GENERAL DENTIST
AMY MORGAN, D.M.D.

PEDIATRIC DENTAL GROUP

PEDIATRIC DENTISTS
DREW MIDDLETON, D.M.D.
CHARLES BELKNAP, D.M.D.
SCOTT TOMLINSON, D.M.D.
JONATHAN NICHOLS, D.M.D.
KYLE NEELY, D.M.D.

THE FOLLOWING INFORMATION AND HISTORY ARE NECESSARY FOR ADEQUATE TREATMENT AND UNDERSTANDING OF YOUR CHILD. THANK YOU FOR COMPLETING IT IN FULL.

Patient's Name _____ Preferred Name _____ Age____
Sex____ Race____ Date of Birth_____ Place of Birth _____
Patient's Address _____ Home Phone _____
Street City State Zip
Father's Name _____ DOB _____ Social Security # _____
His Address _____ Phone _____
Street City State Zip
Where Employed _____ Phone _____
Mother's Name _____ DOB _____ Social Security # _____
Her Address _____ Phone _____
Street City State Zip
Where Employed _____ Phone _____
With whom does patient live _____
Other children in family who have received dental care in this office _____
Dental Insurance? Yes____ No____ Company _____ Number _____
Child's Physician _____ Family Dentist _____
Whom may we thank for referring you to our office _____
(Name)

E-mail Address _____

Doctor ☐ Dentist ☐ Patient ☐ Parent ☐ School/Day Care Visit ☐

HEALTH HISTORY

	Yes	No
Is your child in good health?		
Does your child have regular medical examinations?		
Is your child up to date with immunizations?		
Is this your child's 1st dental visit?		

Is your child a thumb/finger sucker?_____ Use a pacifier?_____
If your child was bottle fed, at what age was it discontinued?_____

Check any of the following that may pertain to your child:

____ Rheumatic fever	____ Bleeding disorder	____ Lung problem	____ Mental disorder	____ HIV/AIDS
____ Heart condition	____ Cerebral palsy	____ Brain injury	____ Emotional disorder	
____ Speech disorder	____ Liver	____ Epilepsy	____ Tuberculosis	
____ Hearing disorder	____ Kidney	____ Hepatitis	____ Sickle Cell Anemia	
____ Vision disorder	____ Asthma	____ Diabetes	____ Autism	
____ Nervous disorder	____ Allergies	____ Retardation	____ Other	

Is your child presently taking any medicine? _____ (Name of Medication)		
Has your child experienced any unfavorable reaction to medicine? (Such as penicillin, aspirin, xylocaine)		
Is your child allergic to any drug or food?		
If so, what? _____		
Is your child presently undergoing medical treatment?		
Has your child ever been hospitalized since birth?		
If so, Date: _____ Reason _____		
Has your child ever had an unfavorable experience in a dental office?		
Date of your child's last dental care _____		
Does your child have a toothache? _____		
Purpose of this appointment _____		

Thank you for your help. If there is any information that you think might be of value to us in treating your child, please feel free to comment _____

Parent bringing patient to our office is responsible to us for payment on account.

PERMISSION:

Since _____ is a minor, it becomes necessary that signed permission be obtained from the parent or guardian before any and/or all necessary dental service can be performed by Pediatric Dental Group. Authorization is hereby granted as such. Furthermore, I will be responsible financially for any bill incurred for this patient for dental treatment.

Date _____ Relationship _____ SIGNED _____

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FINANCIAL POLICY

Welcome to our practice. It is our policy to make definite financial arrangements with you before any treatment starts. Below is an explanation of our payment procedures.

1. Patient portion of services is due at the time services are rendered.
2. For new patient emergency visits, we require payment in full at the time of payment.
3. We will provide you with a copy of the charges to submit to your insurance carrier for your reimbursement or you may assign the payment to our office and we will file insurance for you.
4. Our office will file your insurance a maximum of two times per appointment.
5. If the claim is not paid by your insurance carrier within sixty days, you will be responsible for the full balance and further insurance appeal becomes your responsibility.
6. You must provide the office with a dental insurance card with the proper mailing address of the insurance company. If this is not available at the time of appointment, you will be responsible for payment of all fees.
7. If insurance benefits are assigned to the doctor, you will be responsible for paying your deductible and co-payments at the time of service. You are responsible for paying all charges not covered by your insurance company, including all fees considered above your insurance company's usual and customary fee schedule. The amount of coverage you will receive will depend on the quality of the plan purchased by your employer, not the fees of the doctor.
8. After 90 days, we will inform you of the delinquent amount by letter and if no action is taken to clear the account, this office will be required to employ a collection service to collect payment. The responsible party agrees to pay all reasonable, related collection fees.
9. For State assistant coverage (Medicaid, CHIP) and private insurance, the parent or guardian who brings the child for their initial visit is responsible for payment independent of what divorce decree or custody arrangements may state. Reimbursement must be made between the divorced parents, Pediatric Dental Group will not intervene.
10. If private insurance is filed for any remaining patient balance, it is the responsibility of the guarantor (insurance holder) on the account.

"I have read and accept the above Financial Policy and agree to the terms set forth."

Signature of Responsible Party: _____ Date: __ / __ / __

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"I have received a copy of the Pediatric Dental Group's Notice of Privacy Practices."

Patient's Full Name: _____

Printed Name: _____

Relationship to Patient: _____

Signature: _____

Date: ___ / ___ / _____

FOR OFFICE USE ONLY:

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

☐ *Refusal to Sign*

☐ *Communication Barriers Prohibited Obtaining the Acknowledgement*

☐ *An Emergency Situation Prevented us from Obtaining Acknowledgement*

☐ *Other:* _____

Patient Name: _____ Date: __ / __ / ____

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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 health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, 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 make the new Notice available upon request.

You may request a copy of our Notice at any times. 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or 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.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. 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.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, 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.

To Your Family and Friends: 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 a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, 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

No-Show/Cancellation Policy:

Purpose: The Doctors and Staff of the Pediatric Dental Group respect your time and we ask the same courtesy in return. Missed appointments and/or checking in late for your appointment affect our ability to provide timely attention to our patients. When a patient does not show up for their appointment, another patient loses the opportunity to be seen. If you are unable to make your scheduled appointment time, we respectfully ask that you notify our office at least **24 hours in advance**.

Missed appointments will be documented in your chart.

- **2** documented cancellations **without 24 hours' notice** or a no-show to an appointment are grounds for immediate dismissal from all Pediatric Dental Group clinics.
- Any unspecified patterns including, but not limited to: continually showing up late for appointments, continually cancelling appointments (even if giving 24 hours' notice) will be grounds for immediate dismissal from all Pediatric Dental Group clinics.
- **Not giving a permanent or reliable number to confirm appointments** will also be grounds for dismissal from all Pediatric Dental Group clinics. We must be able to contact you to confirm your child's appointment 24 hours in advance.

I have read the above and understand The Pediatric Dental Group's policy. I will do everything I can to assure that I confirm appointments 24 hours prior to and when I have confirmed an appointment, I will arrive on that specified day and time. **Appointments not confirmed 24 hours in advance are subject to be given to another patient. We cannot guarantee your child will be seen if you present late or without prior confirmation for scheduled appointments.**

_____

Patient Name

_____ _____

Parent/Guardian Signature Date