WELCOME

Today's Date: _____/_____/_____

_____
Child's Full Name

_____ _____/_____/_____
Child's nickname Date of Birth
Sex ____ male ____ female

Parent's Name:_____

Parent's cell (____)_____-_____

Parent's Name: _____

Parent's cell (____)_____-_____

Address: _____

City: _____ State ____ Zip_____

Home phone (____)_____-_____

Email Address: _____@_____
How did you hear about us? _____

INSURANCE

Name of Subscriber: _____
Relation to Patient: _____
SSN or ID # _____
Subscriber's birth date: _____/_____/_____
Name of
Employer:_____
Insurance Co: _____
Group # _____

Name of Subscriber: _____
Relation to Patient: _____
SSN or ID # _____
Subscriber's birth date: _____/_____/_____
Name of
Employer:_____
Insurance Co: _____
Group # _____

The information provided here is accurate and complete to the best of my knowledge and is only for use in treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____
Signature of parent/guardian Date

DENTAL HISTORY

Name of former Dentist: _____

City _____Phone #_____

Does Child brush teeth? YES NO
Does Child floss teeth? YES NO
Does Child take fluoride? YES NO
PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY:
_____bad breath _____Thumb sucking, pacifier
_____bleeding gums _____sleeps with bottle
_____grinds teeth _____chews fingernails,etc
_____clicking or popping jaw
_____ injury to mouth , head or teeth
Any unhappy dental experiences? YES NO

What happened? _____

MEDICAL HISTORY

Physician: _____

City: _____Phone# _____

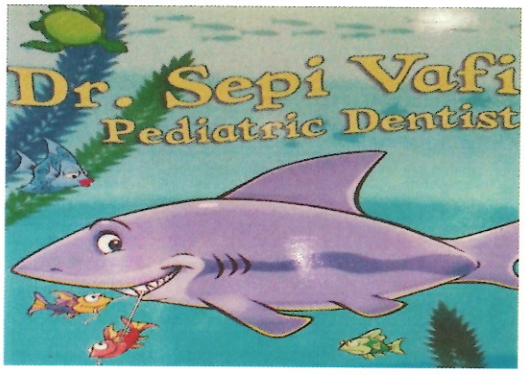
List of medications child is currently taking:

_____

_____

ALLERGIES: _____

Has the child had any of the following?
_____HEART MURMUR _____DIABETES
_____KIDNEY DISEASE _____ LIVER DISEASE
_____CERELBRAL PALSY _____CHICKEN POX
_____RHEUMATIC FEVER _____CONVULSIONS
_____EPILEPSY _____ASTHMA _____FAINTING
_____MEASLES _____CANCER _____SINUSITIS
_____HEPATITIS _____AUTISM * _____PDD*
*IF Yes to AUTISM or PDD, please fill out additional questionnaire



SHOREVIEW DENTAL FINANCIAL POLICY

Thank you for choosing us for your dental care. We are committed to providing you excellent care, and payment of your bill is part of successful treatment. Our financial policy is based on open and honest discussion of our fees.

- **FINANCIAL POLICY**
  Payment is due at the time of treatment, unless other arrangements are made prior. Payment or services of the treatment of minors is the responsibility of the adult accompanying the minor.

- **INSURANCE**
  As a service to our patients, we will bill your insurance company directly to help maximized your benefits.

  I, the undersigned, have insurance with _____
  (Name of insurance company)
  and assign directly to **SHOREVIEW DENTAL** all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid for by the insurance. I hereby authorize SHOREVIEW DENTAL to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ _____
Date Signature of patient / parent

- **USUAL & CUSTOMARY RATES**
  Our fees reflect our commitment to the quality our patients deserve and are considered usual and customary for the area, **regardless of any insurance company's determination**
- **SERVICE CHARGES**
  All accounts that are over 60 days past due(regardless of insurance claim status) will be charged an interest rate of 10% per month
- **COLLECTION FEES**
  Fees incurred to collect payment will be billed to, and payable by the patient/parent.

_____ _____
Date Signature of patient / parent

SHOREVIEW DENTAL

Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this Acknowledgement

Purpose: this form is used to obtain acknowledgement of receipt of our HIPPA & Your Privacy Rights notice or to document our good faith effort to obtain that acknowledgement.

I, _____ have received a copy of this office's Notice of HIPPA & Your Privacy Rights.

_____
PRINT NAME

_____ _____
SIGNATURE DATE

For office use only

We attempted to obtain written acknowledgement of receipt of our HIPPA &Your Privacy Rights, but acknowledgement could not be obtained because:

□ Individual refused to sign

□ Communication barriers prohibited obtaining acknowledgement

□ An emergency situation prevented us from obtaining acknowledgement

□ Other (please specify) _____

Staff initials _____

HIPPA & YOUR PRIVACY RIGHTS

We strongly believe in doing everything we possibly can to safeguard the privacy and security of your health information and records.

As a result, we have made some changes in our office management procedures to make sure we follow the Health Information Portability and Accountability Act (HIPPA)Passed into law in 1996, HIPPA sets federal standards for the privacy and security of patient information for all healthcare providers, plans, insurance companies and anyone they do business with.

HIPPA give you additional rights regarding control and use of your health information, **meaning you have more access and control than ever.** Please take a few minutes to review these new rights. We're happy to answer any questions you may have.

Control over your health information

All healthcare providers (and health plans) are now required to give you a written explanation of how they use and disclose your personal health information before they can treat you. This way, you can decide if a provider is doing everything they should to protect your privacy before you choose them as your caregiver.

We must , by law, post a Notice of Privacy Practices, which outline how we secure the privacy of patient information, in a place where you can easily see it.

We must get your signature for non-routine uses and disclosures of your information. A non-routine use is any situation not directly related to treatment, payment or operations. For example, if your child is going to summer camp and the camp needs a medical history you will be asked to authorize us to release it before we can send the information. You have the right to say no, and you don't have to tell anyone why.

Authorizations of non-routine information are one-time-only, case by case, for the use defined by you.

Access to your Health Information

You can get copies of your medical records simply by asking for them. Health care providers are required to get you a copy of your records within 60days of your request. There may be a cost for this service.

Providers also must give you a history of non-routine disclosures if you ask for it. All you need to do is ask for the record and it is provided to you – no justification is needed.

You can also amend your medical records. You cannot change the existing record, but you can add notes or comment on any procedures, treatments, payment, or operations.

The provider then has the right to respond to your amendment. This way, you can be sure your records reflect your side of the story about treatment and payment issues.

Patient Recourse If Privacy Protections are Violated

Every healthcare provider must also inform you of grievance procedures. If your privacy is violated, report the incident to our Privacy Officer immediately. You also have the right to report any violation to the Dept of Health and Human Services, Office of Civil Rights, 200 Independence Ave, SW Washington, DC 20201

Aside from these new rights to access and control of your medical information under HIPPA, there are also clear limits on healthcare providers regarding how they disclose medical information. Here are some of the key aspects of these boundaries:

Providers must ensure that health information is not used for non-health purposes. Health information (covered by the privacy rules) generally may not be used for purposes not related to health care-such as discloser to employers to make personnel decisions, or to financial institutions – without your explicit authorization.

There are clear strong protections against using health information for marketing. The privacy rules set new definitions, restrictions and limits on the use of patient information for certain marketing purposes. Providers must get your specific authorization before sending you any materials other than those related to treatment.

Use only the minimum amount of information necessary. In general, uses or disclosures of information will be limited to the minimum necessary. This does not apply to disclosure of records fro treatment other providers may need access to the full record to provide quality care.

Exceptions

There are situations where healthcare providers may not have to follow these privacy rules. They include: judicial and administrative proceedings; limited law enforcement activities' and activities related to national defense and security.

We understand your right to have your medical information kept confidential. Our compliance with HIPPA is one example of our advocacy and leadership on issues of patient's rights and privacy of information. We encourage you to ask questions and look forward to working together to improve the quality of your healthcare experience.

Additional questionnaire for Autistic, PDD patients

MEDICAL INFORMATION

Patient Name:_____ Nickname:_____ Parent/Guardian_____
Phone Number (____)_____-_____ Parent/Guardian_____
Describe the nature of your child's disability: _____
Are they currently taking any medications? **YES NO** List of Medications: _____
Has your child ever had seizures? **YES NO** Date of last seizure: _____/_____/_____
Describe type of seizure_____
Does your child have any allergies? **YES NO** List of Allergies: _____
Does child wear Hearing Aids? **YES NO**
Does child have any physical challenges that the dental team should be aware of? **YES NO**
What are they? _____

COMMUNICATION AND BEHAVIOR

Is your child able to communicate verbally? **YES NO**
Are there any certain cues that might help the dental team? _____
Are there any useful phrases or words that work best with your child? _____
Does your child use non-verbal communication? **YES NO**
Please check the following that your child uses:

- □I-pad
- □Mayer Johnson Symbols
- □ Sign Language
- □Picture exchange Communication System (PECS)
- □Sentence Board or Gestures

Are there any symbols/signs that we can have available to assist with communication? _____
BEHAVIOR/EMOTIONS
Are there specific behavioral challenges that you would like the dental team to be aware of?_____

SENSORY ISSUES

Are there any sounds that your child is sensitive to? **YES NO** _____
Does your child prefer quiet? **YES NO** Is you child comfortable in a dimly lit room? **YES NO**
Is your child sensitive to motion and moving? **YES NO** (i.e. dental chair moving or reclining)
Does your child have any specific oral sensitivity? **YES NO** (i.e. gagging, gum sensitivities)
Do certain tastes bother your child? **YES NO**
Is your child more comfortable in a clutter-free environment? **YES NO**
Please provide us with any additional information that may help us to prepare for a successful dental experience:
_____
_____

ORAL CARE

Has your child visited the dentist before? **YES NO** How was it? _____
Does your child use a powered toothbrush? **YES NO** Manual toothbrush? **YES NO**
Does your child floss? **YES NO**
Does your child brush independently? **YES NO** who helps your child? _____
What are your dental health goals? _____
How often does your child snack during the day? **YES NO** What types of snacks? _____