Dentists 4 Children LLC

Patient Information

Dr. Richard K. Vann, Dr. Heather Thornton, Dr. James M. Jenkins

Registration & History

Child's Name _____ Nickname _____

☐ Male ☐ Female Age _____ Birth Date _____

Siblings & Ages _____

Child's Custodial Parent

☐ Both ☐ Father ☐ Mother

Are Mother & Father

☐ Married ☐ Divorced ☐ Other

	Information of Father or Guardian	Information of Mother or Guardian
Name		
Address		
City, State, Zip		
Phone #	Home	Home
	Work	Work
	Cell	Cell
E-mail Address		
Social Security		
Driver's License		
Date of Birth		
Employer		
Dental Insurance		

Insurance Additional Information (not listed above) _____

Nearest Relative _____ Relative Phone _____

Referred By _____

Child's favorite Sport _____ Toy _____ Hobby _____ Character _____

Regardless of insurance carrier or divorce decree, we will assign responsibility to the parent bringing the child to our office. If needed, we will gladly supply you with receipts or itemized statements so that you may be reimbursed by the other party.

Dental History

Name of previous dentist _____ Location _____

Date of last visit to a dentist _____ For what service? _____

1) Has child complained about dental problems? ☐ Yes ☐ No

List _____

2) Any unhappy dental experiences? ☐ Yes ☐ No

List _____

3) Any injuries to mouth, teeth or head? ☐ Yes ☐ No

List _____

4) Any past or present mouth habits? ☐ Yes ☐ No

Biting, mouth breathing, nursing bottle habits, pacifier,etc _____

5) Any unusual speech habits? ☐ Yes ☐ No

Explain _____

6) Any lost teeth? ☐ Yes ☐ No

List _____

7) Have missing teeth been replaced? ☐ Yes ☐ No

8) Orthodontic treatment now or in the past? ☐ Yes ☐ No

9) Does your child brush teeth daily? ☐ Yes ☐ No

10) Do you assist child with tooth brushing? ☐ Yes ☐ No

How Often? _____

11) Is dental floss used? ☐ Yes ☐ No

How Often? _____

12) Is fluoride taken in any form? ☐ Yes ☐ No

13) Do you desire complete dental service for the child? ☐ Yes ☐ No

14) Child's attitude toward dentistry _____

15) Summary (for doctor's use) _____

Health History

Child's Physician _____ Phone _____

Address _____

Date of last physical exam _____ Results _____

1) Is child under care of a physician now? ☐ Yes ☐ No

Who _____

2) Is child receiving any medication or drugs? ☐ Yes ☐ No

List _____

3) Does child have excessive bleeding when cut? ☐ Yes ☐ No

Explain _____

4) Has child ever been hospitalized? ☐ Yes ☐ No

Why? _____

5) Has child ever had surgery? ☐ Yes ☐ No

Why? _____

6) Does child have allergy to penicillin or other drugs? ☐ Yes ☐ No

List _____

7) Does your child have other allergies? ☐ Yes ☐ No

Food, pollen, animals, dust or other _____

8) Does your child have good physical coordination? ☐ Yes ☐ No

Explain _____

9) Does your child have any emotional problems? ☐ Yes ☐ No

List _____

10) Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information we should be aware of that have not been discussed.

_____

Has child had any history or difficulty with any of the following?

- ☐ Anemia
- ☐ Asthma
- ☐ Autoimmune
- ☐ Diseases (HIV, AIDS, Lupus)
- ☐ Bladder
- ☐ Bleeding
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Chicken Pox
- ☐ Chronic Sinus
- ☐ Convulsions
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Fainting
- ☐ Heart
- ☐ Hepatitis
- ☐ Kidney
- ☐ Liver
- ☐ Malignancies
- ☐ Mastoid
- ☐ Measles
- ☐ Mononucleosis
- ☐ Mumps
- ☐ Rheumatic Fever
- ☐ Thyroid
- ☐ Toothache
- ☐ Tuberculosis

Other _____

CONSENT Because the patient is a minor, it is necessary for us to have the consent of the child's parent or legal guardian prior to rendering dental services. Therefore, your signature below authorizes DRS. VANN, THORNTON, JENKINS and their staff to perform any and all forms of dental treatment that your child may need, including nitrous oxide, local anesthesia, and mouth prop. (sedation and/or papoose board will need your approval and signatures each visit). Please be aware that some services offered may not be covered by your insurance company and you should get verification of fee schedules and percentages covered.

AGREEMENT TO PAY I understand that as a courtesy my insurance claims will be processed for me by the dental office but I will be responsible for deductibles and co-pays at the time services are rendered. I authorize and request my insurance company to pay directly to Dentists 4 Children LLC. This office may not participate with my insurance company so I will be responsible if a lesser amount is paid or if any part of my claim is denied for any reason. If another parent or guardian has insurance on my child, I understand that I am ultimately responsible for all fees including co-pays and denial of claims. I understand that Dentists 4 Children LLC will not attempt collection on another party such as billing anyone other than me. I understand that finance charges may be applied to past due balances and additional fees may be added for missed appointments without a 24 hour notice. I am accepting the fee charges as a lawful debt and promise to pay said fee including the cost of collection, attorney fees, and court costs if such be necessary, waiving now and forever the right to claim exemption under the constitution and laws of the state of Alabama.

Patient Signature (if over 14 years old) _____ **Have parent initial** _____

Parent's Signature _____ **Date** _____

Dentists 4 Children LLC

Thank you for completing this form. We look forward to serving you.

DENTISTS 4 CHILDREN, LLC

Richard K. Vann, D.M.D.
Heather C. Thornton, D.M.D.
James M. Jenkins, D.M.D.

Patient name: _____

Because of young age, many children cannot receive dental treatment without some behavior management techniques. The most commonly used in our office includes the use of nitrous oxide/oxygen (the gas) and mouth props. It is our experience that these procedures help to make it a more pleasant experience for your child. These techniques are endorsed by the American Academy of Pediatric Dentistry and will be used to assist in giving your child the best dental care possible. Your signature below will give Drs. Vann, Thornton, Jenkins and our staff the discretion to choose if these techniques should be used. If you **do not** wish to use these procedures, please discuss with the assistant before EACH VISIT.

In the event that the use of passive (papoose) restraint is necessary to complete the dental treatment, you will be notified by the assistant. YOU WILL BE ASKED FOR YOUR CONSENT AND SIGNATURE BEFORE THIS TECHNIQUE IS USED.

With the signing of this statement, the undersigned gives a knowing and voluntary informed consent that we have EXPLAINED the different behavior techniques available in our office.

******* (YOU ARE ONLY SIGNING THAT YOU HAVE READ THIS INFORMATION. IF RESTRAINT IS NEEDED, WE WILL ASK FOR YOUR PERMISSION PRIOR TO USING)**

Signature _____

Relationship to Patient _____ Date _____

DENTISTS 4 CHILDREN, LLC

Richard K. Vann, D.M.D.
Heather C. Thornton, D.M.D.
James M. Jenkins, D.M.D.

Patient name: _____Date of Birth: _____

As your child's dental office, we want to provide you with your choice of dental services. However, there may be certain services that are not covered by your insurance policy. You will be responsible for any non-covered charges. Please contact your insurance company before your child's dental visit. Your contract usually pays a percentage on your dental treatment leaving you with a dental co-pay. Your co-pay will be estimated by our receptionist and payment is due at the time of service. Please keep in mind that all insurance policies are different. Therefore, calculations of co-pays may not always be exact, depending on your policy's guidelines. Our office staff will be glad to discuss and assist you with any of these fees. The following are procedures that are most commonly used in our dental office.

- Nitrous Oxide, better known as "the laughing gas" is not always a covered procedure. In our experience, using "the laughing gas" does make for an easier and more comfortable visit for your child and is recommended. <u>If you choose NOT to use the gas, please notify the assistant EACH VISIT so we will be aware each time</u>.
- Our Policy is to do routine x-rays and fluoride treatments EVERY 6 months. Also, dental sealants may be recommended by our hygienist for your child's 1st or 2nd molars. All policies vary on the coverage of sealants, x-rays and fluoride depending on age and frequency limitations. <u>PLEASE NOTIFY US IF YOU DO NOT WISH TO HAVE THESE SERVICES</u>.
- Also, your contract may only allow benefits for an amalgam or "silver" filling in the posterior (back teeth) when a composite or "white" filling is used. Please be aware that if you choose a "white" filing, there will be an extra charge in addition to your co-pay. Please notify the assistant AT TIME OF SERVICE which procedure you prefer. **Please verify all policy benefits with your insurance company before services are rendered.**

Signature _____

Relationship to Patient _____ Date _____

Dentists 4 Children, LLC
7015 Halcyon Park Drive
Montgomery, AL 36117
334-284-1100 Fax 334-281-1245

Child's Name:_____ d.o.b _____

Per the guardian's request, please transfer any records including x-rays to:

Dentists 4 Children, LLC
7015 Halcyon Park Drive
Montgomery, AL 36117
334-284-1100 Fax 334-281-1245

Please contact our office if further information is needed.

Sincerely,

Dentists 4 Children, LLC

_____ Date _____
Signature

_____
Relationship to patient

Privacy Policy

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.**

The **Health Insurance Portability and Accountability Act of 1996 (HIPAA)** is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.

- Payment includes, but is not limited to, activities such as: obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

- Health care operations are the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all reference to an individual or any individuals.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

All other uses and disclosures will be made only with your written authorization. You may revoke the authorization in writing and we are required to honor an abide by that written request, except in relation to disclosures made prior to that date.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses, and disclosures, of protected health information, including information disclosed to family members, other relatives, close personal friends, or any other person you identify. 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.

- The right to reasonable requests to receive confidential communication of protected health information from us by alternative means or at alternative locations.

- The right to inspect and copy your protected health information.

- The right to amend your protected health information.

- The right to receive an accounting of disclosures of protected health information.

- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of September 5th, 2005 and we are required to abide by the terms of the *Notice of Privacy Practices* currently in effect. We reserve the right to change the terms of our *Notice of Privacy Practices* and to make the new provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised *Notice of Privacy Practices* from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

Dentists Children, LLC
7015 Halcyon Drive
Montgomery, Alabama 36117
(334) 284-1100

For more information about HIPAA or to file a complaint:
The US Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue, SW
Washington DC 20201
202-619-0257
Toll free: 1-877-696-6775

PARENT INFORMATION

If a child's mouth is to develop and grow properly, the first (primary) teeth must be healthy. Please realize that x-rays enable the dentist to thoroughly examine and condition a patient for treatment. Moreover, this is an easier introduction to dentistry rather than rushing into the mouth with instruments.

At the first visit the teeth are cleaned, painted with fluoride, and x-rays will be taken. Your child will be instructed on the care of his or her teeth. This will include tooth brushing instruction as well as diet control. If the child is suffering from a toothache, emergency treatment will be made on that tooth only. No fillings will be done on a first visit. We do prefer to see our smaller children (6 years and under), special needs patients, and/or uncooperative patients during our morning appointments.

On completion of these procedures, your child will be examined by Dr. Vann, Dr. Thornton, or Dr. Jenkins, and the condition of your child's mouth will then be related to you. If you prefer a specific doctor, please inform the assistant who calls your child back to the treatment room otherwise, either or all doctors may examine your child.

We find as a general rule, that children enjoy being the center of attention. As a result of this desire, they cooperate better if the parent does not accompany them into the treatment room. Let your child enjoy "His or Her Day". The doctors, hygienists, and assistants will discuss your child's dental health with you at the proper time.

It is essential that you discuss dentistry at home so that your child understands why he or she is being brought to the dental office. Please use positive phrases and refrain from saying "the doctor will not hurt you." Instead, say "the doctor will be gentle while working".

We will treat your child as we would our own children while rendering dental care to them. We want them to have a fun experience but the important thing is to do the dentistry and do it correctly. Children's dentistry is not a game or a plaything but a health service. We do offer special techniques such as nitrous oxide and mouth props to help make the treatment visit as pleasant as possible. Papoose procedures and other behavior management techniques will require your signature and will be discussed before these techniques are used.

Please do not be upset if your child cries. Crying is a normal reaction to fear. Children are sometimes afraid of things new or strange. We will explain procedures and spend as much time as is needed in order to make them feel as comfortable as possible!

It is our intention never to keep a patient waiting past his or her appointment time. For this reason, we ask that you be prompt for all appointment. However, please realize that a child may require more attention than was expected and may run into your allotted time. Please understand that we will give your child the exact attention that he or she needs when it is their turn. If an appointment needs to be canceled or rescheduled please notify us at least 24 hours in advance.

Our appointment reminder system will call you two days prior to confirm your scheduled appointment. You will be prompted to confirm by pressing the "1" key on your touch tone telephone. You also have the option to cancel by pressing the "2" key. We will attempt to contact you the next business day to reschedule for a day more convenient. If you are not available, the system will leave a message on your voice mail and you can call the next day (7:00 am – 4:00 pm) to confirm or cancel your child's appointment.

If you ever need to discuss your child's dental health, please feel free to call our office. Thank you for allowing us to be a part of your child's "SMILE".