHI 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 locations, you may send a complaint to us using the contact information at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file this complaint 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 for the U.S. Dept. of Health and Human Services.

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