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Patient's Information

Last Name: _____ First: _____ Middle: _____

Preferred Name: _____ Gender: ☐ M or ☐ F

Date of Birth: _____ Age: _____ SSN: _____

Does the patient attend school: ☐ Yes or ☐ No. If yes, where? _____

Child's physician: _____ Phone #: _____

Address of physician:_____

Pharmacy name & number: _____

Parent's Information

Mother's Full Name: _____ Date of Birth: _____

Address: _____ SSN: _____

City/State/Zip: _____

Home #: _____ Cell #: _____ Work #: _____

Employer: _____

If the above information is not for the mother, what is the relationship to the child? _____

Father's Full Name: _____ Date of Birth: _____

Address: _____ SSN: _____

City/State/Zip: _____

Home #: _____ Cell #: _____ Work #: _____

Employer: _____

If the above information is not for the father, what is the relationship to the child? _____

Who does the child live with? ☐ Both Parents, ☐ Mother, ☐ Father, ☐ Other _____

Do you have a personal or business website, blog, twitter, or other social media outlet that you would like to

share with us? If so, please list _____

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Insurance Coverage Information

Policyholder's Name: _____Relationship to Patient: _____

Policyholder's Date of Birth: _____ Policyholder's SSN: _____

Policyholder's Employer: _____

Insurance Company Name: _____

Group#: _____Member #: _____

☐ I certify the insurance information listed above is the patient's primary dental insurance plan.

If your child is covered by more than one dental insurance plan, please be aware there are industry guidelines that determine which plan is considered primary and which is secondary. We only accept assignment of benefits for primary dental insurance plans. As a courtesy, we will file secondary claims for you and assign the payment to the primary policyholder.

Appointment Reminders

☐ Please send me email and/or text message reminders about my child's appointments.

Email: _____ Phone to Text: _____

☐ I prefer a phone call reminder for my child's appointments.

How Did You Hear About Us?

☐ Community Impact, ☐ Focus Magazine, ☐ View Magazine, ☐ Facebook, ☐ School Talk, ☐ Google,

☐ Macaroni Kids Newsletter, ☐ Referral by Friend _____

☐ Referral by Doctor _____ ☐ Other _____

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Health History

Check all of the following that pertain to your child.

Heart: ☐ Heart murmur, ☐ Congenital heart defect,

☐ Low/high blood pressure, ☐ Other _____

Kidney: ☐ Bladder, ☐ Urinary problems

Liver/GI: ☐ Stomach/intestinal ulcers, ☐ Gastritis, ☐ Colitis, ☐ Hepatitis, ☐ Liver disease

Endocrine system: ☐ Diabetes, ☐ Thyroid disease

Lung/breathing: ☐ Hay fever, ☐ Sinus trouble, ☐ Allergies or hives,

☐ Asthma, ☐ Chronic cough, ☐ Emphysema, ☐ TB or Tuberculosis

Neurological: ☐ Nervous disorder, ☐ Mental disorder, ☐ Cerebral palsy, ☐ Seizure disorder/epilepsy, ☐ Fainting, ☐ Brain injury, ☐ Developmental delay, ☐ Headaches, ☐ Speech disorder

Hearing/eye: ☐ Vision problems, ☐ Glaucoma, ☐ Eye pain, ☐ Earaches, ☐ Hearing loss

Dermal/musculoskeletal: ☐ Rash, ☐ Allergy to latex, ☐ Arthritis, ☐ Fever blisters, ☐ Ulcers

Sleep related breathing problems: ☐ Snoring, ☐ Restless sleeper, ☐ Falling asleep at school, ☐ Frequently tired, ☐ Trouble concentrating at school, ☐ Morning headaches

Does the patient have any disease, condition, syndrome or other health problem not listed above?

☐ Yes or ☐ No If yes, please list: _____

Is the patient in good health? ☐ Yes or ☐ No

Is he/she up to date with immunizations? ☐ Yes or ☐ No

Has he/she been hospitalized since birth? ☐ Yes or ☐ No

If yes, for what: _____

Is the patient currently taking any medications? ☐ Yes or ☐ No

If yes, please list: _____

Is the patient allergic to any medications or drugs? ☐ Yes or ☐ No

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If yes, please list: _____

Healthy History Continued

Is he/she presently receiving medical treatment? ☐ Yes or ☐ No

If yes, for what? _____

When was the child's last physical exam? _____

Describe your child's personality and interaction with parent/guardian: _____

Dental History

Date of patients last dental visit: _____ Name of dentist: _____

Were x-rays taken? ☐ Yes or ☐ No Has patient had any unhappy dental experiences? ☐ Yes or ☐ No

If yes, please list: _____

Does the patient have a toothache? ☐ Yes or ☐ No

Does the patient have any jaw pain? ☐ Yes or ☐ No

At what age did patient discontinue the bottle or nursing? _____ years _____ months

Does patient have any mouth habits (thumb/finger sucking, pacifier, grinding, etc.)? ☐ Yes or ☐ No

If yes, please explain _____

Does patient brush daily? ☐ Yes or ☐ No If yes, how many times? _____

Does patient use floss? ☐ Yes or ☐ No

What type of water is typically used for brushing, cooking, drinking? ☐ City Water, ☐ Well Water, or ☐ Bottled

Does an adult assist with home dental care? ☐ Yes or ☐ No If yes, who: _____

Is there any additional information that you feel might be of value to us?

If so, please comment:_____

Signature: _____ **Date:** _____

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Office Policies

Welcome!
Thank you for entrusting us with your child's dental care. In order to enhance communication and promote an understanding of how our office operates, please read carefully the following information. By providing your signature below, you indicate that you have read, fully understand, and agree to our office policies.

Insurance:
Our office is committed to helping you maximize your insurance policy and will gladly accept assignment of benefits. Insurance policies vary greatly; therefore we can only estimate your coverage in good faith but cannot guarantee coverage due to the complexities of insurance contracts. As a service to our patients, we will bill insurance companies for services and allow them 45 days to render payment. After 60 days, you are responsible for the entire balance, paid-in-full. If you have any questions, our courteous staff is always available to answer them.

You should be aware that our doctors are Board Certified Pediatric Dentists and have received additional training in how to best care for your child. Therefore, the fees for dental treatment may be higher than that of a general practitioner, and higher than those recognized by some dental insurance companies. Your estimated patient portion must be paid at the time of service. Should your payment exceed the estimated patient portion, you will promptly be refunded the difference.

Our office is not a contracted or an "in-network" provider for all insurance companies, and as such, any fees not covered by your insurance company are solely your responsibility.

Financial Policy
Please be aware the estimated patient portion for your child's office visit will be collected at the time of service. We accept cash, personal check, debit cards and credit card payments. We can also assist you in obtaining third party financing through Care Credit, which offers convenient monthly payment options, no up-front costs, no prepayment penalties and no annual fees.

Billing:
If a balance remains on your account after insurance has been processed, you may authorize our office to automatically charge your debit or credit card for the balance. As a courtesy we will place a phone call to you, prior to charging your card. If a response is not received, after 48 hours your card will automatically be charged. Once the card has been charged we will provide you with an account statement either via email or regular mail, whichever you prefer. If you would like to enjoy the convenience of automatic billing, simply complete the "Paperless Billing" form on the following page. Please be aware you may cancel the automatic billing authorization at any time by contacting us.

If a balance remains on your account after insurance has been processed and you are not set up for automatic billing, we will send you an account statement either via email or regular mail, whichever your prefer. Once the statement has been sent, you will have 30 days to settle the balance without incurring a rebilling fee.

Rebilling Fee:
A $50 rebilling fee will be assessed to your account should your balance not be cleared in a timely manner (30 days after first billing). After 120 days in which your account balance is not paid in full, your account will be turned over to a collections agency. Please contact our office to discuss additional payment options should the need arise.

Returned Check Fee:
A $50 returned check fee will be assessed to all returned checks and no future checks can be accepted as payment.

Broken Appointments:
Appointment times are specifically reserved for your child. If you must change your appointment, we request at least 24 hours notice to avoid a $50 per half hour cancellation fee. We also reserve the right to reschedule any appointment arriving 15 minutes after your reserved appointment time.

Signature: _____ **Date:** _____

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Paperless Billing

In an effort to reduce the amount of paper used by our office we would like to offer you two exciting options for going paperless: Automatic Billing and Email Statements.

Automatic Billing:
Please be aware the estimated patient portion for your child's office visit will be collected at the time of service. Once your insurance has been processed, if an account balance remains on your account you can authorize Georgetown Pediatric Dentistry and Orthodontics to automatically charge your debit or credit card for the remaining balance.

As a courtesy we will place a phone call to you, prior to charging your card. If a response is not received, after 48 hours your card will automatically be charged. Once the card has been charged we will provide you with an account statement either via email or regular mail, whichever you prefer.

If you would like to enjoy the convenience of automatic billing, simply complete the Card Authorization below and sign this form. All requested information is required.

Please be aware you may cancel this automatic billing authorization at any time by contacting us.

☐ I wish to enroll in automatic billing

☐ I do not wish to enroll in automatic billing

_____

Your name as it appears on the credit card

_____ _____ _____

Credit Card Number Expiration Date Security Code

_____ _____

Your address as it appears on your credit card bill City/State/Zip:

Email Statements:

☐ I wish to receive statements via email

☐ I do not wish to receive statement via email, please mail statements to the address on my account.

Email address: _____

Signature: _____ **Date:** _____

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Acknowledgment of Receipt of Notice of Privacy Practices

I certify that I have received a copy of Georgetown Pediatric Dentistry and Orthodontics

Notice of Privacy Practices.

Patient Name: _____

Parent/Guardian Name: _____

Signature: _____ **Date:** _____

Staff will complete this section if patient's signature is NOT obtained. Our office made a good faith effort to obtain **Acknowledgement of Receipt** of our **Notice of Privacy Practices,** but it could not be obtained for the following reason(s):

☐ Patient/Parent/Guardian refused to sign

☐ Emergency situation kept us from obtaining a signature

☐ Language barriers kept us from obtaining a signature

☐ Other: _____

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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 review it carefully. If you have any questions about this Notice please contact our Privacy Officer.
This Notice of Privacy Practices describes how we may use and disclose your child's protected health information to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. We are required by Federal Law to give you this Notice and to maintain the privacy of your child's health information. We must also abide by the terms of this Notice while it is in effect. We reserve the right to change our privacy practices and the terms of this Notice at any time. Before we make significant changes in our privacy practices, we will change this Notice and make the Notice available upon request.

How We May Use And Disclose Your Child's Protected Health Information

When we give you our Notice of Privacy Practices, you will be asked to sign an Acknowledgement of Receipt. Once you have received our Notice and signed the Acknowledgement, we will use your child's protected health information for treatment, payment, and health care operations. We may use or disclose your child's protected health information in an emergency treatment situation. If this happens, we will try to obtain your signature on the Acknowledgement of Receipt as soon as is reasonable practical after the delivery of treatment. The following examples show the types of uses and disclosures of your child's protected health information that our office is permitted to make.
Treatment: Your child's protected health information may be used and disclosed by our office and others outside of our office that are involved in their dental care. We will use and disclose your child's protected health information to other dentists and physicians to provide, coordinate, or manage their health care.
Payment: Your child's protected health information may be used and disclosed to pay their health care bills. Your child's protected health information will be used to obtain payment for the services we provide for them. This may include certain activities that your insurance plan may undertake before it approves or pays for the services we recommend.
HealthCare Operations: We may use or disclose your child's protected health information in order to support the business activities of our practice. Healthcare operations include quality assessment activities, employee review activities, licensing or credentialing activities, conducting training, and auditing/review activities. For example, we may call your child's name in the waiting room when the doctor is ready for them or send you postcards for appointment reminders. You may contact our Privacy Officer to request that these materials not be sent to you.
Business Associates: We may share your child's protected health information with third party business associates that perform various activities for our practice. Whenever we disclose this protected health information to a business associate, we will have a written contract that will protect the privacy of your child's protected health information.

Written Authorization Is Required For Other Uses Of Your Child's Protected Health Information

Any other uses and disclosures of your child's protected health information will be made only with your written authorization, unless otherwise permitted by law. You may revoke this authorization at any time, in writing, except to the extent that our office has already released your health information as provided for in your authorization.

Use and Disclosure Permitted Without Authorization But With An Opportunity To Object

Family Members and Friends: Unless you object, we may disclose to your family member, a relative, a close friend, or any other person you select, your child's protected health information to the extent necessary to help with dental care or payment for the services we have provided. We will also use our professional judgment and common practice to make reasonable decisions in your best interest in allowing a person to pick up dental supplies, x-rays, prescriptions, or other similar forms of health information.

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Notice of Privacy Practices Continued

Other Disclosures That May Be Made Without Your Authorization

Required By Law: We may use or disclose your child's protected health information when we are required to do so by law.
Abuse or Neglect: We may disclose your child's protected health information to appropriate authorities if we reasonably believe that if your child is a possible victim of abuse, neglect, or domestic violence. We may disclose to authorize official health information required to lawful intelligence, counterintelligence, and other national security activities.

Worker's Compensation & Health Oversight Activities: We may disclose your child's protected health information to comply with Worker's Compensation Laws and to health oversight agencies when conducting investigations or inspections as authorized by law.
Required Uses and Disclosures: Under the law, we must make disclosures to you and when required, to the Department of Health and Human Services when determining our compliance.

You Have The Following Rights

Inspect and Copy your Child's Protected Health Information: 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 practically do so. You must make the request in writing to obtain access to your child's health information. You may obtain access by sending a letter to our Privacy Officer listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses. If you prefer, we will prepare a summary or an explanation of your child's health information for a fee.
Request a Restriction of Your Child's Protected Health Information: You have the right to request that we place additional restrictions 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.
Request Alternative Communications: You have the right to request that we communicate with you about your child's protected health information by alternative means or 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.
Request an Amendment to Your Child's Health Information: You have the right to request that we amend or correct your child's health information. This request must be in writing. The request must explain why the information should be amended or corrected. We may deny your request under certain circumstances.
Receive an Accounting of Disclosures we Have Made of your Child's Health Information: You have the right to an accounting of disclosures of your child's health information that occurred after August 13, 2008. This accounting will be for purposes other than treatment, payment, or healthcare operations, or disclosures we have made to you, to family members, or friends involved in your child's care. The right to receive this information is subject to some exceptions. If you request this accounting more than one in a 12 month period, we may charge you a reasonable, cost-based fee.
Make a Complaint About our Privacy Practices: If you are concerned that we have violated you or you child's privacy rights, you may file a complaint with our Privacy Officer using the contact information listed at the bottom of the page. You may also file a written complaint with the Department of Health and Human Services. We will provide you with the address upon request. We will not retaliate against you for making a complaint or change the way we treat you or your child.

You have the right to obtain a paper copy of this Notice from us, upon request, even if you have agreed to accept this notice electronically.

Effective Date: June 2, 2013

Privacy Officer: Kenneth S. Havard, DDS
4507 Williams Dr.,
Georgetown, TX 78633
(512) 869-4100