

T U R N E R

Pediatric Dentistry

Today's Date _____

We are so pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we'll be glad to help you.

We look forward to working with you in maintaining your child's dental health!

PATIENT INFORMATION

Child's Name: _____
Last First Middle Preferred Name

Male Female Age: _____ Date of Birth: ____/____/____ Hobbies: _____

Address: _____
Street Apt.# City State Zip

Home Phone: _____ Mom's Cell: _____ Dad's Cell: _____

Email Address: _____

How would you prefer us to contact you for confirming your child's appointment? _____

Whom may we thank for referring you: Individual Yellow Pages Website Other Marketing:

PARENT'S INFORMATION

Father Stepfather Guardian

Name: _____

Address (if different than above): _____

Home # (if different than above): _____

Work# _____ Ext: _____

Employer: _____

Social Security #: _____

Date of Birth: _____

Insurance Co: _____

Phone #: _____

Group #: _____ ID#: _____

PARENT'S INFORMATION

Mother Stepmother Guardian

Name: _____

Address (if different than above): _____

Home # (if different than above): _____

Work# _____ Ext: _____

Employer: _____

Social Security #: _____

Date of Birth: _____

Insurance Co: _____

Phone #: _____

Group #: _____ ID#: _____

EMERGENCY CONTACT

In the event of an emergency, whom should we contact?

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

DENTAL HISTORY

Date of last dental visit: ____/____/____ Last Cleaning/Flouride: ____/____/____ Last X-Rays: ____/____/____

My child brushes his/her teeth ____ (#) of times during the day.

Do you ever help your child brush his/her teeth? (Please circle) Always Sometimes Never

Does your child floss every day? Yes No

Is flouride taken in any form? Yes No

Any unhappy dental experiences? Yes No

Any injuries to the mouth/teeth/head? Yes No

Has your child complained about dental problems? Yes No

Does your child have any mouth habits? (please circle one or more)

Thumb sucking Nail biting Mouth Breathing Pacifier Sleeping with bottle Other: _____

Last Dentist's Name: _____

MEDICAL HISTORY

Child's Physician: _____ City/State: _____ Phone: _____

Date of last physical exam: ___/___/___

Has he/she been hospitalized? Yes No If so, why? _____

Has he/she had surgery? Yes No Please List: _____

Any handicaps/disabilities? Yes No Please List: _____

Place a mark on "yes" or "no" if your child has had any of the following:

- | | | | |
|--------------------------|--|----------------------|--|
| ADD/ADHD | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| AIDS/HIB | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mumps | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valve | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemophilia | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Autism | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney/Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bladder Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Learning Disability | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Measles | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer/Tumors | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mental Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cerebral Palsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mononucleosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hearing Impairment | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chicken Pox | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sickle Cell Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Convulsions/Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Drug/Alcohol Abuse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other: _____ | |
| Fainting | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Girls: Are you pregnant? Yes No Taking Birth Control Pills? Yes No Nursing? Yes No

MEDICATIONS

Please list any medications your child is currently taking and the correlating diagnosis: _____

ALLERGIES

- None Aspirin Iodine
- Penicillin Local Anesthetic Sulfa
- Latex

Other (Please List): _____

HEALTH HISTORY UPDATE (office use only)

Date: ___/___/___ Allergies: _____ Date: ___/___/___ Allergies: _____

Medications: _____ Medications: _____

Current Health Conditions: _____ Current Health Conditions: _____

Parent/Guardian: _____ Staff: _____ Parent/Guardian: _____ Staff: _____

Date: ___/___/___ Allergies: _____ Date: ___/___/___ Allergies: _____

Medications: _____ Medications: _____

Current Health Conditions: _____ Current Health Conditions: _____

Parent/Guardian: _____ Staff: _____ Parent/Guardian: _____ Staff: _____



NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU/YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR/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/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 health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect March 1, 2003, and will remain 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.

Uses and Disclosures of Health Information: Your child's health information and the rights associated with that health information also rest with the "personal representative" of that individual, generally the parent or legal guardian. We use and disclose health information for treatment, payment, and healthcare operations. Examples are as follows:

Treatment ~ We may use or disclose your child's health information to a physician or other healthcare provider who provides treatment to your child.

Payment ~ We may use and disclose your child's health information to obtain payment for services we provide you.

Healthcare Operations ~ We may use and disclose your child's health information in connection with our healthcare operations. Health care 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 ~ You may give us written authorization to use your child's healthcare information or to disclose it to anyone for any purpose. If you give us 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.

Family and Friends ~ We must disclose your child's health information to you, as described in the Patient Rights in this Notice. We may disclose the 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 with Care ~ We may use or disclose health information to notify, or assist in the notification of a family member (including identifying or locating), your child's personal representative or another person responsible for your child's care, of your child's location, the 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 disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment and our experience with common practice to make reasonable inferences of your child's 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 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 disclose your child’s health information to appropriate authorities if we reasonably believe that the child is a possible 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 Armed Forces personnel under certain circumstances. We may disclose to federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders ~ We may use or disclose your child’s healthcare information to provide you with appointment reminders such as voicemail, postcards, messages or letters.

Patient Rights:

Access: You have the right to look at or get copies of your child’s health information if they are under the age of 18, with limited exceptions.

Disclosure Accounting: You have the right to receive a list of instances in which we, or our business associates disclosed your child’s healthcare information for purposes, other than treatment, payment, healthcare operations and certain other activities.

Restrictions: You have the right to request that we place additional restrictions on our use and disclosure of your child’s healthcare 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.

Amendment: You have the right to request that we amend your child’s healthcare 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 (email), you are entitled to receive this Notice in written form.

Questions and Concerns: 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 child’s privacy rights, or you disagree with a decision we made about access to your child’s healthcare information, 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.

Authorization for Additional Disclosure: I am the “personal representative” (generally parent or legally guardian) of and have legal authority to make health care decisions about the following minor patient: _____.
As the “personal representative” of the above named patient, I authorize the following individuals to accompany my child and have access to health information:

Name:	Relationship:
_____	_____
_____	_____

“Personal Representative” (Parent/Legal Guardian)

Date

CONSENT FOR TREATMENT

The information that I have given is correct to the best of my knowledge. It will be held in the strictest confidence and is my responsibility to inform this office of any changes in my child's medical status. I authorize Dr. Turner and/or associates to perform the necessary dental procedures including, but not limited to, the use of Nitrous Oxide (laughing gas), Local Anesthetic (Lidocaine), and any necessary x-rays needed on my child.

ALL PROCEDURES WILL BE DISCUSSED WITH YOU PRIOR TO ANY DENTAL TREATMENT.

Parent/Guardian: _____ Date: _____

FINANCIAL INFORMATION

Our policy requires payment in full at the time of service. Insurance reimbursement for covered services is subject to maximum allowable fees, deductibles, and co-payments. Your responsibility is estimated and due at the time of treatment. It is also your responsibility as a parent/guardian to pay any remaining balance on your account after any and all insurance benefits have been collected.

If your account is not paid within 90 days, you will be liable for all collection fees, legal and court fees, interest charges, and any other expenses incurred while collecting your account.

I hereby authorize all insurance benefits, if any, to be assigned directly to Turner Pediatric Dentistry, otherwise payable to me for services rendered. I authorize the release of any information required to process insurance claims, including the use of my signature on all insurance submissions.

Parent/Guardian: _____ Date: _____

OTHER OFFICE POLICIES

If you are unable to keep any appointment, please notify our office within 24 hours. We are dedicated to providing our patients with timely scheduling. Please do not skip appointments or avoid calling to reschedule if needed. This will help ensure other deserving patients may be able to be scheduled in your original appointment times.

There may be a \$50 fee charged to your account for all appointments that are cancelled and/or broken within less than 24 hours.

After having 2 missed or broken appointments, we may be no longer able to provide your child with dental care. If this happens, you will be notified by mail of your child's dismissal from our practice. We will continue to provide emergency dental care for your child for up to 30 days following the dismissal.

We will be unable to reschedule your child's first new patient visit if you do not show up for that visit or do not notify us of the cancellation within 24 hours of that visit.

In general, we use white (composite or glass ionomer) material for fillings. These materials allow for more conservative tooth preparation and often have antibacterial properties (contains fluoride) that decreases the chance of a cavity around/under the filling in the future. Often there is a difference in benefits to be paid by insurance companies between these white fillings and "silver" fillings. It is your responsibility to let our office know if you would prefer a silver filling for your child due to insurance.

Parent/Guardian: _____ Date: _____