Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: _____ Birth Date: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Name of Parent/Legal Guardian: _____ Relationship to patient: _____

Health Information

Date of Last Dental Visit: _____ Reason for visit today: _____

Have you ever had any of the following? Please check those that apply:

- ☐ ADD/ADHD
- ☐ Allergies _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Autism/Aspergers
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy Due date: _____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHER:

- ☐ _____
- ☐ _____
- ☐ _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Primary Care Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

_____
Print name- Patient/Guardian

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient (please specify below)

☐ Dental Office (please specify below) ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Responsible Party Information

The following is for: ☐ the person responsible for payment ☐ the legal guardian of the patient

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Birth Date: _____

PLEASE PROVIDE AS MANY PHONE NUMBERS AS POSSIBLE AS WELL AS AN E-MAIL ADDRESS:

Home Phone #: _____ Work Phone #: _____ Ext: _____ Best time to call: _____

Cell Phone # (if applicable): _____ E-Mail Address***: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Additional Parties

I authorize disclosure of information to the parties listed below in addition to myself (please list any/all <u>legal guardians</u> whom you authorize to bring child to future appointments.)

Name: _____Birth Date_____ Relation to Patient:_____

Address: _____

Name: _____Birth Date_____ Relation to Patient:_____

Address: _____

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Social Security #: _____ Insured's Birth Date: _____

ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

*** E-Mail address is to be used for communication purposes in conjunction with our office website only (i.e. e-mailed confirmation of appointments, reminders, newsletter, etc.) and will not be distributed or sold under any circumstances. If you have questions or concerns please speak with one of our staff members.

Office Policies

We strive to provide your child with the best care possible. Please be advised of the following policies that will help us greatly in that endeavor. *Please initial each line*:

_____We have a strict policy that we require 48 hour notice for any appointment that cannot be kept. If an appointment is cancelled within 48 hours of the appointment it will be considered as broken, regardless of the reason. A missed appointment fee of $85 will be applied to your child's account for each missed appointment. This fee can be waived at the discretion of the office manager or the doctors. Subsequent missed appointment fees cannot be waived. Fees for a missed appointment must be paid prior to rescheduling the appointment.

_____We have a policy that after two missed appointments a family become subject to dismissal. Please note that this potentially applies to all children in the family. If one child misses two appointments it places the entire family in jeopardy. In addition, if you have more than one child scheduled and fail to attend those appointments we may not be able to reschedule them together.

_____We require that patients present for their appointments at their scheduled time. Ideally, each patient would arrive for their appointment 5 minutes early**. If you are more than 10 minutes late we will reschedule your appointment.** There are **NO** exceptions to this policy. Our office runs by the time we have in our office at the front desk.

_____We require a parent or legal guardian at ALL dental appointments. This does **NOT** include step-parents, grandparents, aunts, uncles, siblings, etc. If are parent/legal guardian cannot attend an appointment, a release form MUST be signed, dated, and present at the time of appointment or we will be forced to reschedule. A hand-written/typed note will NOT be accepted. Our release forms can be obtained on our website, via email/fax or in-office

_____We guarantee restorative work only so long as a patient is coming in for regular recalls at six month intervals. If a filling comes out and we have not seen your child in over one year you will be responsible for all, or a portion of, the customary charge.

_____Our records need to remain as complete as possible. This includes medical history, contact information, insurance information, etc. It is your responsibility to notify us of any changes in the items mentioned above.

_____We do **NOT** allow food or drink past the waiting room or (non-service) pets in the office.

_____Use of cell phones is strictly prohibited. We will delay treatment until such time as the distraction has ceased. It is at our discretion to remove you form the treatment area in the case of multiple infractions.

_____For the safety of everyone at this office we do not allow more than one person to accompany a child into the treatment area. This includes multiple parents and siblings. The only exception to this rule would be an infant restricted in a car seat.

_____I understand that there might be a fee to transfer records if my account is not in good standing.

_____Financial arrangements are the responsibility of the parent/legal guardian when an account has not been paid in 60 days by any insurance company. Any balance over 60 days will no longer be chased with the insurance companies.

_____Any/All fees related to collection agencies or collection of fees in excess of 60 days past due are the responsibility of the parent/legal guardian.

_____All returned checks due to non-sufficient funds will be subject to any and all bank fees, as well as an office fee($50) at the doctors' or manager's discretion.

_____ _____

Signature(Parent or Guardian) Date

_____

Patient Name(Please Print)

PRIVACY POLICY (HIPAA)

Children's Dentistry of Cocheco Valley, LLP takes patient privacy very seriously and protecting confidential health information is of the utmost concern to our office.

Please be advised of the following regarding our privacy practices:

We will use and disclose your health information as it pertains to three topics: treatment (i.e. working with other providers-orthodontists, oral surgeons, etc); payment (i.e. to obtain payment from an insurance company) or healthcare operations (various action taken by health care companies-i.e. audits; quality assessments, etc.). There are times when we will disclose your child's information to another healthcare provider without consent. You can request disclosure of health information to any party. It is our office policy that said request must be done in writing to our office. Release of this information will be done at our discretion. We can, at our discretion, impose a reasonable, cost-based fee for the cost of copying said records. Any permission that you provide to our office can be revoked at any time and must be done in writing. Our general office policy is that disclosure of information to anyone other than the legal guardian requires explicit written consent. At times implied consent may be applied and information shared with a caretaker that has brought the patient to the appointment (i.e. treatment needs; scheduling appointments, etc.). If an emergent situation arises and we are unable to obtain consent from a legal guardian we will use our best judgment in releasing any information to any caregivers. Information will be transmitted until such time as written consent can be obtained from the patient's legal guardian. Please be advised that we are required by law to make certain disclosures to the Department of Health and Human Services if they request information from our office. Please also be advised that we are required by law to disclose information when we suspect abuse or neglect. Our office often times will use mailings or phone calls as a way of contacting patients (i.e. appointment reminder cards, continuing care cards, birthday cards, correspondence regarding missed appointments, etc.). These can be restricted by you at any time. If you would like to restrict these we request a formal written request. Although our office makes every effort to protect information, from time to time an incidental disclosure of information may happen when another patient or parent may hear a conversation in our office. We make every effort to minimize and eliminate any possibility of this happening however at times it will be unavoidable. Our office will employ a principle of minimum necessary when releasing information and only release essential information.

Below is a brief summary of your rights as our patient:
It is our policy that our patients always have access to their designated record set. Depending on who is making the request we may request a written request for release of information. Also, it is at our discretion to impose a reasonable and customary fee for release of records. We will make every effort to release records as expeditiously as possible, however preparation of same may, at times, take two full business days depending on the nature of the request received. Patients are allowed to amend their records when we have complete or inaccurate information. Individuals have a right to a disclosure accounting if requested from the patient. We must release only certain disclosures that have occurred in the past six years. Patients may file a restriction request whereby we would be restricted in our use or disclosure of protected health information. We are under no obligation to grant this request however if we do grant the request we must comply with the restrictions unless in the case of a medical emergency. Said requests for restrictions must be made in writing. Our office generally uses four methods of communication: verbal face to face communication; regular United States mail (letter or postcards); telephone communications; and electronic mail. You can restrict any of these at any time by submitting a written request. This can include something as simple as restricting telephone numbers that we use.

Below are your options if you do not agree with a disclosure or restriction we have made:
If you are worried about a disclosure or restriction we have made regarding your records please submit written correspondence regarding same to Privacy Coordinator; Children's Dentistry of Cocheco Valley, LLP; 750 Central Ave Suite B, Dover, NH 03820. You can also direct questions regarding this policy to the Drs. Lucier or the privacy coordinator who is the office manager. You can also, at any time, submit a written complaint to the Secretary of Health and Human Services. Please direct any questions regarding this policy to the Privacy Coordinator.
This privacy policy is effective as of the date signed below.

_____ _____

Patient/Guardian Signature **Date**

Photograph Agreement:
There are different times when we would want to take photographs of your child either for record recognition which would remain in the child's chart in our computer system only. Also, the 'No Cavities Club' in which the child's picture would be posted on the wall inside the office. Please sign acknowledging and allowing the pictures to be taken and possibly posted.

___ I would like my child's photograph to be taken and possibly posted inside the office of Children's Dentistry of Cocheco Valley, LLP.

___I do NOT want my child photographed.

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I further agree to advise Children's Dentistry of any and all changes to my insurance plan. I understand that it is my responsibility to advise your office of changes in employment which result in a change in insurance carrier.
I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____
Signature of parent or guardian/person responsible for payment

_____ Relationship to Patient: _____

Printed Name of parent or guardian/person responsible for payment