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Date:_____

Patient Information

Patient Name:_____ Age:_____

Preferred Name: _____ DOB:_____ Gender:☐M ☐F

Weight:_____ School Attending:_____ Grade:_____

Street Address:_____

City: _____ State: _____ Zip Code:_____

Name(s) and age(s) of siblings:_____

Favorite pet, playmate, toy, hobby, or sport:_____

Who is accompanying child today?_____ Relationship:_____

I consent to Aledo Pediatric using my child's name/photo on social media☐Y ☐N

Primary Phone# for Appointment Confirmation:_____

With whom, does the patient live?_____

How did you hear about us?

☐Patient:_____ ☐Dental Office:_____

☐ Google ☐Facebook ☐Magazine ☐

Other_____

Parent Information

Mother's Information:

☐Mother ☐Step ☐Legal Guardian

Name:_____

DOB :_____

Marital Status:

☐Single ☐Married ☐Domestic Partnership

☐Separated ☐Divorced ☐Widowed

Father's Information:

☐Father ☐Step ☐Legal Guardian

Name:_____

DOB:_____

Marital Status:

☐Single ☐Married ☐Domestic Partnership

☐Separated ☐Divorced ☐Widowed

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Mother's Information Continued:

Home #_____

Cell#:_____

Work#:_____

Email: _____

☐Check if Address is same as patient's listed above

Street Address:_____

City:_____

State:_____ Zip Code:_____

Employer:_____

Position:_____

Mother's Dentist:_____

Father's Information Continued:

Home #:_____

Cell#:_____

Work#:_____

Email:_____

☐Check if Address is same as patient's listed

StreetAddress:_____

City:_____

State:_____ ZipCode:_____.

Employer:_____

Position:_____

Father's Dentist:_____

Who else has permission to bring child to their appointment?

Name:_____

Relationship to patient:_____

Marital Status:

☐Single ☐Married ☐Domestic Partnership

☐Separated ☐Divorced ☐Widowed

☐Check if Address is same as patient's listed above.

Street Address:_____

DOB:_____

SS#:_____

Home#:_____

Cell#:_____

Work#:_____

Email:_____

City/State/Zip:_____

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Dental Insurance Information

Primary Coverage:

Policy Holder's Name:_____

DOB:_____ SS#:_____

Employer: _____

Insurance Company: _____

Phone: _____

Street Address: _____

City/State/Zip: _____

Policy/Member ID#:_____

Group #:_____

Secondary Coverage:

Policy Holder's Name:_____

DOB: _____ SS#:_____

Employer: _____

Insurance Company: _____

Phone: _____

Street Address: _____

City/State/Zip: _____

Policy/Member ID #:_____

Group #:_____

Policy Holder Social Sec #_____

Medical History

Has your child been diagnosed and/or treated for any of the following:

☐ Blood Disorder/Anemia
☐ Abnormal Bleeding/Hemophilia
☐ Immune Disorder/HIV/AIDS
☐ Cancer/Tumor/Leukemia
☐ Epilepsy/Seizures/Convulsions
☐ Cerebral Palsy
☐ Cystic Fibrosis
☐ Kidney Problems
☐ Heart Murmur/Defect/Heart surgery
☐ Liver Disease/Jaundice/Hepatitis
☐ Diabetes
☐ Tuberculosis (TB)
☐ Asthma/Reactive Airway
☐ Tonsillitis
☐ Congenital Birth Defects
☐ Cleft Lip/Palate
☐ Autism Spectrum
☐ ADD/ADHD
☐ Eating Disorder
☐ Premature/low birth rate
☐ Speech Disorder
☐ Vision Problems

Allergies

☐ Penicillin
☐ Sulfa Drugs
☐ Codeine
☐ Other

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☐ Sickle Cell Trait
☐ Hearing Problems/Deaf
☐ Stomach/GI Disorders
☐ Mental/Cognitive/Social Delay

Child's Physician:_____ Phone:_____

Was your child full term? ☐ Yes ☐ No If not, how may weeks at delivery?_____

Date of Last Exam:_____ Are immunizations current? ☐ Yes ☐ No

History of
Hospitalizations:_____

Is your child taking any medication(s) now? ☐ Yes ☐ No
If so, please list:_____

Dental and Diet History

Does your child currently have a toothache? ☐ Yes ☐ No

If yes, how frequent? _____

Is this your child's first visit to a dentist? ☐ Yes ☐ No

If not, please share with us why you wish to make a change?_____
Previous dentist?_____ Date Last X-
Rays:_____

How would you describe your child's previous medical or dental experiences?
_____

How would you rate your own anxiety at this moment? ◯ High ◯ Medium ◯ Low

How would you expect your child to react in the dental chair? ◯ Good ◯ Medium ◯ Poor

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Does your child have a history of any of the following?

1. Cavities/decayed teeth: ☐Yes ☐No
2. Clinching/grinding teeth:☐Yes ☐No
3. Excessive gagging:☐Yes ☐No
4. Family history of cavities or dental characteristics?☐Yes ☐No
   If so, please explain:_____
5. Does your child have any oral habits?
   ☐Pacifier ☐Sucks Thumb ☐Sucks fingers ☐Grinds teeth ☐Other
   If so, how often do they do it?_____
6. Has your child ever had any trauma to a tooth?☐Yes ☐No
   If so, when and how?_____
7. Has your child ever had previous orthodontic treatment (braces, spacers, or other appliances)? ☐ Yes ☐ No If so, where?_____

Brushing and Flossing

1. Does your child brush in the morning and night? ☐Yes ☐No
2. Does your child brush with fluoridated toothpaste?☐Yes ☐No
3. Does an adult help?☐Yes ☐No If so, when?_____
4. Are your child's teeth flossed?☐Yes ☐No
   If so, how often?_____ By Whom?_____
5. Does your child usually drink anything other than water BEFORE bed, AFTER brushing?
   ☐Yes ☐No

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Dietary Habits

1. Is your child on a special or restricted diet? ☐ Yes ☐ No
2. What does your child snack on during the day? _____
3. How many times does he/she snack during the day? ☐ 1-3 times ☐ > 3 times/day
4. What does your child generally drink during meals? ☐ Water ☐ Juice ☐ Milk ☐ Other
5. What does your child generally sip on during the day? ☐ Water ☐ Juice ☐ Milk ☐ Other

I affirm that the above information I have given is correct to the best of my knowledge. It will be held in confidence and it is my responsibility to inform this office of changes in the patient's medical status. I authorize the dental staff to perform all necessary dental treatment the patient may need. I understand that Aledo Pediatric Dentistry may use and disclose pertinent health information and dental records to coordinate and manage dental care and related services to one or more health care providers or other dental specialists. I authorize the release of all information necessary to secure benefits such as obtaining reimbursement for services, confirming coverage, bill or collection activities and utilization review. I understand that I am responsible for the full balance of the account regardless of my dental benefits and directly assign Aledo Pediatric Dentistry all insurance payments otherwise payable to me. In case of default, I agree to pay all reasonable costs and fees associated with the collection of the account balance, including but not limited to third party collection fees, court filing fees and attorney fees. I affirm that my signature represents my agreement to all of the terms mentioned above.

Guardian Signature: _____ Date: _____

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FINANCIAL POLICY

Our office is committed to providing you with the highest quality dental care using only the best material and technology available. Our Clinical and Business Teams work closely together to provide a positive environment for visits to our office and assistance with financial requirements. A member of our Business Team will be delighted to discuss our options with you!

Payment Due: The full balance of treatment is due at the time services are rendered. Payment plans are not available from our office. For your convenience we accept cash, check, debit card, CareCredit®, Master Card, Visa and Discover.

Financial Responsibility: The parent or guardian bringing the child to our office and authorizing treatment is legally responsible for payment of all charges. We cannot send statements to other persons.

Statements: If you have a balance on your account, we will send you a statement in the mail. It will show your previous balance, any new charges, and any payments or credits applied to your account.

Past Due Accounts: Unless prior arrangements have been approved in writing by our office, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the due date printed on the statement. A $5.00 late fee may be charged on any account that is not paid within fifteen (15) days of the statement date. If necessary, accounts that are not paid within forty five (45) days may be referred to a collection agency. All reasonable expenses incurred in the collection process will be the account holder's responsibility.

Insurance: We are happy to file dental claims for our families who have dental insurance! In general, we will file claims to any company that will pay us directly and does not restrict coverage to a list of participating providers. Filing your insurance is not a guarantee of payment. Please understand that the parent or guardian has the final responsibility for payment of any services rendered. Our doctors recommend treatment based on your child's needs, not on what insurance will pay. Therefore, we will do everything possible to maximize your benefits.

Your complete insurance information/card must be presented at the time services are provided and updated as necessary. Most benefits will be verified before your insurance company can be billed.

In the event that your insurance has not paid your account within 60 days, the balance may be transferred to your account. We reserve the right to discontinue or refuse to file a claim.

Federal Employees: Insurance plans for federal employees make payments directly to the member. Payment in full will be collected on the day that treatment is provided.

Required Payments: At treatment visits, we collect a percentage of the total cost of treatment, determined by an ESTIMATION of what your insurance will cover, plus any deductible required by your insurance. In the event of underpayment, we will send you a statement in the mail. In the event of overpayment on your part, you will be reimbursed by check in the mail.

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Divorce/Separation: The party responsible for the account prior to the divorce or separation remains responsible for the account. After the divorce or separation, the parent or guardian bringing the child and authorizing treatment will be the person responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from them.

We will provide you additional copies of receipts if needed.

Returned Checks: There is a $35.00 fee for any checks returned by the bank.

CareCredit®: A convenient alternative to credit cards, cash or checks, CareCredit® is a health care card that is exclusively utilized for dental and medical services. They offer flexible payment options that fit your timetable and budget. For additional information, contact us or visit www.carecredit.com.

Initial: _____

APPOINTMENT POLICY

Children tend to do better in the dental office when they are not tired. Therefore, we encourage morning appointments, especially for pre-school or nervous children. For many children, just a simple filling at the end of a long day, when they are tired, can seem like a major ordeal. Please keep in mind, one of our goals is providing dentistry that is as pleasant as possible for your child. Also keep in mind that a dental appointment is an excused absence from school.

When we schedule an appointment for your child, that time is reserved solely for your child. We do not double book and we take pride in the fact that because we value your time, as much as we hope you value ours, we make every effort to see your child at the time scheduled. For this reason, it is very important that you have your child in the office at the time scheduled. If you are more than 10 minutes late, it may be necessary to reschedule your child's visit.

Cancelling or Rescheduling: If you are unable to keep a scheduled appointment, a 48-hour notice is required. We understand that unforeseen emergencies do occur, however, we reserve the right to charge your account a $25.00 fee for repeated last minute cancellations or broken appointments.

Effective Date: Once you have signed this policy, you agree to all the terms and conditions contained herein and the agreement will be in full force and effect.

Initial:_____

I have read the above policies and understand my obligations with Aledo Pediatric Dentistry for my child's dental care. I affirm that my signature represents my agreement to all of the terms mentioned above.

Guardian Print Name: _____

Guardian Signature: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE READ IT CAREFULLY.
THE PRIVACY OF YOUR CHILD'S HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY: **We are required by applicable federal and state law to maintain the privacy of your child's health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your child's health information. We must follow the privacy practices that are described in the notice while it is in effect. This notice took effect on 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.

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 child's health information to a physician or other healthcare provider providing treatment to your child.

Payment: We may use and disclose your child's healthcare information to obtain payment for services we provide.

Healthcare Operations: We may use and disclose your child's healthcare 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 child's 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 child's health information for any reason except those described in this notice.

To Your Family and Friends: We must disclose your child's health information to you, as described in the Patient Rights section of this notice. We may disclose your child's health information to a family member, friend or other person to the extent necessary to help with your child's healthcare or with payment for your child's 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 (including identifying or locating) a family member, your child's personal representative or another person responsible for your child's care, of your child's location, your child's general condition, or death. If you are present, then prior to use or disclosure of your child's health information, we will provide you with an opportunity to object to such uses or disclosure. 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 person's involvement in your child's healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your child's best interest to allow 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 child's health information for marketing communications without your written authorization.

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

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

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

Appointment Reminders: We may use or disclose your child's health information to provide you with appointment reminders (such as voicemail messages, emails, post cards or letters).

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PATIENT RIGHTS

Access: You have the right to look at, or get copies of, your child's 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 of your child's health information. You may obtain a form to request access by using the contact information listed at the beginning 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 beginning of this notice. If you request copies, we will charge you a reasonable fee for each page, a reasonable rate per hour for staff time to locate and 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 child's health information in that format. If you prefer, we will prepare a summary or an explanation of your child's health information for a fee. Contact us using the information listed at the beginning 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 child's 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 restriction on our use or disclosure of your child's 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 child's health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or locations, and provide a 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 child's 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 website 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 you or your child's rights, you disagree with a decision we made about your access to your child's health information, to have us communicate with you by alternative means or alternative locations, or in a response to a request you made to amend or restrict the use or disclosure of your child's health information, you may complain to us using the contact information listed at the beginning of this notice. You may also 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 privacy. We will not retaliate in any way if you choose to file a complaint with us or the U.S. Department of Health and Human Services.

I have read and accept the above Notice of Privacy Rights, understand it and agree to it.

_____

Patient Name(s) Please Print

_____ _____

Signature of Parent or Guardian **Date**

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print 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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Consent To Electronic Communication via Email

Unencrypted email is not a secure form of communication. There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email maybe misdirected, disclosed to or intercepted by unauthorized third parties.

However, you may consent to receive email from us regarding your treatment. We will use the minimum necessary amount of protected health information in any communication. Our first email to you will verify the email address you provide.

- ○ I consent and accept the risk in receiving information via email. I understand I can withdraw my consent at any time.
- ○ I consent only to receiving appointment and recall reminders via email. I understand I can withdraw my consent at any time.
- ○ I do not consent to receiving any information via email. I understand that I can change my mind and provide consent later.

_____

Please Print Name

_____ _____

Signature **Date**

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