

Algonquin Kids Dentistry

**** In order to setup new patients in our system and verify Insurance benefits, all forms must be completed, signed and returned to our office at least 48 hours before first appointment.**

Patient (Child's) Name: _____ DOB: _____ Gender: M F

Parent/Legal Guardian Name: _____ Date of Birth: _____

Home Address: _____ City: _____ Zip: _____

Marital Status: Married___ Single___ Divorced___ Separated___ Child resides with: _____

Primary Email: _____ Secondary Email: _____

Primary Cell Num: _____ Secondary Cell Num: _____

Who holds dental insurance: Mom___ Dad___ Full Name: _____

Date of Birth: _____ (req.) Soc Sec # _____ - _____ - _____ (req.)

Employer's Name: _____ Address _____

Insurance Co: _____ Ins ID#: _____ Group#: _____

If secondary insurance, who holds? Mom___ Dad___ Full Name: _____

Date of Birth: _____ (req.) Soc Sec # _____ - _____ - _____ (req.)

Employer's Name: _____ Address: _____

Insurance Co: _____ Ins ID#: _____ Group#: _____

* Soc Sec number is required to file claims with most dental plans

Referred by or how you found us: _____

Health Provider Information

Pediatrician/Physician: _____ Phone#: _____

Previous Dentist's Name: _____ Phone#: _____

Current / Referring Orthodontist: _____

Medical History

Patients last dental visit: _____ Date of last X-Rays: _____

Patients last PCP visit: _____ Does the patient get vaccinated? _____

Has the patient had any recent hospitalizations or surgeries?

If so, when: _____ Procedure: _____

Have you ever been told your child needs to take Antibiotics before a dental treatment: _____

Patient's oral habits:

Pacifier use___ Thumb Sucker___ Nail biting___ Chews on toys/blankets___ Nursing/Bottle Habits___

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Allergies:

Seasonal/Environmental Latex Dogs Cats
 Fish Dairy Milk Peanuts Tree Nuts
 Gluten Eggs Soy
 Antibiotics: Other: _____
If other, please describe: _____

Check all the apply:

ADHD Down Syndrome Tuberculosis
 AIDS/HIV Positive Fainting/Vertigo Speech Impairment/Disorder
 Anemia Headaches Aproxia
 Asperger Syndrome Hearing Impaired Tonsillitis
 Asthma Hemophilia/Abnormal Bleeding
 Autism Kidney Disease or Malfunction
 Bi-polar Liver Disease Sleep Apnea
 Cancer Respiratory Disease Other Heart Conditions
 Cerebral Palsy Skin rash/Eczema
 Epilepsy/Seizures Thyroid Disease or Malfunction
 Chronic Bronchitis Heart Murmur (innocent or not)
 Diabetic Other: _____

Therapies:

Occupational
 Speech
 Behavior
 Other
Describe: _____

Diagnosed with:

Anxiety
 Sensory Disorder or Sensory Issues
 Depression
 Other
Describe: _____

Mental Development: Normal 1-2 years behind More than 2 years behind

Medications the patient is currently taking:

1. _____ Reason: _____
2. _____ Reason: _____
3. _____ Reason: _____
4. _____ Reason: _____

***I understand the information given is correct to the best of my knowledge and it is my responsibility to inform the office of any changes to patient's medical history. **

Parent/Guardians Signature: _____ Date: _____

Financial Policy and How We Work With Your Insurance

How We Work With Your Insurance:

Our practice is non-contracted and “**out of network**” with all insurance companies. We have no contracted write off amount with your insurance provider. As a courtesy, we will attempt to estimate your insurance benefits based on the information your insurance provides us as accurately as possible. This is an estimate only and may change once it processes through your insurance plan.

We will submit your claim to your insurance, but we require the patient estimate portion for all treatment and appointments to be paid for at the time of service. The parent/guardian bringing the child to the appointment is responsible for payment and MUST have a method of payment with them at the appointment. Our office does not call spouses, ex-spouses, or any other relatives for payment. If your insurance pays you directly, (i.e.: some Delta Dental plans) payment is due in full at the time of treatment.

For patients without dental insurance, payment is due at the time of treatment. For larger treatment plans or when insurance is not available, we accept CareCredit as a convenient and timely payment method. Please visit carecredit.com to learn about different treatment financing options and to complete an application.

Financial Agreement

I understand I am responsible for any outstanding balance on my account not covered by insurance including the full balance in the event that; my insurance does not cover the entire cost of the treatment; my insurance has denied submitted claims; my insurance coverage was terminated or otherwise not in effect at time of treatment; the insurance info provided was incorrect or expired; or if plan benefits had already been exhausted for coverage period. I understand I am responsible for providing updated insurance information when coverage changes occur, when requested by the practice or on day of the patient’s appointment.

Insurance Holder / Responsible Party Signatures:

Name: _____ Date: _____ Signature: _____

Name: _____ Date: _____ Signature: _____

Late Appointments: If you arrive to your scheduled appointment more than 10 minutes late, we reserve the right to reschedule your appointment. Initial _____

Missed Appointments: We require a 48-hour notice if you need to cancel/miss your appointment. Otherwise, we reserve the right to charge an amount of \$50.00 for the canceled or missed appointment. Initial _____

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS FORM CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment of health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your right to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. **Uses and Disclosures of Protected Health Information** Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment:

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment:

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations:

We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you.

We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases; Health Oversight, Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroner, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures; Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will Be Made with Your Consent, Authorization or Opportunity to Object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

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Your Rights

Following is a stamen of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. 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 alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/ or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Person(s) Responsible for the account and Insurance Holder(s)

Name: _____ Date: _____ Signature: _____

Name: _____ Date: _____ Signature: _____