YOUNG
DENTISTRY

PATIENT INFORMATION

Your Child's Name:________________________________ Nickname:___________________________

Date of Birth:______ /______ /______ Age: _______ Identifies Male: ________ Female: _______

School: ____ Grade: _______________________

Child's primary address: ____

City: ____________________________ Zip:________________ Telephone:______________________

Parent/Legal Guardian #1:

Name:____ Date of Birth: _____ /_____ /______

Occupation/Employer: ____ SS#:___________________

Work phone: _________________ Mobile: _______________________ Home: __________________

Email address:____

Parent/Legal Guardian #2:

Name:____ Date of Birth: _____ /_____ /______

Occupation/Employer: ____ SS#:______________________

Work phone: ___________________ Mobile: _____________________ Home: ____________________

Email address:____

Parent's Marital Status (circle one):

Single Married Divorced Widowed Separated

Who is accompanying the child today?

Name: ____ Relationship: __________________________

Do you have legal custody of this child? ____

Do we see any other of your children? Y N

If yes, please give names and ages:____

Whom may we thank for referring you to our office? Doctor Friend Internet Other

Name of doctor, friend, or patient who told you about us: _____________________________________

Person Responsible for Account (If not listed above):

Name:____ Relationship to child:______________________

Date of Birth: _________ / _________ / _______ SS#_______________________________________

Billing Address (if different from child): ____

Email: ____________________________________ Mobile phone:_______________________________

Dental History

Please circle the reason(s) for today's visit:

Complete checkup   Toothache   Accident to teeth   Appearance of teeth

Other: ____

Is this your child's first visit to the dentist? _____ Y ______N

If not, when was your child's last visit to the dentist? ______________________________

Was it a family dentist or specialist? Name of previous dentist: ______________________

Other dentists, orthodontists oral surgeons your family has seen:

____

Were previous x-rays taken? _____Y ______ N If yes, when? ________________________

Any unhappy dental experience? _____ Y ______ N If yes, please explain

____

____

Any injury to the mouth or teeth? ______Y ______N If yes, please explain:

____

____

Does your child drink tap water? ______Y ______N Filter/type: ______________________

How often does your child brush?_________________ Alone or with help? _____________

Does your child floss? ______Y ______N How often? ______________________________

Please circle if your child has any mouth habits?

Thumb sucking   Nail Biting   Mouth breathing   Pacifier   Lip sucking   Tongue thrusting

Grinding/Clenching   Other:____

How do you think your child will react to dental treatment?

_____ Excellent _____ Good_____ Fair _______ Poor ________ I don't know

Any unusual speech habits? ______Y _______N

Is there any special information that you believe would be helpful to us in your child's visit today or in general? Please comment: ____

____

____

Medical History

Name of Pediatrician: ________________________ Phone: ____________________

Name of Pharmacy: ________________________ Phone: ____________________

Date of last exam: ______________________ Vaccinations up to date? _____ Y _____N

Current medications: ____

History of allergies? _____ Y _____ N

If yes, circle all that apply: Penicillin Aspirin Anesthesia Latex Food Other

____

Describe symptoms of reaction: ____

Has your child ever had any of the following? Please circle

Abnormal Bleeding	ADD/ADHD	AIDS/HIV	Allergy	Anemia
Anxiety	Asthma	Autism	Cancer	Cleft Lip/Palate
Depression	Diabetes	Epilepsy	Fainting	Headaches
Heart Disease	Heart Murmur	Hepatitis	Kidney Problems	Psychiatric care
Liver problems	Mental Delays	Measles	Muscle weakness	
Mumps	PDD	Physical delays	Pregnancy	
Rheumatic Fever	Seizures	Sinus Problems	Sickle Cell Anemia	
Bone or joint problems	Birth Defects	Tuberculosis	Other: _________________	

Please describe: ____

Has your child ever been hospitalized? ____

Does your child see any specialists? ____

Any medical treatments including drugs, pending surgery, recent injuries or any information that you would like to make us aware of that has not been covered?

____

Is there anything you would like to discuss with the doctor in private or without your child being present?

____

____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing inaccurate information can put my child's health at risk, and that it is my responsibility to inform Young Dentistry of any changes in my child's health status.

Signature of Parent/Legal Guardian: _______________________ Date: ____________

<u>HIPAA NOTICE OF PRIVACY PRACTICES</u>

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 options (TPO) and for other purposes that are permitted or 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. This notice will take effect on April 1st, 2014 and will remain in effect until we replace it.

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

Treatment: We may use and disclose your protected health information to other physicians or health care providers that are providing care to you in order to coordinate and manage your health care and any related services.

Payment: Your protected health information may be used to obtain payment for services we provide to you. For example, obtaining approval for a necessary procedure may require that your relevant protected information be disclosed to your medical or dental insurance provider.

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 students and staff, licensing, and conducting or arranging for other business activities. 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 an 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 Disclosure: 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 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 your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

PATIENT RIGHTS

Access: You have the right to view or receive 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 to the extent that we can practically do so.
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. If you request this accounting more than once in a 12-month period, we reserve the right to 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 honor our agreement unless an emergency situation arises that prohibits us from doing so.
Alternative Communication: You have the right to request (you must make your request in writing) that we communicate with you about your health information by alternative means or to alternative locations. Your request must specify the alternative means or location and provide satisfactory explanation as to 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.
If you receive this Notice electronically, you are entitled to receive this Notice in written form.

SIGNATURE

I, ________________________________(Parent/Legal Guardian), have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations

Signature: ____Date: ________________
Patient's Name: ____
Relationship to Patient: ____

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 or to have us communicate with you by alternative means or at alternative locations, you may address your complaint using the following contact information listed at the end of this Notice. You may also submit a written complaint 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.

Contact Person: Dr. Marcie Young

Telephone: 561-789-5437 Address: 241 NE 4th ST, Suite A, Delray Beach, FL 33444

FINANCIAL POLICY

Please understand that financial arrangements are made directly with you. For your convenience, the following outlines our financial policies:

1. Payment is due in full for each appointment as services are rendered and is to paid by the person accompanying the child. We accept cash, MasterCard, Visa, American Express, and Care Credit. You will be responsible for payment of all costs and fees incurred, including attorney's fees, should collection efforts be made in order to fulfill a debt.

2. Dental Insurance: Please check with our staff to make sure that we accept your child's insurance plan. For all insurances that we do not accept, we will be happy to submit a claim to your insurance electronically, however payment is due in full at the time of service. The type of plan chosen by your and/or your employer determines your insurance benefits. As such, we have no control over the terms of your contract, the method of reimbursement or the determination of your insurance benefits. Any reimbursements by your insurne company other than othose we directly participate with should be made directly to you according to the terms of your contract with them.

3. Pre-treatment Authorization: Some insuance companies recommend an estimate of the work to be done and the fees to be charged before determining their benefits to you. If so, we will provide you with the pre-treatment fe estimate. It will be your choice to determine if you wish to proceed with the treatment before the insurance benefit is determined.

4. Fillings and Crowns: Please be informed that we do not use amalgam restorations, but use white (composite resin) restorative materials. Your insurance company may not pay for a white filling or may downgrade the reimbursement. We also have white (zirconia) crowns available as an alternative to stainless steel crowns. For white fillings or crowns, the co-payment is your responsibility.

5. Nitrous Oxide Analgesia: Our office uses Nitrous Oxide Analgesia (Laughing Gas) for the comfort of our patients. This fee may or may not be covered by your dental insurance.

6. Appliances: The entire cost of the appliance must be paid on the day your child's impressions are taken to cover the laboratory fee.

7. Emergency Treatment: All emergency treatment must be paid in full at the time of services rendered.

Please remember, even if you have insurance coverage, you are responsible for payment of your account. Understand that your insurance coverage is a relationship between you, the insured patient, and your insurance company. Your understanding and cooperation with this matter is greatly appreciated. Past due accounts are subject to a monthly service charge and will be turned over for collection by an outside agency. I have read and understand my obligations.

Signature of Parent/Guardian:___________________________________ Date: _________________________