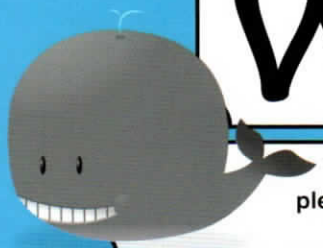
WELCOME



We would like to welcome your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on a 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: _____

Hobbies: _____

Child's Home #: (____) _____

Child's Home Address: _____

_____
City State Zip

2. General Information

Who is accompanying the child today?

Name: _____ Relation: _____

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

Whom may we Thank for referring you? _____

Other siblings: _____

Previous/Present Dentist: _____ Last Visit Date: _____

Dentist's Phone #: (_____) _____

Relative or Friend not living with you:

Name: _____ Phone: (_____) _____

Address: _____
City State Zip

3. Parent's Information

Person Responsible for Account: _____ Parent's Marital Status ❑ Single ❑ Married ❑ Partnered ❑ Widowed ❑ Divorced ❑ Seperated

❑ Father ❑ Step Father ❑ Guardian

Name: _____ Birthdate: _____

Address: (If different than Child's) Hm #: (____) _____

_____

_____
City State Zip

SS #: _____ DL#: _____

Wk #: (____)_____ Ext: ___ Cell/Other #:(____)_____

Email: _____

Employer: _____

Employer's Address: _____

_____
City State Zip

If you have Dental Insurance Coverage for the Child, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____

_____
City State Zip

Insurance Phone: (___)_____

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

❑ Mother ❑ Step Mother ❑ Guardian

Name: _____ Birthdate: _____

Address: (If different than Child's) Hm #: (____) _____

_____

_____
City State Zip

SS #: _____ DL#: _____

Wk #: (____)_____ Ext: ___ Cell/Other #:(____)_____

Email: _____

Employer: _____

Employer's Address: _____

_____
City State Zip

If you have Dental Insurance Coverage for the Child, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____

_____
City State Zip

Insurance Phone: (___)_____

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

4. Release

I certify that my child is covered by _____ Insurance Co. and I assign all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any copayment 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

Continued on Back

5. Dental History

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

_____

Is the child currently in pain? ❑ Yes ❑ No

Does the child require antibiotics before dental treatment? ❑ Yes ❑ No

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

How often does your child brush their teeth per day? _____

Floss per day? _____

Do you help? ❑ Yes ❑ No

How often does your child snack per day? _____

What type of snacks? _____

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

Child's Physcian: _____

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

Please list all prescription/over the counter or herbal supplement drugs that the child is currently taking: _____

_____

Aside from items listed, please list all drugs/things that the child is allergic to: _____

_____

_____

Yes No Latex | Yes No Metals/Nickel | Yes No Plastic

6. Medical History

❑ Yes ❑ No	Abnormal Bleeding/Hemophilia	❑ Yes ❑ No	Handicaps/Disabilities
❑ Yes ❑ No	ADD/ADHD	❑ Yes ❑ No	Hearing Impairment
❑ Yes ❑ No	AIDS/HIV+	❑ Yes ❑ No	Heart Murmur
❑ Yes ❑ No	Anemia	❑ Yes ❑ No	Hepatitis
❑ Yes ❑ No	Any Hospitalizations or Operations?	❑ Yes ❑ No	High Blood Pressure
		❑ Yes ❑ No	Skin Rash/ Hives
❑ Yes ❑ No	Artificial Bones/Valves	❑ Yes ❑ No	Kidney Problems
❑ Yes ❑ No	Asthma	❑ Yes ❑ No	Liver Problems
❑ Yes ❑ No	Autism	❑ Yes ❑ No	Lupus
❑ Yes ❑ No	Cancer	❑ Yes ❑ No	Measles
❑ Yes ❑ No	Congenital Heart Defect	❑ Yes ❑ No	Mitral Valve Prolapse
❑ Yes ❑ No	Convulsions/Seizures	❑ Yes ❑ No	Mononucleosis
❑ Yes ❑ No	Diabetes	❑ Yes ❑ No	Premature Birth
❑ Yes ❑ No	Delayed Development	❑ Yes ❑ No	Prosthetics
❑ Yes ❑ No	Down Sydrome	❑ Yes ❑ No	Rheumatic Fever
❑ Yes ❑ No	Emotional Problems	❑ Yes ❑ No	Scarlet Fever
❑ Yes ❑ No	Epilepsy	❑ Yes ❑ No	Tuberculosis (TB)
❑ Yes ❑ No	Exposed to HIV, but Neg		

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 the child experiences/ed: _____

_____

_____

Does your child currently have any of these habits?

❑ Yes ❑ No	Bottle/Sippy Cup	❑ Yes ❑ No	Nursing
❑ Yes ❑ No	Chewing on Objects	❑ Yes ❑ No	Pacifier
❑ Yes ❑ No	Clenching/Grinding Teeth	❑ Yes ❑ No	Speech Problems
❑ Yes ❑ No	Lip Sucking	❑ Yes ❑ No	Thumb/Finger Sucking
❑ Yes ❑ No	Mouth Breather	❑ Yes ❑ No	Tongue/Cheek Biting
❑ Yes ❑ No	Nail Biting	❑ Yes ❑ No	Tongue Thrust

Our office is HIPAA 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 change in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

_____ _____

Signature of Parent or Guardian Date

OFFICE USE ONLY • OFFICE USE ONLY • OFFICE USE ONLY • OFFICE USE ONLY • OFFICE USE ONLY

I have verbally reviewed the medical/dental information above with the parent/guardian and patient named herein.

_____ _____

Signature of Dentist Date

Dentist's Comments: _____

_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY, THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT

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 April 14th, 2003, 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. We reserve the right to make the changes in our privacy practices and the terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available 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.

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 dentist 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. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

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. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect, Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patients Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with payment for your healthcare, but only if you agree that we may do so.

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, your general location, your 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 a 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 inferences of your best interest in allowing a person to pick up x-rays or other similar forms of health information.

Making 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.

AKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT****

I, _____, have received a copy of this office's Notice of Privacy Practices.
(PRINT NAME)

Patient Name:_____ Date: _____

Parent/Patient/Guardian Signature: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of Receipt of Notice of Privacy Practices, but acknowledgement was refused.

Employee Name: _____ Date:_____ Signature: _____

Waterford
Pediatrics & Orthodontics

CALE RANCH PEDIATRICS

Main Street Pediatric
Dentistry & Orthodontics

Office Policies

New Patient Paperwork

Please complete the new patient paperwork prior to arriving to your appointment. When you do not do this, it delays your appointment and other patients after you.

Missed Appointments

Our goal is to provide quality to all of our patients. When an appointment is scheduled, a block of time in the doctors' schedule has been allotted for you and your family.

We reserve the right to charge an initial $50.00 fee for any missed appointment that has not been canceled 24 hours prior to the scheduled appointment time.

Late Appointments

All patients that arrive more than 15 minutes late for a scheduled appointment may be rescheduled. This does not apply if prior arrangements have been made.

Customary Diagnostic and Preventative Services

All patients are recommended to have an exam, a dental cleaning and a professional fluoride application minimally on a biannual basis. Dental check-ups periodically will involve radiographic films when age appropriate and will be taken with a frequency supported by the guidelines of the American Academy of Pediatric Dentistry.

Unable to COMPLETE Treatment

If we are unable to complete treatment due to behavior; there is a $50 Behavior Management Fee AND if Nitrous Oxide (N2O) is also being utilized, an additional $75 will be applied.

Financial Responsibility

Your signature on this form acknowledges that you, the patient, parent, or legal guardian, agree to bear full financial responsibility for all services provided if:

1. You are determined not to be eligible for insurance coverage.
2. The services are not a covered benefit under your plan.
3. There is a patient portion determined by your insurance plan.

Please keep in mind that any estimates presented to you for dental treatment is only an ESTIMATE of what your insurance company will pay. Financing options are available.

Returned checks

A fee of $35.00 for returned checks returned to us for any reason. Future services will require payment by cash or credit card.

Signature _____ Date _____