Little Peaches Pediatric Dentistry

Patient Information

Date:_________________

Child's name:_______________________________________ Nick Name:________________________

Date of Birth:_____________________ Grade:____________________ Sex(circle): Male / Female

School:____

Home Address:____
Street City, State Zip Code

Dental Insurance: _________________________________ Policy Holder: ________________________

Name(s)/Age(s) of Siblings:____________________________ ________________________________

_______________________ __________________________ ________________________________

Who has legal custody of the patient(circle)? Mother / Father / Guardian / Other_________________

Mother's Name: ____Date of Birth: __________________

Social Security #: _________________________Employer:_____________________________________

Home Address:____
Street City, State Zip Code

Cell Phone: _______________________________ Home Phone:________________________________

Email: ____

Father's Name: ____Date of Birth: __________________

Social Security #: _________________________Employer:_____________________________________

Home Address:____
Street City, State Zip Code

Cell Phone: _______________________________ Home Phone:________________________________

Email: ____

How would you like to be contacted for appointment reminders? Phone / Text / Email / Mail
Circle

How did you hear about Little Peaches Pediatric Dentistry? ____________________________________

Who should we notify in case of an emergency? _________________________Phone_______________

What is the reason for your child's dental visit today? ____

Health History

Name of child's physician: ____

Physician's phone number: ___________________________________

If yes, please explain or list.

Question	YES / NO	
Is your child in good health?	YES / NO	______________
Has your child ever had a health problem?	YES / NO	______________
Hospitalizations or surgeries? Reason and dates.	YES / NO	______________
Any problems with severe or prolonged bleeding?	YES / NO	______________
Allergic to penicillin, antibiotics, or other drugs?	YES / NO	______________
Allergic or sensitive to latex or metals?	YES / NO	______________
Any allergies?	YES / NO	______________
Currently taking any medications? Please list.	YES / NO	______________
Were there any problems at birth?	YES / NO	______________

Please check if your child has been treated for any of the following:

__AIDS / HIV	__Cancer / tumors	__Frequent Infections	__Recurrent Headaches
__Anemia	__Cerebral Palsy	__Heart Problems	__Rheumatic Fever
__Asthma	__Cleft Lip / Palate	__Hepatitis	__Seizures / Epilepsy
__Autism	__Birth Defects	__Kidney Disease	__Speech/ Hearing Problems
__Behavior/Learning problems	__Diabetes	__Liver / GI Disease	__Thyroid Disease
__Bladder Difficulties	__Down Syndrome	__Mental Delays	__Tuberculosis
__Bleeding / Transfusions	__Eye Problems	__Social Disorders	__Other Problems
__Blood Dyscrasia	__Fainting	__Physical delays	

Please elaborate on any checked tems:____

Do you consider your child to be:

Advanced in the learning process_____ Progressing normally _____ Slow in the learning process_____

Dental History

When does your child brush his/her teeth?

Upon rising_____ After eating any food__ Right after meals_____ Before going to bed_____

Has your child ever had a dental visit? Yes / No

Name of dentist and date ____

Has your child experienced any unfavorable reaction from previous dental care? Yes / No

If yes, please explain. ____

Yes / No Does your child suck a finger, thumb, or pacifier?

Yes / No Does your child have pain with chewing, yawning, or wide opening?

Yes / No Does your child's jaw make noise and is there pain associated with the sounds?

Yes / No Have there been any injuries to teeth, such as falls, blows, chips, etc.?

Please check if your child is having problems with any of the following:

____Cavities ____Toothache ____Teeth Sensitivity ____Trauma ____ Gum Infections

____Orthodontics ____Color of Teeth ____ Jaw sounds ____Other

Comments:____

Does your child primarily drink:

Tap Water_____ Bottled Water_____ Fluoridated Bottled Water_____ Refrigerator Water_____

Yes / No Do you have a reverse osmosis water filtration system?

Yes / No Does your child use toothpaste with fluoride?

Yes / No Do you give your child any other form of fluoride? If so, what ____________________________________

Consent for Dental Treatment

I request and authorize Dr. Charisse Caswell to examine, clean, and provide dental treatment on my child's teeth. I further request and authorize the taking of dental x-rays as it may be considered necessary by Dr. Caswell to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or child's teeth for diagnostic, educational, or marketing purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr. Caswell will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone. I will be responsible for any charges incurred on this child for dental treatment.

Parent/Guardian Signature ____ Date _______________

Financial Policy

Thank you for choosing Little Peaches Pediatric Dentistry as your child's oral healthcare provider. We are committed to the successful treatment of your child. The following is the statement of our financial policy that we require that you read and sign prior to treatment. Please understand that this financial policy is enforced to keep costs at a reasonable level, thus preventing frequent fee increases. We hope that you communicate with us to avoid additional fees. This also allows us to concentrate on what we do best, *caring for your child*.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE

We accept cash, checks, or most major credit cards.

Insurance: We may accept assignment of primary insurance benefits; however, we do require deductibles and co-payments be paid at the time of service. The balance is your responsibility. Your insurance policy is a contract between you and your insurance company; we are not a party to that contract nor are we responsible for procedures that are not covered for any reason. We must have complete and up to date insurance information in order to bill your insurance company on your behalf. In the event that your insurance company has not paid their portion within 60 days, the balance will become your responsibility.

______Initials

Finance Charges:
A monthly late fee of $10 will be billed to any account in which the balance remains unpaid for 60 days without payment arrangements.

> Unpaid accounts: Accounts 90 days past due may be sent to a collection agency or settled in small claims court. In these events, you will be responsible for a $100 collection fee and/or any court fees.

______Initials

Missed Appointments: Unless canceled at least 24 hours in advance, our policy is to charge $25 for missed appointments. Please help us to serve you more efficiently by keeping scheduled appointments.

______Initials

Returned Checks: If a check is returned with insufficient funds, there will be a $50 charge. From that point on checks will no longer be accepted.

______Initials

I, the undersigned, assume financial responsibility as stated above and responsibility for all collection and legal fees if my account becomes past due. I have read, understand, and agree to this Financial Policy.

X____ Date_________________________
Signature of Responsible Party

____
Print Name

____
Patient Name

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 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.

For more information about our privacy practices, or to request a copy of our Notice, please contact us using the information listed on this website.

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 section 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 locating) 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 our 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, 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. We may charge you a reasonable cost-based fee for expenses such as copies and staff time. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format.

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, 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 your 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 request under certain circumstances.*

Electronic Notice: If you receive this Notice on our website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

Charisse Caswell, DMD
Little Peaches Pediatric Dentistry

Acknowledgement of Review of Privacy Practices

I, ________________________________, have reviewed a copy of this offices Notice of Privacy Practices.

____
Guardian's Signature

____
Guardian name (Print)

____
Patient's Name

____
Date

APPOINTMENT POLICY

Appointments scheduled by you are specifically reserved for your child. This reserved time allows us to provide excellent dental treatment to your child in a timely manner. Our office staff makes phone calls well in advance to remind you of this reserved appointment. As a courtesy to other patients we have always required at least a 24 hour notice to change an appointment. This allows us to fill your reserved time with another patient who is in need of dental treatment. For appointments not kept or cancelled in less than 24 hours a fee of $25 will be imposed. We regret being so firm with our policy, however due to the inconvenience and disruption to our other patients who are in need of dental care we feel compelled to remind you of this policy. Thank you for your understanding.

Parent/Guardian Signature____________________________________ Date________________