concord
PEDIATRIC DENTISTRY

Patient Information

Patient Name: ______________________________ Goes by: __________
First Middle Last

DOB: ______________ Age: ________ Sex: __________ Weight: ________ lbs.

Address: ____
Street City State Zip

Child Lives with (circle one): Both Parents Mother Father Other (write in): ______________

Name(s) of siblings: ____

School Name: ____________ Doctor's Name: ____________ Preferred Pharmacy: ____________

Family Dentist: ____________ Doctor's Office: ____________ Pharmacy Phone: ____________

How did you hear about Concord Pediatric Dentistry? ______________________

Responsible Party Information

Mother's Name: ______________________ Marital Status: ____________

Address (if different from above) ______________________________

DOB: ________ Social Security Number: ____________ Employer: ____________

Email: ______________________ Occupation: ____________

Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________

Father's Name: ______________________ Marital Status: ____________

Address (if different from above) ______________________________

DOB: ________ Social Security Number: ____________ Employer: ____________

Email: ______________________ Occupation: ____________

Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________

Dental Insurance Information

Insurance company: ______________________ Company phone number: ____________

Claims address: ______________________________

Primary insured name: ______________________ Employer: ____________

Insured SS#: ______________________ Insured DOB: ____________

Group number: ______________________ Subscriber ID: ____________

I hereby authorize payment of the dental benefits otherwise payable to me directly to the above named dental entity.

Parent/Guardian Signature: ______________________ **Date:** ____________

Medical History

Has your child ever had any of the following medical problems? **Please CIRCLE yes [Y] or no [N]**

Y N Allergies
Y N Anemia
Y N Asthma
Y N Bleeding Disorder
Y N Bronchitis
Y N Cancer/Chemotherapy
Y N Cerebral Palsy
Y N Congenital Heart Defect
Y N Heart Murmur
Y N Down Syndrome
Y N Convulsion/Epilepsy
Y N Diabetes
Y N Drug/Alcohol Abuse
Y N Fainting
Y N Handicap/Disabilities
Y N Hearing Impairment
Y N Hepatitis
Y N HIV/AIDS
Y N OCD/ODD
Y N Autism
Y N Thyroid disorder
Y N Lung Problems
Y N Mental Disorder
Y N Nervous System Disorder
Y N Rheumatic Fever
Y N Speech Disorder
Y N Tuberculosis
Y N Tumors/Growths
Y N ADD/ADHD
Y N Kidney Problems

If yes to any above, please explain: ____

Has your child experienced any other physical or mental disorder that is not listed above? Yes: ______ No: ______

If yes, please describe: ____

Is your child adopted? Yes: ______ No: ______ Doctor's Comments: ______________________________

Is your child allergic to any of the following drugs? Y N Penicillin Y N Amoxicillin Y N Codeine Y N Dental Anesthetic

Is your child allergic to any other drugs? Yes: ______ No: ______ If yes please list: ______________________________

Is your child allergic to latex, red dye, eggs, or anything we need to be aware of? Yes: ______ No: ______

If yes please list: ____

Is your child presently under the care of a physician for any reason? Yes: ______ No: ______

If yes please explain: ____

List any drugs or medicines presently being taken: ______________________________

Is your child up to date on vaccinations? Yes: ______ No: ______

Has your child ever been hospitalized? Yes: ______ No: ______ If Yes, please give reasons and dates:

____

Dental History

Is this your child's first visit to the dentist? Yes: ______ No: ______

How do you expect your child to behave in our office? ______________________________

Why did you bring your child to see us today? ______________________________

Date of last dental visit: ____________________ Name of Dentist: ______________________________

For what service: ______________________________Were any x-rays taken? Yes: ______ No: ______

If yes, have x-rays been sent to our office? Yes: ______ No: ______ Date requested: ______________________________

Would you like your child to receive fluoride treatment at our office? Yes: ______ No: ______

Has your child ever had a serious/difficult problem associated with previous dental work? Yes: ______ No: ______

If yes, please explain: ____

Y N Does your child brush his/her teeth daily?
Y N Is dental floss used?
Y N Do you assist child with tooth brushing?
Y N Does your child take any type of fluoride supplement?
Y N Any mouth habits (thumb sucking, nail biting, mouth breather, nursing bottle habits, pacifier, etc.)
Y N Any injuries to mouth, teeth, head? If yes, list dates: ______________________________

May we request the release of your child's medical records? ______________________________

Thank you for your help. If there is any information that you feel might be of value to us in the treatment of your child, please add it here:

____

I give my consent to needed dental treatment and the use of proper and acceptable methods to complete said treatment for my child,

(child's full name) ______________________________*. I accept responsibility for payment of services rendered.*

Signed (Parent or Guardian) ______________________________ Date: ______________________________

Kerry A. Dove, DMD MS

PAYMENT AGREEMENT

PLEASE INITIAL:

_______ Thank you for choosing our practice to help with your child's dental needs. We are willing to openly discuss any questions regarding finances that you may have. Please understand that we do operate on a fee-for-service basis and therefore payment is required at each appointment, unless prior arrangements have been made. We also need for you to be aware that the parent bringing the child to the office is responsible for payment. Upon checking in for appointments, we ask that you advise us of all insurance policies.

_______ Please note we are considered out-of-network for most insurance companies, but after we verify your eligibility, we will file your claims as a courtesy. For treatment other than preventive, we ask for one-half (1/2) of the cost on the day of treatment. If your child needs sedation/hospital care, we will discuss financial arrangements at the time treatment is proposed. If we do not receive payment within five (5) weeks from the date of treatment from your insurance company, you will be expected to pay for all dental services. If we receive payment from your insurance company, we will send you a statement via email if there is a balance, or we will send you a refund check in the event of overpayment.

______ We ask that you pay balances promptly to minimize the inconvenience and cost of collection efforts. We will begin charging a service fee of 1.0% per month, (12% annually), on balances exceeding 60 days. In addition, you agree to pay additional fees and expenses incurred due to late payment.

APPOINTMENTS

______ **Patients are seen by appointment only. Please call in advance so that we may reserve a time for you. The office telephone number is 704-795-2300. We make every effort to be on time for our patients and ask that you extend the same courtesy to us. If you cannot make your appointment with us, please call at least 48 hours in advance. We may be able to use the time that was reserved for your child in a way that could be very helpful to another patient.**

______ **In consideration of our patients that are waiting to be scheduled, it is necessary to charge for last minute cancellations or no show appointments. There may be a $50 charge on your account if it occurs more than once. In addition, we will help you find another dentist who better suits your schedule.**

I have read and understand the information above. **Signed:** ______________________________ Date: ______________

Again, please note we are considered out of network for most insurance companies, but after we verify your eligibility, we will file your claims for you as a courtesy.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**** You may refuse to sign this acknowledgement ****

I, ______________________________ have received a copy of this office's Notice of Privacy Practices.
(printed name)

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 because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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Concord Pediatric Dentistry
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED 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 (06/01/03), 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 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.

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 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 incapacity or 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 persons 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.

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.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

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 of protected health information of inmate or patient under certain circumstances.
Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as texts, emails, and voicemails).

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. We will charge you a reasonable cost based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. 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. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. {You must make your request in writing.} Your request must specify the alternative means or location, and provide satisfactory explanation 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: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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.

Owner: Dr. Kerry Dove Telephone: (704) 795-2300 Fax: (704) 795-2301

E-mail: info@concordncsmiles.com Address: 580 Woodhaven Place NW Concord, NC 28027

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concord
PEDIATRIC DENTISTRY

HIPAA Form

Name of Patient ______________________________ Date of Birth ____________________

Name of Patient ______________________________ Date of Birth ____________________

Name of Patient ______________________________ Date of Birth ____________________

Name of Patient ______________________________ Date of Birth ____________________

Concord Pediatric Dentistry is authorized to release protected health information about the above named patient in the following manner and to identified persons.

Entity to Receive Information. Check each person/entity that you approve to receive information.
Description of information to be released. Check each that can be given to person/entity on the left in the same section.

Other person(s) (provide name and relationship)
(i.e. Parent, Grandparent, Stepparent, Relative, Friend etc…anyone who may bring child(ren) to appt. even in case of emergency.)

- ☐ ______________________________
- ☐ ______________________________
- ☐ ______________________________

- ☐ Financial
- ☐ Treatment

Initials: ____________

***For email and text communication to occur, accept the disclosure below:**

☐ For email and/or text communication I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.

Email communication - Provide email address*

____

- ☐ Financial
- ☐ Treatment
- ☐ Appointment Reminders
- ☐ Breach Notification

Text communication - Provide number*

____

- ☐ Appointment Reminders
- ☐ Other: ______________________

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

______________________________________ Date: ____________________

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

____

Kerry A. Dove, DMD MS

Please release dental record for the names listed below:

Patient Name: ______________________ Date of Birth: ______________

Patient Name: ______________________ Date of Birth: ______________

Patient Name: ______________________ Date of Birth: ______________

Patient Name: ______________________ Date of Birth: ______________

Reason for transfer (optional): ______________________

Send records and x-rays to: ______________________

____

____

Rights of the Patient

I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. I understand that information disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to revoke this authorization by sending a written notification to the address below and that a revocation is not effective if the information has already been disclosed but will be effective going forward.

______________________ ______________

Signature Date

580 Woodhaven Place NW Concord, NC 28027
Phone: (704) 795-2300 Fax: (704) 795-2301
Email: info@concordncsmiles.com