PEDIATRIC DENTAL CARE
OF YUKON

PATIENT REGISTRATION FORM

TELL US ABOUT YOUR CHILD

Child's Name: _____ (Last) _____ (First) ____ (Mi) _____ (Preferred Name)

Gender: ◯ Male ◯ Female Child's Birth Date: _____ Child's Age: _____

School: _____ Grade: _____

Child's Home Phone: _____ Social Security #: _____

Child's Home Address: _____

_____ (City) _____ (State) _____ (Zip Code)

WHO IS ACCOMPANYING THE CHILD TODAY?

Name: _____ Relationship: _____ Do you have legal custody of the child? _____

In case of emergency, contact (Name & Phone #): _____

Whom may we thank for this referral?: _____

PERSON RESPONSIBLE FOR THE ACCOUNT

Mother's Information

Name: _____ DOB: _____

Address: _____

Phone Number: _____ (Home) _____ (Cell)

Drivers License: _____ State: _____

Occupation: _____

Employed by: _____

Business Phone Number: _____

Father's Information

Name: _____ DOB: _____

Address: _____

Phone number: _____ (Home) _____ (Cell)

Drivers License: _____ State: _____

Occupation: _____

Employed by: _____

Business Phone Number: _____

DENTAL INSURANCE COMPANY

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone: _____ Group # (Plan or Policy): _____

Insured's Birthdate: _____ Social Security #: _____ Insured's Employer: _____

AUTHORIZATION

◯ I certify the truth of all information given. I also authorize the release of pertinent information to those persons requiring it for the treatment of my child or for the purpose of payment of the account or credit reference. Under certain circumstances, I authorize payment of insurance benefits directly to Dr. Brackett, otherwise payable to me. I understand that my dental insurance carrier may pay less that the actual bill for services. I understand I am financially responsible for payment of services not paid, in whole or in part, by my dental care payer.

Signature of Parent/Guardian: _____ **Date:** _____

PEDIATRIC DENTAL CARE
OF YUKON

MEDICAL & DENTAL HISTORY FORM

MEDICAL HISTORY

Patient Name: _____ (Last) _____ (First) _____ (Mi) Date: _____

Is your child under the care of a physician? ◯ Yes ◯ No If yes, since when and why?: _____

_____ Name of physician: _____

Is your child receiving any medication? ◯ Yes ◯ No

List current medications: _____

Is your child allergic to any drugs, such as penicillin? ◯ Yes ◯ No Does your child have other allergies? ◯ Yes ◯ No

Has your child had any serious illness? ◯ Yes ◯ No Has your child ever had surgery or been hospitalized? ◯ Yes ◯ No

Has your child had a history of any of the following?:

- ◯ Heart Trouble, Murmur, or Surgery
- ◯ Rheumatic Fever or Scarlet Fever
- ◯ Asthma, TB or Lung Problems
- ◯ HIV Infection or AIDS
- ◯ Hemophilia or Bleeding Problems
- ◯ Sickle Cell Anemia/Blood Disorder
- ◯ Hepatitis or Liver Problems
- ◯ Kidney Infections
- ◯ Diabetes
- ◯ Cancer, Tumor, Leukemia
- ◯ Thyroid or Other Glandular Problems
- ◯ Latex or Rubber Allergy
- ◯ Epilepsy, Seizures, or Fainting
- ◯ Cerebral Palsy or Development Delay
- ◯ Vision Problems
- ◯ Speech or Hearing Problems
- ◯ Emotional or Psychological Problems
- ◯ Congenital Birth Defects
- ◯ Cleft Lip or Palate
- ◯ Malignant Hyperthermia
- ◯ Other Medical Condition
- ◯ Is Parent or Patient Pregnant

For Office Use Only:

PEDIATRIC DENTAL CARE
OF YUKON

MEDICAL & DENTAL HISTORY FORM

DENTAL HISTORY

When and where was your child's last dental visit? _____

What was the purpose of the visit? _____

_____ Where any x-rays taken at your child's last dental visit? ◯ Yes ◯ No

Did your child have difficulty cooperating? ◯ Yes ◯ No Was/is your child bottle-fed? ◯ Yes ◯ No

Was/is your child breast-fed? ◯ Yes ◯ No If your child has been weaned please indicate at what age: _____

When does your child brush his/her teeth? ◯ Rising ◯ After Eating any Food ◯ Right after Meals ◯ Before Going to Bed

Do you assist/supervise your child's brushing? ◯ Yes ◯ No Does your child take fluoride supplements? ◯ Yes ◯ No

Have any cavities been noted in the past? ◯ Yes ◯ No Were any teeth (baby or permanent) removed by extraction? ◯ Yes ◯ No

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

Has anyone in the family, including parents, had orthodontics? ◯ Yes ◯ No

Has your child had a toothache recently? ◯ Yes ◯ No If yes, please explain: _____

_____

Do you expect your child to be cooperative? ◯ Yes ◯ No Does your child have other siblings seen by us? ◯ Yes ◯ No

Purpose of today's visit: _____

◯ I understand that the information I gave is correct and to the best of my knowledge, and that it will be held in the strictest of confidence. Because my child is a minor, it is necessary that signed permission be obtained from a parent or legal guardian before any dental services can be rendered. I give my consent to Dr. Brackett and his staff to perform such treatment, services, medication, behavior management techniques, local anesthesia and/or analgesia necessary to treat any dental/oral deficiency, abnormality, and/or infection.

Signature of Parent/Guardian: _____ **Date:** _____

PEDIATRIC DENTAL CARE
OF YUKON

HIPPA 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 IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted and required by law. It also describes your rights 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.

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, or your child, to pay your health care bill, to support the operation of the physician's practice, and any other use required by law.

Treatment

We will use and disclose your/your child's 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 surgery may require that you 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: Coroners, 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 only 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 you physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

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

PEDIATRIC DENTAL CARE
OF YUKON

HIPPA NOTICE OF PRIVACY PRACTICES

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 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 your 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 to our HIPPA Compliance Officer in person or by phone at 405-354-4545.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Patient Name: _____

Signature of Parent/Guardian: _____ **Date:** _____

PEDIATRIC DENTAL CARE
OF YUKON

OFFICE FINANCIAL POLICY

We appreciate you allowing us to provide dental care for your child. Because we value our relationship with you and believe the best relationships are based on understanding, we offer these clarifications of methods of payment for services.

Payment in full by cash, check, or credit card at each appointment as service is rendered is required. For you convenience, Visa, Mastercard, and Discover are accepted.

We will be happy to file your insurance claim on the first visit if we have received all of your insurance information. You will need to be prepared to pay any amount that is determined not payable by your insurance plan, such as deductibles and percentages.

The parent or guardian who accompanies the child is responsible for payment at the time of service. This includes divorce situations.

To ensure prompt and efficient patient care, we require 24 hours notice to reschedule or cancel appointments. A $25.00 reactivation fee may be assessed in order to reschedule if 24 hours is not given.

We are dedicated to providing the best treatment for our patients and our fees are based on the most appropriate treatment for your child. Please not the following:

1. We must emphasize that as healthcare providers, our relationship is with you, not your insurance company. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.

2. The amount not covered by your insurance is payable at the time of service, such as deductibles and co-payments. However, if we do not receive payment from the company within 60 days after the submission of a claim, you will be expected to pay for all dental services in full within 10 days of notification. In the event of duplicate payment, you will be reimbursed.

3. You are responsible for payment regardless of any of any insurance company's arbitrary determination of fees. Please be aware that some services provided may be non-covered services and not considered reasonable and necessary under your dental insurance.

4. A charge of $25.00 will be assessed on any returned checks and a charge of 2% of any unpaid balances will be added monthly.

5. Should your account be turned over for collection, you will be responsible for all cost of collection, without limitation, attorney's fee and court cost. Your child will no longer be seen in our office.

We will do our best to maximize the insurance benefits that you are eligible to receive and we do appreciate your prompt settlement of any charges that may be incurred during treatment. We look forward o years of close association with you as we work together to maintain your child's oral health.

◯ I have read and understand the Office Financial Policy and agree to abide by its contents.

Signature of Parent/Guardian: _____ **Date:** _____