Welcome

① About Your Child

Today's Date: _____/_____/_____

Child's Name:

_____

Last First MI

Child's Nickname: _____ O Boy O Girl

Child's Social Security # _____

Child's Birth Date: _____/_____/_____ Age_____

School: _____Grade: _____

Child's Home Phone #: (____)_____

Child's Address: _____

_____

City State Zip

Referred By:_____

② Child's Family Information

Who is accompanying this child today?

_____

Full Name (If Other than Parent) Relation to Child

Mother's Name:_____

OStepmother O Guardian

_____

Home Address/City/State/Zip

(____)_____(___)_____

Home Phone # Work Phone #

_____

Mother's SS # Date of Birth Driver's License #

_____

Employer's Name _____

****

Father's Name:_____

O Stepfather O Guardian

_____

Home Address/City/State/Zip

_____

Father's SS# Date of Birth Driver's License #

_____

Employer's Name

Jasper Pediatric Dentistry LLC

Infants, Children, Teenagers, Special Needs
Diplomate of American Board of Pediatric Dentistry

1400 Hwy. 78 West • Suite 300
Jasper, Alabama 35501

Phone: (205) 384-9104
Fax: (205) 384-9102

③ Insurance Information

Primary Dental Insurance

Co. Name: _____

Insured's SS#: _____

Insured's Name: _____

Relation: _____ Date of Birth: _____

Insured's Employer: _____

Secondary Dental Insurance

Co. Name: _____

Insured's SS#: _____

Insured's Name: _____

Relation: _____ Date of Birth: _____

Insured's Employer: _____

④ Permanent Account Information

Permanent Contact Telephone # _____

)Method of Payment: (Copy of Insurance Card Required

Private Insurance _____

Medicaid # _____

Self Payment _____

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

Initials _____

⑤ Child's Dental Information

Why did you bring the child to the dentist today?

_____

_____

Previous Dentist: _____

_____

City State

_____

⑥ Child's Medical Information

Please list all drugs that the child is currently taking_____

_____

Is child allergic to any medications or materials?

_____

_____

Please describe the child's current physical health:

○ Good ○ Fair ○ Poor

Child's Primary Physician:

_____

Approximate Date of Last Medical Exam: _____

⑥

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform any necessary services needed during diagnosis and treatment.

THE PARENT OR GUARDIAN WHO ACCOMPANIES THE CHILD IS RESPONSIBLE FOR PAYMENT AT THE TIME OF SERVICE.

I HAVE RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES.

_____

Signature of Parent or Guardian Date

⑦ Child's Medical History

Does child have or ever had any of the following diseases, medical conditions or procedures?

Y	N	Heart Murmur
Y	N	Requires Antibiotic Pre-med
Y	N	Rheumatic Fever
Y	N	Artificial Heart Valves
Y	N	Congenital Heart Defect
Y	N	Scarlet Fever
Y	N	Surgeries/Operations
Y	N	Cancer/Tumors
Y	N	Chemotherapy
Y	N	Hearing Problems
Y	N	Asthma/Difficulty Breathing
Y	N	Leukemia/Anemia
Y	N	Diabetes/Hypoglycemia
Y	N	Hemophilia
Y	N	Abnormal Bleeding
Y	N	Cleft Lip/Palate
Y	N	High/Low Blood Pressure
Y	N	Hepatitis
Y	N	Artificial Bones/Joints/Implants
Y	N	Liver/Kidney/Organ Problems
Y	N	HIV+/AIDS/ARC
Y	N	Tuberculosis TB
Y	N	Psychiatric Problems
Y	N	Hyper Active/ADD
Y	N	Fainting/Seizures/Epilepsy
Y	N	Cerebral Palsy

Please list any other medical condition(s) child has or ever had: _____

Office Use Only

I have reviewed the medical/dental information with the parent/guardian and patient named herein _____

Initials Date

Medical History Update

_____

Initials Date Comments

_____

Initials Date Comments

Jasper Pediatric Dentistry, L.L.C.

Infants, Children, Teenagers, Handicapped

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Jasper, Alabama 35501
Phone: (205) 384-9104
Fax: (205) 384-9102

Our office is committed to your child's dental treatment. Please understand that payment of your bill is considered part of the treatment. We make every effort to keep down the cost of your child's dental care. You can help by following our office guidelines. We ask that you read and sign this agreement prior to treatment.

PAYMENTS

- We accept cash, checks, VISA and Mastercard
- Full payment is due at time of service
- Insurance deductibles and co-payments are due in full at time of service
- Payment arrangements may be offered prior to treatment

Because of the difficulty of third party billing, in the event of divorce or separation, the parent who brings the child in for his/her care will be financially responsible for treatment costs.

INSURANCE INFORMATION

As a courtesy to our patients, we accept assignment on most dental insurances. We would need all of your insurance information prior to the visit. We will verify coverage and inform you of the estimated balance due. In the event we cannot get this detailed information, we would require payment in full and a statement of actual services will be provided to you so that you can be directly reimbursed by your insurance carrier. If your carrier has not made payment in 60 days, your outstanding insurance balance will be your responsibility.

Due to the many different insurance policies and frequent changes in coverage, it is impossible for us to know them all. Please familiarize yourself with your dental coverage. We recommend that you contact your insurance carrier to understand your benefits. Please know your insurance policy is contract between you and the carrier. We are not a party to that contract, therefore it is important for you to be involved to help assure timely payments on your account.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best dental care for your child. We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Our fees are based on the treatment selected, the time needed to provide your child with necessary dental care and the overhead involved in our practice.

MISSED APPOINTMENTS

Charges will not be made for broken appointments and canceled appointments with a 24 hour notice. We do reserve the right to terminate our professional relationships if you fail to keep two appointments. Please help us serve your better by keeping your scheduled appointments.

FINANCIAL

Any expense incurred for returned checks, legal fees and collection agency fees will become your responsibility and will be added to your account balance.

We know questions can arise on billing matters. We encourage you to discuss any financial concerns that you may have so that we may assist you in the effective management of your account.

I authorize you to release information acquired in the course of treatment and examination for insurance requirements or dental care purposes. I understand I will be responsible for any charges not paid by insurance company. In the event of default, I agree to pay all costs of collection including but not limited to reasonable attorney fees and cost. I waive exemption rights under the state of Alabama. I authorize verification of employment or insurance benefits to you or your agents.

I have read, understand and agree to the financial policy described above.

Signature_____ Date_____

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1400 Hwy. 78 West • Suite 300
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TO OUR NEW PATIENT

If you have any records at another dental office (mainly x-rays) you will need to bring them. Your previous dentist may make a copy for you to bring. Also, please bring your insurance card.

A NOTE TO PARENTS:

As with most offices that specialize in dentistry for kids, we will ask that you remain in the reception area if your child has reached school age. We must develop a trusting relationship with you and your child in order to deliver the best care possible. Frequently this relationship is not achieved if the child's focus is on the parent rather than on the dental experience. More times than not, when the parent is out of sight, the child will become engrossed in all the activity and visual stimulation and, before they know it, they are done and on their way home.

If your child is pre-school age, we will allow one parent to accompany the child on the initial visit. After the first visit, you should send them back on their own. This gives them a great sense of accomplishment and independence.

Once your child's visit is complete, the doctor or helper will go over all findings and recommendations with you and answer any questions that you might have.

Please do your part in preparing your child for visits. Be relaxed and at ease. Any anxiety on your part will be sensed by your child. We have developed a vocabulary that will fully explain our procedures without using words that are frightening, such as "shot", "drill", or "hurt". We will help you with wording that is appropriate. We hope dentistry will always be seen as positive to your child.

JASPER PEDIATRIC DENTISTRY, LLC.
1400 Hwy. 78 West ◆ Suite 300
Jasper, Alabama 35501

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your 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 April 14, 2003 and will remain in effect until April 14, _____.
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 using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare 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: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an 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 health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or location) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your 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 your professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your 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 health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your 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 authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your 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 practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you a $5.00 fee plus $1.00 per page and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost=based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us by using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your 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).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make this 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.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your requests under certain circumstances.

QUESTIONS AND COMPLAINTS

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 privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complains 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.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U. S. Department of Health and Human Services.

Privacy Contact Officer: **Rhonda Scott**
Jasper Pediatric Dentistry, LLC.
1400 Hwy 78 West Suite 300
Jasper, AL. 35501

Phone No. 205-384-9104 Fax No. 205-384-9102