

WELCOME TO THE PROVINCES DENTAL CARE

Child's Name _____ Child's Birth Date _____ Child's Sex _____
 With whom does this child live?
 ___ Mother ___ Stepmother ___ Legal Guardian ___ Father ___ Stepfather ___ Legal Guardian
 Name _____ Name _____
 Home Phone _____ Home Phone _____
 Work Phone _____ Work Phone _____
 Cell Phone _____ Cell Phone _____
 The best number for daytime Home Work Cell
 Occupation _____ Occupation _____

How did you hear of our office?

Financially Responsible Party:

Name _____ Relationship to child _____
 Social Security # _____ Birth Date _____ Employer _____
 Address _____ City _____ State _____ Zip _____
 Home Phone _____ Work Phone _____ Cell Phone _____

Primary Dental Insurance

Insured's Name _____
 Relationship to Patient _____
 Insured's Birthdate _____
 Social Security # _____
 Insurance ID# (If different from SS#) _____
 Claim Address _____
 Insurance Phone # _____
 Group # _____

Secondary Dental Insurance, if applicable

Insured's Name _____
 Relationship to Patient _____
 Insured's Birthdate _____
 Insured's SS# _____
 Insurance ID# (If different from SS#) _____
 Claim Address _____
 Insurance Phone # _____
 Group # _____

DENTAL HISTORY

REASON FOR TODAY'S VISIT _____	___ CIGARETTE, PIPE, OR CIGAR SMOKING _____	___ ORTHODONTIC TREATMENT _____
FORMER DENTIST _____	___ CLICKING OR POPPING IN JAW _____	___ PAIN AROUND EAR _____
CITY/STATE _____	___ DRY MOUTH _____	___ PERIODONTAL TREATMENT _____
DATE OF LAST DENTAL CARE _____	___ FINGERNAIL BITING _____	___ SENSITIVITY TO COLD _____
DATE OF LAST DENTAL XRAY'S _____	___ FOOD COLLECTION BETWEEN TEETH _____	___ SENSITIVITY TO HEAT _____
PLEASE INDICATE IF CHILD HAS OR HAS HAD ANY OF THE FOLLOWING:	___ FOREIGN OBJECTS _____	___ SENSITIVITY TO SWEETS _____
___ BAD BREATH _____	___ GRINDING TEETH _____	___ SENSITIVITY WHEN BITING _____
___ BLEEDING GUMS _____	___ GUMS SWOLLEN OR TENDER _____	___ SORES OR GROWTHS IN MOUTH _____
___ BLISTERS ON LIPS OR MOUTH _____	___ JAW PAIN OR TIREDNESS _____	HOW OFTEN DOES HE/SHE BRUSH? _____
___ BURNING SENSATION ON TONGUE _____	___ LIP OR CHEEK BITING _____	HOW OFTEN DOES HE/SHE FLOSS? _____
___ CHEW ON ONE SIDE OF THE MOUTH _____	___ LOOSE TEETH OR BROKEN FILLINGS _____	
	___ MOUTH BREATHING _____	
	___ MOUTH PAIN WITH BRUSHING _____	

WHAT WOULD YOU CHANGE ABOUT YOUR CHILD'S TEETH? _____
 I understand that providing incorrect or incomplete information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. To the best of my knowledge, I have provided The Provinces Dental Care with accurate and complete health and dental information. I authorize the dental staff to perform the necessary dental services my child may need.

Parent or Guardian Signature _____ Parent or Guardian's Printed Name _____ Date _____

THE PROVINCES DENTAL CARE

Child _____ Child's Birth Date _____ Child's Sex _____

HEALTH HISTORY

Place a mark to indicate if your child has, or has had in the past, any of the following:

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> CONGENITAL HEART LESIONS | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> SHORTNESS OF BREATH |
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> CORTISONE TREATMENTS | <input type="checkbox"/> JAUNDICE | <input type="checkbox"/> SINUS TROUBLE |
| <input type="checkbox"/> ARTHRITIS, RHEUMATISM | <input type="checkbox"/> COUGH, PERSISTENT | <input type="checkbox"/> JAW PAIN | <input type="checkbox"/> SKIN RASH |
| <input type="checkbox"/> ARTIFICIAL HEART VALVE | <input type="checkbox"/> DIABETES | <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> SPECIAL DIETARY NEEDS |
| <input type="checkbox"/> ARTIFICIAL JOINTS | <input type="checkbox"/> EMPHYSEMA | <input type="checkbox"/> LIVER DISEASE | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> EPILEPSY | <input type="checkbox"/> LOW BLOOD PRESSURE | <input type="checkbox"/> SWOLLEN FEET OR ANKLES |
| <input type="checkbox"/> BACK PROBLEMS | <input type="checkbox"/> FAINTING OR DIZZINESS | <input type="checkbox"/> MITRAL VALVE PROLAPSE | <input type="checkbox"/> SWOLLEN NECK GLANDS |
| <input type="checkbox"/> BLEEDING ABNORMALLY, W/ SURGERY, EXTRACTIONS | <input type="checkbox"/> GLAUCOMA | <input type="checkbox"/> NERVOUS PROBLEMS | <input type="checkbox"/> THYROID PROBLEMS |
| <input type="checkbox"/> BLOOD DISEASE | <input type="checkbox"/> HEADACHES | <input type="checkbox"/> PACEMAKER | <input type="checkbox"/> TONSILLITIS |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> HEART MURMUR | <input type="checkbox"/> PSYCHIATRIC CARE | <input type="checkbox"/> TUBERCULOSIS |
| <input type="checkbox"/> CHEMICAL DEPENDANCY | <input type="checkbox"/> HEART PROBLEMS | <input type="checkbox"/> RADIATION TREATMENT | <input type="checkbox"/> TUMOR OR GROWTH ON HEAD OR NECK |
| <input type="checkbox"/> CHEMOTHERAPY | <input type="checkbox"/> HEPATITIS TYPE ____ | <input type="checkbox"/> RESPIRATORY DISEASE | <input type="checkbox"/> ULCKER |
| <input type="checkbox"/> CIRCULATORY PROBLEMS | <input type="checkbox"/> HERPES | <input type="checkbox"/> RHEUMATIC FEVER | <input type="checkbox"/> VENEREAL DISEASE |
| | | <input type="checkbox"/> SCARLET FEVER | |

Does he/she smoke? YES NO
 If Yes: What, and how much?

Females:
 Is she pregnant? YES NO
 Is she nursing? YES NO
 Is she taking birth control? YES NO

Medications	Allergies		
List any medications you child currently takes, and why your child takes it:	For your health and safety, please mark any known drug or material allergies:		
	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Iodine	<input type="checkbox"/> Penicillin
	<input type="checkbox"/> Barbituates	<input type="checkbox"/> Latex	<input type="checkbox"/> Sulfa
Pharmacy Name	<input type="checkbox"/> Codeine	<input type="checkbox"/> Local Anesthetics	
Pharmacy Phone Number	Other (list):		

Physician's Name _____ Date of Last Medical Visit _____

Previous hospitalizations, serious illnesses, operations, or anything you would like for us to know about your child & their medical or dental health :

THE PROVINCES DENTAL CARE FINANCIAL POLICY

PLEASE READ & INITIAL EACH PARAGRAPH

We appreciate your selection of this office to serve your dental needs. Our interest is to provide our patients with the finest possible, quality dental care. We must attend to the financial aspects of dental treatment as well. Following is an overview of our office financial policy.

___ **Payment.** Payment in full is required at the time of service. For your convenience, we accept cash, debit, and credit cards, including Visa, Master Card, Discover, and American Express. Our office also offers No Interest and Extended Payment Plans, upon approved credit, through Care Credit.

___ **Insurance, if applicable.** Dental Insurance never pays for 100% of all dental services. As a courtesy, in most cases, we will bill one dental insurance for your care, providing you give us the needed information for claim submission.

- ___ At the time of service, we will request from you an initial payment, the estimated portion of the charges which insurance may not cover, including all applicable deductibles and co-pays.
- ___ Payment from the insurance company is expected within thirty (30) days. If your insurance company has not responded within thirty days from the date of service, the entire balance in full is your immediate responsibility. The account will then be considered aged 30 days.
- ___ Questions and concerns with your dental coverage and the payment of your claim(s) are the sole responsibility of the insured, and is your responsibility to resolve with the insured's employer and/or dental insurance company. Your coverage is a result of the contract between the insured's employer and the dental insurance company, and our office has no control over payment or non-payment of your claims.
- ___ As your dental care provider, we advise treatment that is in the best interest of your medical and dental health. Insurance companies select the dental procedures that they will and will not cover without regard to your personal situation, health, and dental needs.
- ___ It is the sole responsibility of you, the patient, to familiarize yourself with the rules, terms, exclusions, clauses, and benefit limitations of your dental insurance policy.

___ **Estimates.** Before treatment, we will perform a diagnosis and provide you with an estimate of the charges involved. As treatment progresses, it is possible that additional circumstances not apparent at the initial exam, may be encountered. In this event, we will discuss options with you and proceed upon your approval.

___ **Aged Account.** All charges are your responsibility, due at time of service. Failure to keep this account current may result in The Provinces Dental Care being unable to provide additional dental services. Default occurs after 30 days, and payment is due in full. I understand that Provinces Dental does not accept "payments" on balances due for services already received. In the event of a default, I agree that any information collected can be used to collect on my account, and I agree to pay all costs incurred in the attempt to collect on this account, up to and including, but not limited to, late fees, finance charges, collection agency fees, attorney's fees and court costs.

___ **Copyright** Any comment posted online in any way relating to The Provinces Dental or any Provinces Doctor or Employee, will be the sole right and property of The Provinces Dental, P.C., and the copyright of the content of the comment, rating, or review is hereby assigned to The Provinces Dental, P.C. to utilize or eliminate at our discretion, and/or in order to protect any patient's or employee's anonymity and privacy.

___ **Appointments.** If unable to keep a scheduled appointment, we ask that you provide us with 48 hours notice as a courtesy. **Notice of less than 48 hours will result in a minimum charge of \$50.00, the amount to vary depending on the magnitude of the failed appointment.**

___ **Assignment of Benefit.** I agree to be responsible for all charges for dental services and materials. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with my dental claims. I hereby authorize Assignment of Benefit to The Provinces Dental Care.

I have read, understand, and agree to the above.

Signature of Person Responsible for Account

Printed Name of Person Responsible for Account

Date

THE PROVINCES DENTAL CARE

Notice of Privacy Practices

Dear Patient,

This is not meant to alarm you! Quite the opposite! It is our desire to communicate to you that we take the new federal (**HIPAA – Health Insurance Portability and Accountability Act**) laws written to protect the confidentiality of your health information seriously. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside our office. **What has changed? Why a policy now? Very good questions!**

The most significant variable that has motivated the federal government to implement HIPAA is the rapid evolution of computer technology and its uses in the healthcare community. **The government seeks to standardize the protection of your PHI – how your Personal Health Information is transmitted.** This challenges us to take a good look at how your information is used in our office, not only in our computers, but with the phone, fax, copy machines, and charts. This has been an important exercise for us because it has disciplined us to put into writing a policy and procedure to ensure the protection of your health information.

We want you to know about these policies and procedures which we developed to make sure your PHI will not be shared with anyone who does not require it. Our office is subject to state and federal law regarding the confidentiality of your health information and in keeping with these laws, **we want you to understand our procedures, and your rights as our valuable patient.**

Our promise to you: We will use and communicate your PHI only for the purpose of providing your treatment, obtaining payment, and conducting dental care operations. Your PHI will never be used for any other purpose unless we have asked for and gotten your permission.

How your Health Information may be used...

...To Provide Treatment

We will use your PHI inside our office to provide you with the best dental care possible! This may include office and clerical procedures used to streamline coordination between the Doctor, his Assistants, Hygienists, and business office staff. In addition, your treatment may require us to share your PHI with other entities such as referring Doctors, Clinical Laboratories, or your pharmacy.

...To Obtain Payment

We may include your PHI with paperwork sent to collect payment for the services you receive in our office, such as with insurance forms sent either through the mail or electronically. We will be sure to only work with companies with a similar commitment to the protection of your PHI.

...To Conduct Dental Care Operations

Your PHI may be used during performance reviews or training of our staff. It is possible your PHI would be disclosed during audits by insurance companies or government agencies as a part of their quality assurance or compliance reviews. Your PHI may be reviewed in the process of certification, licensing, or credentialing.

...In Patient Reminders

Because we believe regular care is very important to your dental health, we will remind you of an appointment you've scheduled or that it is time to contact us and make an appointment. Additionally, we may contact you to follow up on your treatment or to inform you of treatment options that may be available for you or your family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best possible preventative, restorative, and cosmetic treatment modern dentistry can provide. This may include postcards, folding postcards, letters, voicemail messages, and electronic reminders such as e-mail (unless you tell us that you do not want to receive these reminders).

...Abuse or Neglect

We will notify the proper government agency if we believe a patient is the victim of abuse, neglect, or domestic violence. We will make this disclosure only

when we are compelled by our ethical judgment, when we are specifically required or authorized by law or with the patient's agreement.

...Public Health or National Security

We may be required to disclose PHI to federal officials or military authorities when it is necessary to complete an investigation related to public health or national security.

...For Law Enforcement

We may be required to disclose PHI to a law enforcement official for law enforcement purposes. An example would be if you are a victim of a crime or in order to report a crime.

...Family, Friends, and Caregivers

With your permission, we may share your PHI with those you tell us will be helping you with your home hygiene, treatment, medication, or payment. If there is an emergency, and you are unable to tell us what you want, we will use our very best judgment in sharing your PHI, and only when it will be important to those participating in providing your care.

...To Coroners, Funeral Directors, and Medical Examiners

We may be required by law to provide PHI to coroners, funeral directors, or medical examiners in order to determine a cause of death or prepare for a funeral.

...Research

Advances in dental knowledge often involve learning from the careful study of the dental histories of prior patients. Formal review of dental histories as a part of a research study will happen only under the ethical guidance of an Institutional Review Board.

Your Rights as a Patient

This new law is careful to describe that you have the following rights related to your PHI:

...Restrictions

You have the right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

...Confidential Communications

You have the right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

...Inspect and Copy

You have the right to inspect and copy your PHI.

...Amend

You have the right to amend your PHI.

...Disclosures

You have the right to receive an accounting of disclosures of PHI.

...Paper Copy

You have the right to obtain a paper copy of this notice from us upon request.

Privacy Practices Acknowledgement

I have received the Notice of Privacy Practices and I have been provided with an opportunity to review it.

Print Patient Name

Signature of Patient or Responsible Party

Birth Date

Today's Date

Office Staff Only:

Written acknowledgement could not be documented due to

Patient refused to sign

Personal representative not able to sign

Language, communication, or effects of disability impeded acknowledgement

Emergency care impeded acknowledgement

Other, please specify _____

