Hurricane Pediatric Dentistry

Patient: First Name ________________ Last Name ________________ Male/Female
Birth date____________ Age ______ School ______________________________
MAILING Address ____________________________City, State, Zip ______________
Child lives with: Father Mother Both Other
If other, please write name address phone:______________________________________
Mother:______________________ Home phone______________Cell ______________
Social Security #________________ Birth date___________Employer_____________
Work phone_______________Address (if different than patient) __________________
Father:______________________ Home phone ______________Cell ______________
Social Security #________________ Birth date___________Employer_____________
Work phone_______________Address (if different than patient) __________________

Person financially responsible ____
If other than parent please fill in: Address__________________________________
Home phone __________________ Cell phone _________________Work phone_______________

Primary Dental Insurance:
Insurance_____________________________
Phone __________Policy # ______________
Address ______________________________
Subscriber ____________________________

Secondary Dental Insurance:
Insurance ____________________________
Phone __________ Policy # ______________
Address ______________________________
Subscriber ____________________________

Who may we thank for referring you to our office? _______________________________

Medical History: Name of physician____
Is your child currently taking any medications? N/Y If yes, what? ____________________
Has your child ever had a traumatic medical or dental injury? N/Y If yes, what? _____________
Has your child ever been hospitalized? N/Y If yes, for what?___________ Date______________
Does your child have any of the following? (please circle if yes)

Autism
ADHD
AIDS
Allergies
Anemia
Artificial Joints
Asthma
Blood Disease/Disorder
Blood Transfusion Date: ________
Behavioral/Learning
Breathing/Lung Problems
Cancer/Tumor
Congenital Birth Defects
Diabetes
Down Syndrome

Developmental Delay
Endocrine System
Fainting
Frequent Headaches
GI System
Heart Condition
Heart Murmur
Hearing/Sight
Head Injury
Kidney Disease
Liver Disease
Mental Disorder
Radiation Treatment
Respiratory Problems

Respiratory Treatment
Rheumatic Fever
Stomach Problems
Tuberculosis
Tubes in ears
Seizure
Allergies/Adverse Reaction to Medications? N/Y
If yes, what type of medication?
____
Frequent Infections? N/Y
If yes, what type of infections?
____
Any other medical conditions Not listed?______________

I hereby give my consent for treatment and care in the office of Hurricane Pediatric Dentistry. I have read the above and answered to the best of my knowledge. I have updated this form as requested.

Signature:______________________________ **Date:**__________________________

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that the information can be used to, but are not excluded to:

- *Conduct plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.*
- Obtain payment from third-party payers.
- *Conduct normal healthcare operations such as quality assessments and physician certifications*

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change the Notice of Privacy Practices from time to time and that I may conduct this organization at any time at the address above to obtain a current copy of Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my privacy information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient's Name____

Name of Parent or responsible party______________________________

Relationship to Patient_______________________________________

Signature____

Date____

Office use only

I attempted to obtain patient's signature in acknowledgment of this Notice of privacy Practices Acknowledgment, but was unable to do so as documented below

Date__________ Initials___________ Reason________________________

Financial Agreement

If the patient does not have dental insurance, payment in full is expected on the day of service. If the patient does have dental insurance, the responsible party will pay the patient estimated portion and deductible on the day of service. The insurance will be billed as a courtesy; however, please be aware if the insurance company does not pay within 60 days, payment in full is expected from the responsible party.

Because it is your insurance you are ultimately responsible for knowing and executing the requirements of your insurance. We strongly suggest you call your insurance to verify your plan. No insurance company will guarantee an exact payment. Please keep in mind that all insurance companies provide a disclaimer that states they are only giving general information when we call to check on your benefits.

We will do everything we can to assist you in obtaining the maximum of your insurance benefits. However the insurance is a contract between you and your insurance carrier. Therefore you are ultimately responsible for payment in full of your account.

I understand that insurance companies pay on a usual and customary fee schedule and that the fees charged by the Doctor are the actual fees. I am responsible for all differences between the Doctor's fee, and the insurance fee. I understand the Doctor will be using white filling material; some insurance companies will reduce the fee to a silver filling rate. It is my responsibility to pay the difference if any between the two fees. I understand that every 6 months my child will have a full exam, x-rays, and a prophylaxis/fluoride treatment. If my insurance does not cover it that often, it is my responsibility to let the staff know before my child goes back for their appointment. I understand that if my child has been referred by another Dentist my insurance my not cover the cost of the exam, or x-rays due to plan limitations, and it is my responsibility to pay.

When scheduling work with an oral sedation I understand that my insurance will not cover this charge. Sedation fee of $150 is due in full along with all estimated dental co-payments on the day of service.

There will be a $25.00 returned check fee assessed to your account on all returned checks. There will be late fees, certified letter fees, rebilling fees, and finance charges added to all accounts over 60 days late. Credit checks will be obtained with all financial arrangements that are not paid in full on the date of service. The responsible party agrees to pay all attorney fees and court costs associated with collecting payment for services rendered. Collection fees of approximately 40% are added to the account when it is turned over to the agency.

I have read and understand the above policy and agree to abide by them

Signature Date