WELCOME to our practice! We strive to make each of your child's visits pleasant and comfortable. Our goal is to teach oral habits which will help keep your child's smile beautiful for their lifetime.

YOUR CHILD

Child's Name _____

Nickname _____

Date of Birth (M) ___/(D)___/(Y)_____ Age____

School _____

Sex: M_____ F_____

Child's mailing address _____

_____

Phone # _____

Siblings _____

DENTAL INSURANCE

Insured's Name _____

Insured's Employer _____

Relationship to Child _____

Date of Birth _____

Insurance Company _____

Group # _____

Policy #_____

Social Security # _____

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

Name _____

Relationship _____

Phone number _____

RESPONSIBLE PARTY

Name _____

Relationship _____

Mailing Address _____

_____

Physical Address_____

_____

_____

Date of Birth (M) ___/(D)___/(Y)_____ Age____

Cell phone # _____

Work phone # _____

Employer _____

Occupation _____

SSN#_____

Email Address _____

How did you hear about us?

A. Radio Station (105.3 FM, 107.3 FM, 107.9 FM, or 1340AM)

B. My friend _____

C. Internet/ Facebook / Website

D. Other _____

FINANCIAL ARRANGEMENTS

Our office will make every effort to provide the best care for your child. You can help us by paying for dental services upon completion of each visit.

IF YOU HAVE INSURANCE, WE WILL BE HAPPY TO COMPLETE YOUR INSURANCE FORM, BUT PLEASE REMEMBER THAT YOU ARE ULTIMATELY RESPONSIBLE FOR ALL SERVICES PERFORMED ON YOUR DEPENDENT. *THANK YOU!*

X _____ _____

Signature of Parent / Guardian **Date**

HEALTH HISTORY

Your child's health as well as any medications which your child takes has an important interrelationship with the dental care your child receives. Please answer each of the following questions carefully. If you need any assistance - please ask us. We will be happy to help.

MEDICAL HISTORY

Name of child's pediatrician _____ Phone # _____

Yes **No** Has your child ever been hospitalized?
If yes, why? _____

Yes **No** Has your child ever received general anesthesia ("been put to sleep")?
If yes, were there any complications? _____

Yes **No** Is your child allergic to any medicine or food?
If yes, what? _____

Yes **No** Is your child taking any medications at this time?
If yes, what? _____

Has your child ever been diagnosed with any of the following conditions?

Yes **No** Abnormal Bleeding
Yes **No** Hemophilia
Yes **No** Anemia
Yes **No** Asthma
Yes **No** Sickle Cell Anemia/Trait
Yes **No** Cancer
Yes **No** Bones/Orthopedics
Yes **No** Arthritis
Yes **No** Cerebral Palsy
Yes **No** Muscle Problems
Yes **No** Mental Retardation

Yes **No** Ear Problems
Yes **No** GI Problems
Yes **No** Leukemia
Yes **No** Pneumonia
Yes **No** Rheumatic Fever
Yes **No** Scarlet Fever
Yes **No** Skin Problems
Yes **No** Hyperactivity
Yes **No** Brain Injury
Yes **No** HIV/AIDS
Yes **No** ADHD/ADD

Yes **No** Hepatitis
Yes **No** Jaundice
Yes **No** Tuberculosis
Yes **No** Whooping Cough
Yes **No** Measles
Yes **No** Diabetes
Yes **No** Nervous System
Yes **No** Convulsions/ Seizures
Yes **No** Autism
Yes **No** Developmental Delay

Please explain any medical problems that your child may have:

_____

_____

DENTAL HISTORY

Does your child:

Yes **No** Brush
Yes **No** Floss
Yes **No** Take fluoride supplements
Yes **No** Suck thumb/finger
Yes **No** Suck/bite lips
Yes **No** Bite nails
Yes **No** Chew on hard objects (pencil, etc)

Yes **No** Has your child seen a dentist before?
Yes **No** Has your child had any accidents involving the teeth?
Yes **No** Grind teeth
Yes **No** Clench jaw

How do you expect your child to react to dental treatment? _____

CONSENT FOR DENTAL TREATMENT

I hereby authorize and direct **Sonia Taylor-Griffith, DDS,** assisted by other dentists and dental auxiliaries of her choice, to perform upon my child/legal ward dental treatment, including the use of any necessary local anesthetic, radiographs (x-rays) and diagnostic aids.

The dental procedure may include:

- Cleaning of the teeth and the application of topical fluoride.
- Application of plastic "sealants" to the grooves of the teeth.
- Treatment of diseased or injured teeth with fillings or crowns.
- Replacement of missing teeth with dental prosthesis (dentures).
- Extraction of teeth.
- Treatment of diseased or injured oral tissues.
- Treatment of crooked teeth and growth abnormalities.
- Use of physical restraints to safely complete the procedures.
- Use of sedative agents to control apprehension and /or disruptive behavior.
- Other _____

I understand that during the course of the procedure(s), unforeseen conditions may arise which may necessitate procedures different from those contemplated. I, therefore, consent to the performance of additional procedures which Dr. Taylor-Griffith may consider necessary.

I am advised that though good results are expected there cannot be a guarantee as to the result of the treatment or as to a cure. I further authorize Dr. Taylor-Griffith to perform dental treatment that in her judgment is advisable for my child/legal ward.

Patient's Name X_____

Signature of Parent/Guardian X_____

Relationship to Patient X_____

Date _____

****

Doctor's Certification:

I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to (including no treatment) and attendant risks to the proposed procedure(s). I have offered to answer any questions and have fully answered all such questions. I believe that the parent/guardian fully understands what I have explained and answered.

_____ _____

Signature of Doctor **Date**

Notice of Privacy Practices for Protected Health Information

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!

With your consent, the practice is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Example of uses of your health information for treatment purposes:
A nurse obtains treatment information about you and records it in a health record. During the course of your treatment, the doctor determines a need to consult with another specialist in the area. The doctor will share the information with such specialist and obtain input.

Example of use of your health information for payment purposes:
We submit a request for payment to your health insurance company. The health insurance company requests information from us regarding medical care given. We will provide information to them about you and the care given.

Example of Use of Your Information for Health Care Operations:
We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

Your Health Information Rights
The health record we maintain and billing records are the physical property of the practice. The information in it, however, belongs to you. You have a right to:

- ∑ Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request granted;
- ∑ Request that you be allowed to inspect and copy your health record and billing record—you may exercise this right by delivering the request in writing to our office;
- ∑ Appeal a denial of access to your protected health information except in certain circumstances;
- ∑ Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office;
- ∑ File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
- ∑ Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care;
- ∑ Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office; and,
- ∑ Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you want to exercise any of the above rights, please contact our administrator, in person or in writing, during normal hours. S[he] will provide you with assistance on the steps to take to exercise your rights.

Our Responsibilities
The practice is required to:

- ∑ Maintain the privacy of your health information as required by law;
- ∑ Provide you with a notice of our duties and privacy practices as to the information we collect and maintain about you;
- ∑ Abide by the terms of this Notice;
- ∑ Notify you if we cannot accommodate a requested restriction or request; and
- ∑ Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

Notice of Privacy Practices for Protected Health Information cont'd

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact our office administrator.

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to our office administrator. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services whose street address and e-mail address is **200 Independency Ave. S.W. Washington, D.C., 20201, phone # 1-877-696-6775, http://HHS.gov**

∑ We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the practice.

∑ We cannot, and will not, retaliate against you for filing a complaint with the Secretary.

Other Disclosures and Uses

Notification

Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Communication with Family

Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Food and Drug Administration (FDA)

We may disclose to the FDA your protected health information relating to adverse events with respect to products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation

If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health

As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse & Neglect

We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Correctional Institutions

If you are an inmate of a correctional institution, we may disclose to the institution, or its agents, your protected health information necessary for your health and the health and safety of other individuals.

Law Enforcement

We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

Health Oversight

Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings

We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.

Other Uses

Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided.

Website

If we maintain a website that provides information about our entity, this Notice will be on the website.

Effective Date: 3/19/2014

I, _____, hereby acknowledge that I have read this practice's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice.

_____ _____

Signature of Parent/Guardian Date

FINANCIAL AGREEMENTS

The parent, guardian, or adult accompanying a minor is responsible for full payment, deductible, or co-pay ***AT THE TIME OF SERVICE.***

Co-pays: Per our contract with your insurance company, co-pays are due and must be collected at the time of service. Co-pays cannot be waived or credited to an account as this would constitute a breach of our contract with your insurance company. We may choose to reschedule an appointment in the event a co-payment cannot be made at the time of the visit. ____ Initials

Insurance Billing: Children's Dental Care, Inc. will bill your insurance company for services provided. Ultimately, you are responsible for any charges not paid by your insurance carrier. By having us bill your insurance company, you are assigning your benefits to Children's Dental Care, Inc. In order for us to accurately and correctly bill your insurance company, we require for you to provide us with current information. This includes an up to date copy of your insurance card, social security number, and a completed patient information sheet. These documents must be updated on an annual basis and/or whenever there is a change. Failure to provide accurate insurance and demographic information may result in you being liable for services rendered that day. If, after 90 days, your insurance has not covered the billed services, you are responsible for the full outstanding balance. _____ Initials

Billing/Payment: Children's Dental Care, Inc. will bill, on a monthly cycle, for charges that have been identified as your responsibility. We will not bill you for charges that are currently submitted to your insurance company or for any contractually agreed upon adjustments. Payment is required within 30 days of the billing date. Any account balance carried over 90 days may be subject to a late fee and a 1.5% interest fee per month (18% annually). In the event the account is turned over to a collection agency, the parent will be responsible for any collection fees incurred. _____ Initials

Missed Appointments: Your appointment is especially reserved for you. We respectfully request that you notify us 24 hours ahead of time in the event you cannot make your scheduled appointment so that we may accommodate other patients. Failure to provide a 24 hour notice and/or failing to show up for appointments may result in a missed appointment fee of $25.00. _____ Initials

Collections: We understand that at times there are extenuating circumstances that may limit your ability to pay off any outstanding balance. In these types of situations we may be able to arrange a payment plan. However, balances greater than 90 days old and where a payment plan has not been established may be turned over to an outside collection agency. In the event this occurs, you may be discharged from the practice and responsible for any collection fees incurred by Children's Dental Care, Inc. _____ Initials

Non-Covered Services: As the subscriber, you are responsible for knowing the terms and limitations of your specific plan. Children's Dental Care, Inc. is not responsible for charges incurred as a result of any particular service not being covered and/or paid for by your plan, nor can the staff of Children's Dental Care, Inc. be responsible for knowing the terms of your policy. You are responsible for any visit, treatment, and/or equipment charged for and not covered under your plan. _____ Initials

Insurance Information
Below is a list of the insurances that we accept assignment of benefit. Please have your card with you at the time of your visit. If we file your claim, you are responsible for only the co-pay at the time of visit. If we are not a provider for your insurance, if you are not insured or we do not file with your insurance company, you will be responsible for the entire charge at the time of service. We are in-network with CIGNA and ELAN and will collect co-pay at the time of visit for restorative treatment. _____ Initials

Aetna, Aflac, APWU, BUPA, Colonial Medical, Corvel, Generali, Guardian, Mapfre PR, Metlife, United Healthcare

I acknowledge and understand these office policies:

_____ _____
Signature of Parent/Guardian Date