

The Greensboro Center for Pediatric Dentistry

PATIENT INFORMATION

Child's Full Name: _____ Name child goes by: _____

M F Date of Birth: _____ Age: _____

Address: _____ City/State: _____ Zip: _____

Home Number: _____

Current School: _____ Grade: _____ Hobbies: _____

Please list any other siblings seen in this office: _____

Who may we thank for referring you to us? _____

PARENT /LEGAL GUARDIAN (LG) INFORMATION

Parent /LG Name _____ Relationship to Patient: _____

Date of Birth: _____ SSN: _____

Address (if different than patient): _____

Employer: _____ Work #: _____ Cell # _____

Primary E-mail: _____

Parent /LG Name: _____ Relationship to Patient: _____

Date of Birth: _____ SSN: _____

Address (if different than patient): _____

Employer: _____ Work #: _____ Cell # _____

Primary E-mail: _____

DENTAL INSURANCE

Policy Holder: _____ SSN: _____ DOB: _____

Insurance Company: _____ Group Number: _____

EMERGENCY CONTACT (other than parents/guardians listed above)

Contact Name: _____ Relationship: _____ Contact Number: _____

Contact Name: _____ Relationship: _____ Contact Number: _____

PATIENT NAME: _____ DATE: _____

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):

- | YES | NO | YES | NO | YES | NO |
|--------------------------|--------------------------|--------------------------|--------------------------|---------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 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

- | YES | NO | YES | NO |
|--|--------------------------|--|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Is this your child's first dental visit? | | Does your child have any habits? (thumb sucking, pacifier, etc) If so, list: _____ | |
| If not, date of last visit: _____ | | | |
| Were X-rays taken? _____ | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Has your child had a bad experience in a dental office? | | Does your child drink juice or soda? If so, how much a day? _____ | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Did your child nurse or use a bottle after 12 months? | | Does your child snack frequently during the day? | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Did/does your child nurse or have a bottle during the night? | | Has your child had a toothache or any type of oral pain recently? | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you assist your child's brushing? | | Has your child ever had a dental injury (bumped or chipped tooth, bruised lip)? | |
| How often do they brush: _____ | | Explain: _____ | |
| _____ | | _____ | |

Type of water source? Private Well City Water System

Purpose of today's visit? _____

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

MISSED APPOINTMENTS / LATE CANCELLATIONS

Broken appointments and late arrivals represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. Excessive missed or late appointments may result in dismissal from the practice.

FINANCIAL POLICY

Our office is out of network with ALL insurance companies. If you have dental insurance, we will be happy to file your claim for you. You will be responsible for your co-payment at each appointment. If you do not have dental insurance, payment for professional services is due at the time dental treatment is provided. Please bring your dental insurance card to every visit. You must be familiar with your insurance benefits. By law, your insurance company is required to pay each claim within 30 days of receipt. PLEASE UNDERSTAND that we file dental insurance as a courtesy to our patients. We do not have a contract with your insurance company, only you do. We are not responsible for how your insurance company handles its claims or for what benefits they pay on a claim. We can only assist you in estimating your portion of the cost of treatment. You are responsible for any balance on your account after 30 days, whether your insurance has paid or not. We will be glad to send a refund to you once your insurance pays us.

Patients with Delta Dental or Federal Blue Cross Blue Shield Insurance 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 within 14 business days.

Fact 1 - NO INSURANCE PAYS 100% OF ALL PROCEDURES

Dental insurance is meant to be an aid in receiving dental care. Many patients think that their insurance pays 90%-100% of all dental fees. This is not true! Most plans only pay between 50%-80% of the average total fee. Some pay more, some pay less. The percentage paid is usually determined by how much you or your employer has paid for coverage or the type of contract your employer has set up with the insurance company. For non-preventive dental treatment, we will ask you to pay 20% of the treatment at the time the service is rendered.

Facts 2 - BENEFITS ARE NOT DETERMINED BY OUR OFFICE

You may have noticed that sometimes your dental insurer reimburses you or the dentist at a lower rate than the dentist's actual fee. Frequently, insurance companies state that the reimbursement was reduced because your dentist's fee exceeds the usual, customary, or reasonable fee ("UCR") used by the company. A statement such as this gives the impression that any fee greater than the amount paid by the insurance company is unreasonable or well above what most dentists in the area charge for a certain service. This can be very misleading and simply is not accurate. Insurance companies set their own schedules and each company uses a different set of fees they consider "reasonable."

We accept cash, personal checks, and most major credit cards. There is a \$25.00 service charge for all returned checks. If it becomes necessary to forward your account to a collection agency, you will be responsible for the fee charged by the collection agency for costs of collections 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 with cash or credit card at the time of the visit.

MOST IMPORTANTLY, please keep us informed of any insurance changes such as policy name, insurance company address, or a change of employment.

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. The most common changes are root canal therapy and extraction, following routine restorative procedures. 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

Appointment Reminders/Requests

We encourage you to participate in our online patient information system (DemandForce). These features include:

- Request appointments online
- Confirm appointments via email
- Receive text message appointment reminders
- Submit patient satisfaction surveys
- Refer your friends online

Please List your Contact Information

Child Name _____

Child Name _____

Child Name _____

Child Name _____

Cell Phone _____

Email _____

Do you want to receive text messages?

YES _____ NO _____

Do you want to receive email reminders?

YES _____ NO _____

We use this information to provide you with excellent treatment. We may disclose your child's Patient Health Information (PHI) to third parties that perform services for the Greensboro Center for Pediatric Dentistry in the administration of your benefits in accordance with HIPAA. These parties are required by law to sign a contract agreeing to protect the confidentiality of your child's PHI. Your child's PHI may be disclosed to an affiliate that performs services for the Greensboro Center for Pediatric Dentistry in the administration of your benefits. Our affiliates do not sell, share or rent our users' personally identifiable information unless required by law, do not send any e-mail or other communication without user permission and do not send spam. By signing below, I agree to allow DemandForce to use this information in providing my services.

Photo Release Form

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, Facebook page and multimedia presentations.

Please Check: _____ YES _____ NO

I give permission to the Greensboro Center for Pediatric Dentistry to tag or identify me (Parent /Guardian) on Facebook or other social media.

Please Check: _____ YES _____ NO

If photos are taken of my child with my permission, I agree that I do not expect any compensation for the reproduction of such photos now or in the future.

Please Check: _____ YES _____ NO

Minor's Name

Your Name (Parent /Guardian) Please Print

Your Signature

Date

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 be 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 exceed six years.

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.

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
5408 W. Friendly Ave.
Greensboro, NC 27410
336-292-0411
om@greensboropediatricdentists.com

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. I understand 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 or indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician 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: Yes/No Work: Yes/No Cell: Yes/ No

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 of Parent /Guardian

Relationship

Date