

PATIENT REGISTRATION FORM

TELL US ABOUT YOUR CHILD

Name _____
Last First MI
Nickname _____ Male / Female
Patient's Preferred Pronouns: ____ / ____ / ____
Child's Birthdate ____/____/____ Age ____
Child's Address _____
Child's Phone # _____
Person responsible for account _____

Parent 1 Guardian

Name _____
Address (if different from child) _____
Home # _____
SS# _____ DOB: _____
Work# _____ Cell# _____
Email _____
Employer _____
Address _____

Parent 2 Guardian

Name _____
Address (if different from child) _____
Home # _____
SS# _____ DOB _____
Work # _____ Cell# _____
Email _____
Employer _____
Address _____

GENERAL INFORMATION

Who is accompanying the child today? _____
Relationship _____
Do you have legal custody? Yes No
Who may we thank for referring you? _____
Parent Marital Status:
Single Married
Divorced Separated Partnered

PRIMARY DENTAL INSURANCE

Insurance Name _____
Insurance Address _____
Insurance Phone # _____
Group # _____
Policy # _____
Policy Owner's Name _____
Relationship to Patient _____

SECONDARY DENTAL INSURANCE

Insurance Name _____
Insurance Address _____
Insurance Phone # _____
Group # _____
Policy # _____
Policy Owner's Name _____
Relationship to Patient _____

ACKNOWLEDGEMENT AND AUTHORITY

Since the child is a minor, it becomes necessary that signed permission is obtained from a parent or guardian before any or all necessary dental services can be rendered. I understand that the information I have given is correct, that it will be held in the strictest confidence and it is my responsibility to inform the office of any changes in my child's medical status. I authorize Children's Dentistry at Odenton to perform the necessary dental services my child may need. I ACKNOWLEDGE FULL RESPONSIBILITY FOR THE PAYMENT OF ALL SERVICES RENDERED ON MY DEPENDENT'S BEHALF, IN FULL, AT THE TIME OF SERVICE.

Parent/Legal Guardian Signature

Date

Please turn page over



MEDICAL HISTORY

Is your child under the care of a physician? YES NO
 Name of Physician: _____ Phone #: _____

Please describe the child's current physical health. (Please circle)
 GOOD FAIR POOR

Please list (if any) drugs that your child is currently taking: _____

Please list any drug and/or food allergies:

Is your child allergic to latex? YES NO

Does your child have history of the following? (Please check all that apply):

- Abnormal Bleeding/Hemophilia
- Anemia
- Cancer
- Diabetes
- Epilepsy
- Heart Problems
- Liver Disease
- Thyroid Problems
- Hospitalizations/Operations _____
- ADD/ADHD
- Asthma
- Cerebral Palsy
- Disabilities/Special Needs
- Fainting
- Hepatitis
- Pregnancy
- Tuberculosis
- AIDS/HIV
- Autism
- Convulsions
- Drug/Alcohol
- Hearing Problems
- kidney disease
- Sinus Problems

DENTAL HISTORY

Reason for visit today: _____

Is your child currently in pain? YES NO
 Is your child taking any medications? YES NO
 Is this your child's first dental visit? If no, state last visit. YES NO
 Does your child require any antibiotics before dental treatment? YES NO
 Has your child had injury to his/her teeth, mouth, head or jaws? YES NO
 Has your child had an unpleasant dental experience? YES NO
 Does your child brush their teeth daily? YES NO
 Does your child floss? YES NO
 Is the child's water fluoridated? YES NO
 Is the child taking fluoride supplements? YES NO
 Has the child ever had fluoride treatment at his/her doctor? YES NO

Child's Existing Habits (Please check, if any)

- Breast Feed
- Nighttime Feeding
- Sippy Cup Use
- Pacifier (over 2 years)
- Grinding of Teeth
- Thumb/Finger Sucking
- Lip/Cheek Sucking
- Tongue Thrust
- Mouth breather

Does your child play sports? YES NO
 Does your child wear a mouthguard during sports/physical activity? YES NO

Cancellation and Broken Appointment Policy

We ask our patients to give us 48 hours' notice if they cannot keep an appointment. This allows us time to fill our schedule with other patients who may be waiting for their opportunity to receive dental treatment. We understand that illness, emergencies, bad weather, and other unexpected situations can occur. We will do our best to accommodate you, however, please do be courteous.

Policy and Fees:

Cancellation or rescheduling of an appointment with 48 hours or more notification – no charge.

Cancellation or rescheduling of an appointment less than 48 hours and up to 24 hours may or may not be considered a broken appointment and will be at our discretion.

When there is a failure to provide a minimum of 24-hour advance notice the fees are as follows:

- \$75 for a hygiene appointment
- \$100 for a doctor's appointment scheduled for operative and restorative treatment.

Definition of "Broken Appointment":

- A broken appointment is when you do not show up for the scheduled appointment or when you show up for the appointment more than 15 minutes late.
- A broken appointment can also be defined as a cancelled or rescheduled appointment with less than a 24-hour advance notice. A voicemail message will suffice if you call us outside of business hours and you receive a phone call back from us confirming your cancellation.

Our number one concern is our patient's dental health. Providing services in a timely manner is critical to accomplish that goal. Our other goal is to keep the cost of dental services as economical and affordable as possible. The appointment you schedule for treatment is reserved for you and your treatment only. When you fail to keep your appointment without providing us adequate notice, this adds to the overall cost of care. It creates a loss when trained professionals and dental facilities are not being utilized.

We appreciate your understanding and consideration regarding our appointment policy and if you have any questions or concerns, please don't hesitate to ask us.

I have read and understand the above-mentioned policy.

Please Print Name

Patient signature (Parent or Legal Guardian) / Date

Please see next page



CHILDREN'S DENTISTRY AT ODENTON

1215 ANNAPOLIS ROAD, SUITE 106, ODENTON, MD 21113

PHONE: (410)672-1100

FAX: (410)672-1107

FINANCIAL OFFICE POLICIES

Payment for services is expected at the time treatment is rendered, unless special arrangements have been made prior to your child's dental appointment. Our office accepts payment by cash, check, Visa, MasterCard, American Express and Care Credit.

Cancellations: Our patients are seen by appointment only and are scheduled to make the most of your time. We reserve a specific time for your child, and we try to see you at the appointed time. Please let us know at least 48 hours on advance should you have to cancel your child's appointment. Unless cancelled at least 48 hours in advance, you may be charged for a missed appointment. Please help keep our practice and your healthcare affordable by keeping your appointments and by being on time.

Insurance Benefits: If your insurance covers dental treatment, you will receive the benefit of reduced personal costs. Insurance policies vary, so we will review your insurance to determine the appropriated course of action. Your dental benefits are based upon a contract made between you, your employer and your insurance company. There will be some recommended services that may be "non-covered services for which benefits are not offered by some insurance companies. We can only estimate your coverage in good faith but cannot guarantee coverage due to the complexities of these insurance contracts. If during the course of treatment your benefits change, you will be accountable for all charges. Our staff will strive to help you obtain your maximum benefit by efficiently processing your claims.

Past Due Accounts: If your insurance company does not pay in full within 45 days of treatment, we will require that you pay the balance due at that time. Balances remaining unpaid after 90 days from the date of service will be subject to collections. Should we require the services of an attorney or outside collection agency for the collection of payment on past due balances; you agree to pay all expenses incurred including any legal fees.

I have read, I understand and agree to the above Financial Office Policies.

Name of Parent / Legal Guardian: _____

Signature: _____ **Date:** _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your protected health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 01/01/21, and will remain in effect until we replace it.

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. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and provide the new Notice at our practice location, and we will distribute it upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

Your Authorization: In addition to our use of your health information for the following purposes, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

Uses and Disclosures of Health Information

We use and disclose health information about you without authorization for the following purposes:

Treatment: We may use or disclose your health information for your treatment. For example, we may disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

To You or Your Personal Representative: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to your personal representative, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your absence or incapacity or in emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Disaster Relief: We may use or disclose your health information to assist in disaster relief efforts.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Public Health and Public Benefit: We may use or disclose your health information to report abuse, neglect, or domestic violence; to report disease, injury, and vital statistics; to report certain information to the Food and Drug Administration (FDA); to alert someone who may be at risk of contracting or spreading a disease; for health oversight activities; for certain judicial and administrative proceedings; for certain law enforcement purposes; to avert a serious threat to health or safety; and to comply with workers' compensation or similar programs.

Decedents: We may disclose health information about a decedent as authorized or required by law.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Patient Rights

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. 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. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying. If you request copies, we will charge you \$0.10 for each page, \$15 per hour for staff time to copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations, and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. In most cases we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). We must comply with a request to restrict the disclosure of protected health information to a health plan for purposes of carrying out payment or health care operations (as defined by HIPAA) if the protected health information pertains solely to a health care item or service for which we have been paid out of pocket in full.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: You may receive a paper copy of this notice upon request, even if you have agreed to receive this notice electronically on our Web site or by electronic mail (e-mail).

Questions and Complaints

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, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, 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. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

ACKNOWLEDGEMENT RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I, _____, have read and received
a copy of the office's Notice of Privacy Practices.

Please print name

Signature

Date

Section for Office Personnel only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign.
- Communications barrier prohibited obtaining the acknowledgement.
- An emergency situation prevented us from obtaining acknowledgement.
- Other (Please specify) _____