PATIENT INFORMATION

Child's Full Name:______________________________ Name child goes by: ______________________

Date of Birth: ______________________ Age: ______ ☐ Male ☐ Female

Address: ____________________________ City/State: ______________ Zip: ______________

Home Number: ______________________ Current School: ____________________ Grade: ________

Hobbies:____

Please list any other siblings seen in this office: ____

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

☐ Friend:____________ ☐ Website ☐ Google ☐ Doctor Office ☐ Event:__________ ☐ Other: __________

PARENT/LEGAL GUARDIAN (LG) INFORMATION

Parent/LG Name: ________________________________ Relationship to Patient: __________________

Date of Birth: ________________________ SSN: ____________________________________

Address (if different from patient): ____

Employer: __________________ Work #: __________________ Cell #: __________________

Primary Email: ____

Parent/LG Name: ________________________________ Relationship to Patient: __________________

Date of Birth: ________________________ SSN: ____________________________________

Address (if different from patient): ____

Employer: __________________ Work #: __________________ Cell #: __________________

Primary Email: ____:

DENTAL INSURANCE

Policy Holder: ____________________ SSN: __________________ Date of Birth: ______________

Insurance Company: ________________________ Group Number: ____________________________

EMERGENCY CONTACTS (Other than parents/guardians listed above)

Contact Name: __________________ Relationship: __________________ Contact #: ______________

Contact Name: __________________ Relationship: __________________ Contact #: ______________

HEALTH HISTORY

Physician/Phone#: ____

Is your child current on immunizations: ☐ YES ☐ NO

Please list any medications your child is currently taking:

____

Please list any allergies (including medication allergies):

____

CHECK IF YES

☐ ADHD/ADD	☐ Developmental Delays	☐ Kidney/Bladder Disease
☐ Anemia	☐ Diabetes	☐ Liver Disease/Hepatitis
☐ Anxiety/Depression	☐ Down Syndrome	☐ Malignancies
☐ Asthma	☐ Epilepsy/Seizures	☐ Rheumatoid Arthritis
☐ Autism/Asperger's	☐ Fainting	☐ Sensory Issues
☐ Cerebral Palsy	☐ Heart Problems	☐ Speech Delays
☐ Chronic Sinusitis	☐ Heart Murmurs	☐ Thyroid Problems
☐ Deaf/Blind	☐ HIV/AIDS	☐ Tuberculosis

Please list any surgeries or hospitalizations: ____

Additional Medical Information: ____

DENTAL HISTORY

☐ Is this your child's first dental visit?
If not, date of last visit: ______________________
Were x-rays taken?

☐ Has your child had a bad experience in a dental office?

☐ Did your child nurse or use a bottle after 12 months?

☐ Did/does your child nurse or use a bottle during the night?

☐ Do you assist your child's brushing?
How often do they brush: __________________

☐ Does your child have any habits? (thumb sucking, pacifier, etc)
If so, list: ____

☐ Does your child drink juice or soda?
If so, how much a day: ______________________________

☐ Has child had a toothache or any type of oral pain recently?

☐ Has your child ever had a dental injury (bumped or chipped tooth, bruised lip? Explain:______________________________

Type of water source? ☐ Private Well ☐ City Water System

Purpose of today's visit: ____

PHOTO RELEASE

By signing below, I give permission to The Greensboro Center for Pediatric Dentistry to publish or display pictures of my child, along with their first name in publications, such as websites, Instagram, Facebook, printed materials, and multimedia presentations. If photos are taken of my child, I do not expect any compensation for the reproduction of such photos now or in the future.

☐ YES ☐ NO

To the best of my knowledge, the answers I have given are accurate. I understand it is important to report changes in my child's medical or dental status to the dentist, and I agree to do so. I give permission to the dentist to obtain additional information from my child's physician regarding medical history needed to provide dental treatment.

____ _________________________

Signature of Parent/Legal Guardian Date

The Greensboro Center for Pediatric Dentistry

APPOINTMENT POLICY

Broken or missed appointments and late arrivals represent a cost to us, to you and to other patients who could have been seen in the time we had set aside for you. We require 24 hours' notice prior to the appointment if you need to reschedule. Our office reserves the right to charge a broken appointment fee of $25.00 for any missed appointment without prior notice. Multiple missed or late appointments may result in dismissal from the practice.

We strive to see all patients on time for their scheduled appointment. There are times when our schedule is delayed in order to accommodate an emergency. Please accept our apology in advance should this occur during your appointment. We will do the exact same if your child is in need of emergency treatment.

If you arrive 10-15 minutes late for your appointment, we will do our best to accommodate you, however you may be asked to reschedule for the next available appointment.

FINANCIAL POLICY

If you have dental insurance, we are happy to file your claims. We accept all traditional insurance plans. Please bring your dental insurance card to every visit and familiarize yourself with your insurance benefits.

If you do not have dental insurance, payment for professional services is due at the time dental treatment is provided. We accept cash, personal checks, and most major credit cards. We also offer financing through CareCredit which offers no interest and extended payments plans with low interest.

We are here to help and can assist you in estimating the cost of treatment. We will collect your co-payment at each visit when your child is scheduled for treatment. You will be responsible for paying any amount that is not covered by your insurance plan. The amount and percentage paid is determined by the plan your employer negotiated with the insurance company, every plan is different.

By law, your insurance company is required to pay each claim within 30 days of receipt. If we have not received payment from your insurance company within 60 days from claim submission, you will be responsible for paying for the services. In the event your insurance pays at a later date, you will be reimbursed. Patients with Blue Cross Blue Shield of NC and most Delta Dental Plans will be required to pay in full when services are rendered. We will still file the claim for you and these companies will reimburse you directly, usually within 14 business days.

There is a $35.00 service charge for all returned checks. All balances are due in full within 90 days of treatment. If it becomes necessary to forward your account to a collection agency, you will be responsible for our costs of collection in addition to the amount of the bill. If your account goes into collections at any time, all future visits must be paid in full at the time of each visit.

If at any time you have questions, please feel free to ask our staff. We are here to help you in any way we can.

Signature of Parent/Guardian ______________________________ Date ______________

Child/Children's Name ____

The Greensboro Center for Pediatric Dentistry

INFORMED CONSENT FOR GENERAL DENTAL PROCEDURES

As the patient's parent/legal guardian you have the right to accept or reject dental treatment recommended by the dentists at The Greensboro Center for Pediatric Dentistry. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments and the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your child's dentist and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide Dr.'s Goldenberg, Pierce and Applebaum with accurate information before, during, and after treatment. It is equally important that you follow their advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow their advice, you may increase the chances of a poor outcome.

Please read and initial the items below and sign at the bottom of the form.

__________ 1. **TREATMENT TO BE PROVIDED**
I understand that during my child's course of treatment the following may be provided: examinations, preventive services (fluoride, sealants and space maintainers), restorations (fillings), crowns and radiographs (x-rays). I will be consulted prior to each appointment.

__________ 2. **DRUGS AND MEDICATIONS**
I understand that antibiotics, analgesics, anesthetic agents and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

__________ 3. **CHANGES IN TREATMENT PLAN**
I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on teeth that were not discovered during examination. Following routine restorative procedures, the most common changes are root canal therapy and extraction. I give my permission to my child's dentist to make any/all changes and additions as necessary. I understand that I will be consulted regarding changes whenever possible.

______________________________ ______________

Parent's Signature Date

____

Child's Name

The Greensboro Center for Pediatric Dentistry

Notice of Privacy Practices Effective
August 1, 2013

Patient privacy is important to the doctors and staff of The Greensboro Center for Pediatric Dentistry. Our office is required by law to maintain the privacy of Protected Health Information (PHI) and to provide individuals with notice of our legal duties and privacy practices with respect to PHI. PHI is information that identifies your child and is related to your child's past, present or future physical or mental health or condition and related health care services. This Notice of Privacy Practices (Notice) explains how we may use and disclose PHI to provide treatment, payment or health care operations and for other purposes permitted or required by law. Also, this Notice describes your rights with respect to your child's PHI.

Our office is obligated to follow the terms of this notice. We will not use or disclose your child's PHI without your written authorization, except as described in this Notice. 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, and to make new Notice provisions effective for all PHI that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

Use and Disclosure of your Child's PHI

We may use and disclose your child's health information for different purposes, including treatment, payment and health care operations. For each of these categories, we have provided a description and an example.

We will use PHI for treatment. We may use and disclose your child's PHI to provide, coordinate or manage your health care services. Example: Should a prescription be needed to treat your child in the office, your child's PHI may disclosed to a pharmacist.

We will use PHI for payment. We may give your child's PHI to others to bill and collect payment for treatment provided. Example: Your child's PHI will be used in billing your insurance company for treatment rendered in our office.

We will use your child's PHI for health care operations. We may use and disclose PHI in performing business activities. Example: We routinely conduct in-office chart audits to ensure correctness of billing.

Individuals involved in your care or payment for your care. We may disclose your child's health information to your family or friends or any other individual identified by you when they are involved in your child's care or in payment for your child's care. Additionally, we may disclose information about your child to a patient representative. If a person has the authority by law to make health care decisions for your child, we will treat that patient representative the same way we would treat you with respect to your child's health information.

Business associates: We contract other companies to perform services in our office. These companies may have access to your child's PHI in assisting us. In order to protect your PHI, we require all business associates to appropriately safeguard the information. Example: We contract an outside company to provide us with technical support on our computer system. In assisting us with maintaining our systems, this company has access to PHI.

As required by law. We must disclose your child's PHI when required to do so by law. Any other uses and disclosures will be made only with your written authorization.

Your Child's Health Information Rights

Access. You have the right to look at or get copies of your child's health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of the supplies and labor of copying, and for postage if you want copies mailed to you.

Request a restriction on certain uses and disclosures of PHI. You have the right to request additional restrictions on our use or disclosure of your child's PHI by sending a written request to our Privacy Officer. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Request an amendment of PHI. If you feel the PHI we maintain about your child is incomplete or incorrect, you may request that we amend it. You may request an amendment for as long as we maintain the PHI. To request an amendment to your child's PHI, contact our office. You must include supporting reasons for the amendment. In certain cases, we may deny your request for amendment. If our office denies your request, you have the right to file a statement of disagreement, and we may give rebuttal to your statement.

Receive an accounting of disclosures of PHI. You have the right to receive an accounting of the disclosures we have made of your child's PHI for purposes other than treatment, payment or health care operations. The accounting may exclude certain disclosures, such as disclosures made directly to you, disclosures you authorize, and disclosures to friends and family members involved in your child's care. The right to receive an accounting is subject to certain other exceptions, restrictions and limitations. To request an accounting of disclosure you must submit your written request to our Privacy Officer. Your request must specify the time period for which you wish to obtain accounting, which may not

The first accounting you request within a 12 month period will be provided free of charge, but you may be charged for the cost of providing additional accountings.

Request communications of PHI by alternative means or at alternative locations. You have the right to request to receive communications of PHI by alternative means. For example, you may want recall cards sent to a post office instead of your home address. Your request must be made in writing. If we cannot communicate with you using these alternative means, we may resort to using other contact information we have.

Right to notification of a breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Incidental Disclosures

Open Bay. We use an open bay in our office for most dental treatments. This type of environment is used for many reasons including positive behavior reinforcement (kids seeing other kids behaving well). Parts of dental treatments and /or conversations may be overheard by other patients or parents in the office. If you find that your child needs additional privacy, please request a closed door operatory.

In order to protect the privacy of all patients and staff in accordance with HIPAA, we require all patients refrain from using cell phones, cameras, or video recorders while in the building for purposes of video or photography.

Appointment Reminders. As a general practice we confirm upcoming appointments via phone calls, text messages, and emails. This is usually done one to two days before each dental appointment. Please let us know if you do not want us to contact you in any manner.

Financial Information. As a general practice we do send financial statements or letters by mail, email, or fax. Please let us know if you do not want us to contact you in this manner.

Questions or Problems

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

The Greensboro Center for Pediatric Dentistry
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The Greensboro Center for Pediatric Dentistry

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my child's protected health information. Iunderstand that this information can and will be used to:

- Conduct, plan and direct my child's treatment and follow–up among the multiple healthcare providers who may be involved in that treatment directly orindirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments andphysician certifications

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my child's health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request, in writing, that you restrict how my child's private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions; however, if you agree then you are bound to abide by such restrictions.

I understand I have the right to revoke this consent except to the extent that we have already taken action covered under this consent. If I chose to revoke this consent, I must do it in writing.

CONTACT INFORMATION

Patient's Name: ____

May we call you at: ☐ Home ☐ Work ☐ Cell

Please list persons with whom we may we discuss your child's health information:

____

Please list persons to whom may we release medical information, including picking up prescriptions:

____

______________________ ______________________ __________
Signature Parent/Guardian Relationship Date