HUNTINGTON smiles pediatric dentistry

PATIENT REGISTRATION

Patient Name: _____ Last Name: _____

Name Child Would Like to Be Called: _____ Date of Birth: _____

Address: _____Town, State, Zip_____

Phone Number: _____Parent's Cell Number: _____

Is anyone in your family currently a patient within our practice? _____

Whom may we thank for your referral or how did you find us? _____

RESPONSIBLE PARTY

Name of person responsible for this account: _____ Relationship: _____

Billing Address (if different from above): _____

Responsible Phone #: _____ Responsible SS#: _____

Date of Birth of Responsible Party: _____

***Please be aware that the person who brings the child is ultimately responsible for consent and final payment. We understand that some of our patients have legal agreements with a former spouse, etc. If this is your case, then you must bring in a notarized letter as such or you will be responsible. ***

PRIMARY DENTAL INSURANCE INFORMATION

Name of Insured: _____ Relationship: _____

Birthdate: _____ SS#: _____ ID #: _____

Name of employer: _____ Union/Local #: _____

Address of employer: _____

City: _____ State: _____ Zip code: _____

Insurance Company: _____ Group Number: _____

Secondary Insurance Company (if applicable): _____ ID #: _____

Name of Insured: _____ Relationship: _____

Birthdate: _____ SS#: _____-_____

DENTAL INFORMATION

1. Is the patient having any discomfort at this time? ☐ Yes ☐ No

510432624. Has the patient ever had any serious trouble with previous dental treatment? ☐ Yes ☐ No

a. If so, explain _____

510432625. Does dental treatment make your child nervous? ☐ No ☐ Slightly ☐ Moderately ☐ Extremely

510432626. Is this the patient's first dental visit? ☐ Yes ☐ No

510432627. Date of last dental visit _____ Name of previous dentist _____

510432628. Does your child do any of the following? Brush in the ☐ am ☐ pm ☐ Both

Use ☐ Fluoride Toothpaste ☐ Non-Fluoride Toothpaste Take vitamins with Fluoride? ☐ Yes ☐ No

510432629. Any current habits? ☐ Thumb sucker ☐ Finger sucker ☐ Pacifier ☐ Tongue Thrust ☐ Other

MEDICAL INFORMATION

Pediatrician's Name: _____ Phone Number: _____

Is your child under a physician's care now? ☐ Yes ☐ No

Has your child ever been in the ☐ NICU ☐ Hospitalized ☐ Had a major operation _____

Is your child taking any medications, pills, or drugs? ☐ Yes ☐ No If so, what are they? _____ __

Does your child have ☐ ADD ☐ ADHD ☐ PDD ☐ Autism ☐ Autism Spectrum Disorder?

Is your child on a special diet? ☐ Gluten Free ☐ No red dye ☐ Other _____

Any allergies to medication or foods. If yes, please explain: _____

Does the patient have, or has had, any of the following?

□ AIDS/HIV Positive	□ Frequent Diarrhea	□ Pain in Jaw Joints
□ Anaphylaxis	□ Hay Fever	□ Parathyroid Disease
□ Anemia	□ Heart Murmur	□ Psychiatric Care
□ Artificial Heart Valve	□ Heart Pace Maker	□ Radiation Treatments
□ Artificial Joint	□ Heart Trouble/Disease	□ Renal Dialysis
□ Asthma	□ Hemophilia	□ Sickle Cell Disease
□ Blood Disease	□ Hepatitis A, B or C	□ Spina Bifida
□ Blood Transfusion	□ High Blood Pressure	□ Stomach/Intestinal Disease
□ Cancer	□ Irregular Heartbeat	□ Stroke
□ Chemotherapy	□ Kidney Problems	□ Thyroid Disease
□ Cold Sores/Fever Blisters	□ Leukemia	□ Tuberculosis
□ Congenital/Heart Disorder	□ Liver Disease	□ Tumors or Growths
□ Diabetes	□ Low Blood Pressure	□ Ulcers
□ Epilepsy or Seizures	□ Lung Disease	□ Venereal Disease
□ Excessive Bleeding	□ Mitral Valve Prolapse	

Has the patient ever had any serious illness not listed above? □ Yes □ No
If yes, please explain: _____

To the best of my knowledge, all of the preceding answers are true and correct. If there are ever any changes in my (or my child's) health or changes in medication, I will inform the dentist, hygienist, or the dental office.

Name of Patient _____ Signature of Legal Guardian X _____

Relationship to Patient: _____ Date: _____

HIPAA NOTICE OF PRIVACY PRACTICES

Policy Number 14A

Effective date of Notice: October 1,2020

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW WE PROTECT YOUR HEALTH INFORMATION, WHAT RIGHTS YOU HAVE REGARDING IT AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information that may identify you and that relates to your past, present, or future physical or mental health or condition related health care services.

Your protected health information may be used and disclosed by your dentist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the dentist’s practice, and any other reuse required by law.

Treatment, Payment, and Health Care Operations
We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a dental facility providing care for you. For example, your protected health information may be provided when referring you to another dentist for specialty care to ensure that the dentist has the necessary information to diagnose and treat you. Examples of how we use or disclose information for treatment purposes are: setting up appointments for you; examining your teeth, mouth, and oral health, prescribing medications and requesting them to be filled; prescribing dental appliances; showing you treatment options; getting copies of your health information from another professional that you may have seen before us.

Examples of how we use or disclose your health information for payment purposes are: asking you about your dental or medical care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney).

Complaints
If you think that we have not properly respected the privacy of your health information, you may complain to us or to the U.S. Department of Health and Human Services, Office for Civil Rights. **We will not retaliate against you for filling a complaint.** If you want to complain to us, send a written complaint to the office via mail, fax, or E Mail. If you prefer, you can discuss your complaint in person or by phone.

For More Information
We are required by law to maintain the privacy of, and provide individuals with, this notice of your legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Name of Patient _____ Signature of Patient (or Legal Guardian) **X**_____

Relationship to Patient: _____ Date: _____

FINANCIAL POLICY AND CONSENT

I request and authorize Dr. Sarah Chicosky and Dr. Maryam Qayumi-Hussain at Huntington Smiles Pediatric Dentistry and staff under their direction to perform treatment for my child, as necessary. I understand that any treatment needs will be explained to me prior to treatment and will require my consent.

I state that I am the child's legal guardian and that I have read and agree to follow all office policies. This consent will remain in effect unless canceled in writing.

I will notify this office of any changes in my child's health, including current medications, allergies, and any hospital stays.

I authorize Huntington Smiles Pediatric Dentistry to release any information necessary for the processing of dental insurance claims and authorize payment directly to Huntington Smiles Pediatric Dentistry of insurance benefits otherwise payable to me.

I acknowledge that I have read and agree with the office financial policy. **I understand that any estimate of my insurance benefits is solely an estimate and not a guarantee of payment**. I understand that this office bills my insurance as a courtesy and that I am ultimately responsible for knowing the coverages and limitations of my plan. I understand that other charges such as (but not limited to) nitrous oxide inhalation aka laughing gas **(ADA Code: D9231, $50**) and fluoride treatment may not be covered by my insurance and will be my financial responsibility. **Also, all non-cash transactions will incur a 3.99% convenience fee.**
Initial: _____

I acknowledge that I have given the correct insurance information to the office and will notify the office of any changes in my insurance carrier at least 48 hours prior to all dental appointments. In the event I fail to notify the office within 48 hours, I am aware of my responsibility for payment in full.
Initial: _____

I acknowledge that payment in full is expected in case of no insurance coverage unless prior financial arrangements have been made.
Initial: _____

I agree that any balances over 60 days will be subject to a bill sent to my address on file. **Please note that we reserve the right to charge a $25 fee per child for all missed or broken appointments when not given a 24-hour notice**. Repeat missed appointments or lateness without notification will result in dismissal from the practice.
Initial: _____

Child(ren)'s Name(s): _____
Name of Responsible Party/Guardian: _____
Signature: _____ Date: _____

This consent will remain in effect unless canceled in writing. No treatment can be rendered unless you have read and signed this form.