Patient Information

Child's Name : _____ Goes By: _____
Last First M.I.

☐ Male ☐ Female Child's Birthdate: _____ Child's Age:_____ Email: _____

Child's Home Address: _____
Street Apt / condo # City State Zip

Phone #: _____ Cell #: _____

School: _____ Grade: _____

Hobbies/Sports: _____

List brothers / sisters with age: _____

General Dentist: _____ Last Visit Date: _____

Who is accompanying your child today? Name: _____

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

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

Mother's Information: ☐ Guardian Name:_____ Birthdate: _____

Address:_____ Phone #: _____ SS #: _____

Employer: _____ Work #: _____ Ext: _____

☐ Stepfather Name:_____ Phone #: _____

Father's Information: ☐ Guardian Name:_____ Birthdate: _____

Address:_____ Phone #: _____ SS #: _____

Employer: _____ Work #: _____ Ext: _____

☐ Stepmother Name:_____ Phone #: _____

Additional Caregiver Name:_____ Phone #: _____

Address_____ Relationship to child: _____

Person Responsible for the Account (if different from above):_____ SS #: _____

Billing Address: _____

Relationship to child: _____ Work #: _____ Ext: _____ Phone #: _____

Name of other person(s) authorized to receive information about this account: _____

How did you hear about us? (Check all that apply):

☐ Friend ☐ Professional Referral _____ ☐ Walked by/Drove By ☐ Mailer ☐ Search Engine _____

☐ Facebook ☐ Other Social Media _____ ☐ Other_____

Appointment Reminders

Please indicate ALL methods in which you would like to be contacted for appointment reminders:

☐ Phone call reminder Phone #: _____

☐ Text message reminder Cell #: _____

Cell Service Provider: (i.e., Sprint, Verizon, etc) _____

☐ Email reminder E-mail address: _____

Medical History

Child's Physician: _____ Date of Last Medical Exam: _____

Please discuss any medical problems that your child has had: _____

Please list all medications your child is currently taking: _____

Has your child had any unfavorable reaction to medications? If yes, please explain: _____

_____

Were there any difficulties during pregnancy or delivery? _____

Has your child ever been in a hospital overnight or had any surgery? _____

When? _____ Does your child bleed for a long period of time following a cut or have frequent nose bleeds? _____

Has your child ever had any of the following medical problems? (Please check all that apply)

- ☐ Abnormal Bleeding
- ☐ Allergies to any Drugs
- ☐ Asthma
- ☐ Convulsions / Epilepsy
- ☐ Hearing Impairment
- ☐ Heart Murmur
- ☐ Kidney / Liver Problems
- ☐ Cancer
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Hepatitis
- ☐ HIV / Aids
- ☐ Rheumatic / Scarlet Fever
- ☐ Tuberculosis (TB)
- ☐ Clenching / Grinding Teeth
- ☐ Lip Sucking / Biting
- ☐ Mouth Breather
- ☐ Nail Biter
- ☐ Speech Problems
- ☐ Thumb / Finger Sucking
- ☐ Tongue Thrust

Dental History

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

Former Dentist: _____ Phone: _____

Date of Last Dental Care: _____ Date of Last X-Rays: _____

Is your child's water fluoridated? _____ Is your child taking fluoride supplements? _____

How many times a day does your child brush his/her teeth? _____

Does your child floss? _____ Do your child's gums ever bleed? _____

Does your child have any oral habits such as thumb sucking or grinding his/her teeth? _____

Do you as a parent visit the dentist regularly? _____ Dentist name(s): _____

Has your child had any unfavorable experience in a dental or medical office? If yes, please explain: _____

_____

Because your child is a minor, a parent or guardian must give permission (by signing below) before any and/or all necessary dental services can be started. Despite our commitment to make dentistry a pleasant and comfortable part of routine health care, occasionally some children may display behavior that could cause potential injury. For safe treatment, management techniques may be used to limit or control movement.

If after discussing treatment needs, you feel your child's behavior might requre additional mangagement controls we will discuss alternatives available for a mutally satisfactory experience for patient, parent and doctor.

Signature _____ Date_____

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

Insurance Information and Financial Policy

Insurance Information

Names of children covered under this policy _____

*Person Carrying Insurance _____ *Their Social Security Number _____

*Their Birthday _____ *Relationship to Child _____ *Home Phone _____

Home Address (if different than child) _____

*Employer _____ *Business Phone _____

*Insurance Company _____ *Phone Number _____

*Insurance Company Address _____

*Group Number _____ *Subscriber Number _____

*Is your child covered by a secondary insurance company? _____

As a courtesy to you, we will bill your insurance company for treatment rendered. Please be advised that you alone are responsible for the payment of this account. Any negotiations of payment, whether estimated or final, are between the insured and the insurance company. We are not party to this contract. It is not the responsibility of Smile Academy Pediatric Dentistry to determine what your insurance will or will not cover. Your insurance company makes the final determination of your eligibility and benefits. By signing this document, you agree to pay any charges incurred.

Financial Policy

Monthly Statement: If there is a balance on your account you will receive a statement. The balance reflected is due upon receipt of the statement.

Insurance co-payment: For restorative treatment we will request an estimate of dental benefits (EOB) from your insurance provider. The EOB will determine the **estimated** portion of the upcoming treatment fee that will be the patient responsibility (co-pay). Your insurance provider may or may not send you a copy of this EOB. If you do not receive a copy of the EOB, it is your responsibility to call our office prior to the appointment in order to determine your **estimated** portion of the restorative charges. **Your co-payment is due at the time of service.** Your insurance company will determine your exact co-payment after processing your claim. If a balance still remains after we have received insurance payment, you will receive a statement for the remaining balance.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid in full at the time of services, regardless of insurance.

Broken Appointment Policy: If you are unable to keep your appointment please give our office no less than 24 hour notice. Failure to give us notice is considered a broken appointment. Each **family** is allowed three (3) broken appointments in a one (1) year period. Additional broken appointments will result in dismissal.

Composite Restorations: It is the policy of Smile Academy to use composite (tooth colored) restorations on anterior and posterior teeth instead of amalgam (silver) restorations in most cases. Most insurance companies will cover the fee for an amalgam restoration on a posterior tooth regardless of which restoration is done. You will be responsible for the difference in cost. If you prefer amalgam restorations instead of composite restorations please consult the Dr. **before** any treatment is rendered.

I authorize any insurance company, acting on my behalf, to pay Smile Academy all insurance benefits otherwise payable to me for services rendered. I authorize that use of this signature on all insurance submissions.

I authorize Smile Academy to release all information necessary to secure the payment of benefits. **I understand that I am financially responsible for all incurred charges to this account.**

Signature _____ Date _____

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.

Understanding Your Health Information

Each time you visit our office, we make a record of your visit in order to manage the care you receive. We understand that the medical information that is recorded about you and your health is personal. The confidentiality and privacy of your health information is also protected under both state and federal law.

This Notice of Privacy Practices describes how this office may use and disclose your information and the rights that you have regarding your health information.

How We Will Use or Disclose Your Health Information

Treatment: We will use your health information for treatment. For example, information obtained by the orthodontist or other members of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your orthodontist will document in your record his or her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations, so the physician will know how you are responding to treatment. We will also provide your physician, or a subsequent healthcare provider, with copies of various reports that should assist him or her in treating you.

Payment: We will use your health information for payment. For example, a bill may be sent to you or your health plan. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

Health Care Operations: We will use your health information for our regular health care operations. For example, we may use information in your health record to assess the care and outcome in your case and others like it. This information will then be used in a continued effort to improve the quality and effectiveness of the services we provide.

Business Associates: We may enter into contracts with persons or entities known as business associates that provide services to or perform functions on our behalf. Examples include our accountants, consultants, and attorneys. We may disclose your health information to our business associates so they can perform the job we have asked them to do, once they have agreed in writing to safeguard your information.

Notification: We may use or disclose information to assist in notifying a family member, personal representative, or another person responsible for your care, of your location, and general condition. If we are unable to reach your family member or personal representative, then we may leave a message for them at the phone number that they have provided to us, e.g., on an answering machine.

Communication with Family: 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 payment related to your care.

Appointment Reminders / Health Benefits: We may contact you to provide appointment reminders or information about treatment alternatives or other health benefits that may be of interest to you.

Funeral Directors and Coroners: We may disclose your health information to funeral directors, and to coroners or medical examiners, to carry out their duties consistent with applicable law.

Organ Procurement Organizations: Consistent with applicable law, we may disclose your health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Research: We may disclose your health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information. We may also disclose your health information to people preparing to conduct a research project, so long as the health information is not removed from us. We may also use and disclose your health information to contact you about the possibility of enrolling in a research study.

Fundraising: We may contact you as part of our fundraising efforts; however, you may opt-out of receiving such communications.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product, and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers' Compensation: We may disclose health information to the extent authorized by and to the extent necessary, to comply with laws relating to workers' compensation or other similar programs established by law.

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

Health Oversight Activities: We may disclose your health information to health oversight agencies for purposes of legally authorized health oversight activities, such as audits and investigations necessary for oversight of the health care system and government benefit programs.

Correctional Institution: Should you be an inmate of a correctional institution, we may disclose to the institution, or agents thereof, health information necessary for your health and the health and safety of other individuals.

Judicial and Administrative Proceedings: We may disclose your health information in a judicial or administrative proceeding if the request for the information is through an order from a court or administrative tribunal. Such information may also be disclosed in response to a subpoena or other lawful process if certain assurances regarding notice to the individual or a protective order are provided.

Law Enforcement Purposes / Serious Threat to Health or Safety: We may disclose your health information to enforcement officials for law enforcement purposes under certain circumstances and subject to certain conditions. We may also disclose your health information to prevent or lessen a serious and imminent threat to a person or the public (when the disclosure is made to someone we believe can prevent or lessen the threat) or to identify or apprehend an escapee or violent criminal.

Victims of Abuse, Neglect, and Domestic Violence: In certain circumstances, we may disclose your health information to appropriate government authorities if there are allegations of abuse, neglect, or domestic violence.

Essential Government Functions: We may disclose your health information for certain essential government functions (e.g., military activity and for national security purposes). The following uses and disclosures will be made only with your authorization: (i) with limited exceptions, uses and disclosures of your health information for marketing purposes, including subsidized treatment communications; (ii) disclosures that constitute a sale of your health information; and (iii) other uses and disclosures not described in this notice. You may revoke your authorization at any time in writing, except to the extent that we have taken action in reliance on the use or disclosure indicated in the authorization.

Your Health Information Rights

Although your health record is the physical property of this office, you have the following rights with respect to your health information.

- You may request that we not use or disclose your health information for a particular reason related to treatment, payment, our general healthcare operations, and/or to a particular family member, other relatives or close personal friend. We ask that such requests be made in writing on a form provided by us. Although we will consider your request, please be aware that we are under no obligation to accept it or to abide by it, except as provided below.

- If you have paid for services out-of-pocket in full, you may request that we not disclose information related solely to those services to your health plan. We ask that such requests be made in writing on a form provided by us. We are required to abide by such a request, except where we are required by law to make a disclosure. We are not required to inform other providers of such a request, so you should notify any other providers regarding such a request.

- You have the right to receive confidential communications from us by alternative means or at an alternative location. Such a request must be made in writing, and submitted to the Privacy Officer. We will attempt to accommodate all reasonable requests.

- You may request to inspect and/or obtain copies of health information about you, which will be provided to you in the time frames established by law. If we maintain your health information electronically in a designated record set, you may obtain an electronic copy of the information. If you request a copy (paper or electronic), we will charge you a reasonable, cost-based fee.

- If you believe that any health information in your record is incorrect, or if you believe that important information is missing, you may request that we correct the existing information or add the missing information. Such requests must be made in writing, and must provide a reason to support the amendment. We ask that you use the form provided by us to make such requests. For a request form, please contact the Privacy Officer.

- You may request that we provide you with a written accounting of all disclosures made by us during the time period for which you request (not to exceed six years), as required by law. We ask that such requests be made in writing on a form provided by us. Please note that accounting does not include all disclosures, e.g., disclosures to carry out treatment, payment, or healthcare operations and disclosures made to you or your legal representative or pursuant to an authorization. You will not be charged for your first accounting request in any 12-month period. However, for any requests that you make thereafter, you will be charged a reasonable, cost-based fee.

- You have the right to be notified following a breach of your unsecured protected health information.

- You have the right to obtain a paper copy of our Notice of Privacy Practices upon request.

For More Information or to Report a Problem

You have the right to complain to us and to the Secretary of the U.S. Department of Health and Human Services (HHS) if you believe we have violated your privacy rights. We will not retaliate against you for filing a complaint.

For more information or to file a complaint with us, contact our Privacy Officer by phone or mail. To file a complaint with the Secretary of HHS, send your complaint to our Privacy Officer.

If you have any questions or want more information about this Notice of Privacy Practices, please contact our Privacy Officer.

Acknowledged By:_____ Date: _____

Signature of Patient or Personal Representative

Effective 01/01/2014

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient Giving Consent

Name: _____

Address: _____

Telephone: _____ **Email:** _____

Patient Number:_____ **Social Security Number:** _____

Section B: To the Patient

Please read the following statements carefully.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Smile Academy Pediatric Dentistry
Phone: (970) 373-4435
Address: 5100 West 20th Street, Suite B
Greeley, CO 80634

Right to Revoke: You will have the right to revoke this Consent at any time by giving us a written notice of your revocation submitted to our office. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or continue to treating you if you revoke this Consent.

Signature

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

Feel free to ask for a copy of this Consent after you sign it as you are entitled to one.

Include completed Consent form in the patient's chart.

Release Form for Media Usage

I, the undersigned, a Patient of Smile Academy Pediatric Dentistry (the "Practice"), do hereby acknowledge that the Practice has a legitimate interest in creating a photographic and/or audiovisual record of me, that the Practice desires to use such photographs and audiovisual recordings in various publications and promotional materials, including printed matter (i.e., flyers, brochures, newsletters, etc.), internet based information sites, DVDs, pod casts and other electronic media, and that my image and/or voice, may be the subject of and/or included in such photographs and/or audiovisual recordings by virtue of my participation in the Practice's promotional activities.

I, do hereby consent and agree that the Practice, its employees, or agents have the right to use photographs, videotape, or digital recordings of me and to use these in any and all forms of media and exclusively for the purpose of the Practice that has provided me with dental or orthodontic services. I further consent that my first name only may be used therein or by descriptive text or commentary.

Accordingly, I hereby grant to the Practice the right to photograph me and to record my image and/or voice by any means now known or herein after devised, in connection with the Practice's promotional activities, together with the perpetual but non-exclusive right to use, duplicate, and publish such photographs, and any such recordings of my image and/or voice, to edit and/or combine such photographs and recordings with other materials, music, and/or special effects, at the Practice's discretion, to identify me by first name only in connection with such photographs and/or recordings, or refrain from doing so, and to sell, license or otherwise distribute same for the purpose of promoting the Practice and its activities.

I hereby waive the opportunity or right to inspect or approve the proofs, negatives, tests, finished films, video, sound recordings and/or photographs or the uses to which the same may be put. All copies of my image and/or voice, created or recorded by the Practice hereunder shall be the sole and exclusive property of the Practice, including any and all prints and negatives depicting same. I waive any rights, claims, or interest I may have to control the use of my identity or likeness in whatever media used.

I hereby acknowledge that the copyright to any performance by me recorded by the Practice hereunder shall be owned exclusively by the Practice for the term of such copyright, all such rights in and to said performances having been transferred by me to the Practice hereby.

I represent that I have read and understand this agreement, and am competent to execute this agreement. No other Agreements currently exist which would prevent my transferring these rights to the Practice, or its successors and assigns. I acknowledge that the Practice intends to rely on this release, and the grant of rights herein contained, and shall incur significant costs in production of such photographs and recordings, and the materials and products containing same. As a result, I agree not to institute any legal action to contest the rights conveyed to the Practice herein. Further, I, for my successors and assigns, hereby release, and agree to indemnify and hold harmless, any and all employees, agents, affiliates, successors, assigns, contractors and/or vendors of the Practice, including those operating in a volunteer capacity, of and from any and all liability arising out the creation of such photographic images and/or audiovisual recordings, the publication, sale or other distribution of same or the exercise of the any other rights granted herein.

I have read and understand the contents of this release and am executing same of my own free will. If I am under 18 years of age, my parent and/or legal guardian _____ has signed below and by so signing acknowledges and agrees to the terms of this agreement, both individually, and on my behalf.

Patient:

Name (print): _____ Date: _____

Signature: _____

Parent and/or legal guardian (if Patient under 18)

Name (print): _____ Date: _____

Signature: _____