# The Shoebox Pediatric Dentistry

*Welcome to our practice!*

**We strive to make every child's visit pleasant and comfortable. Our goal is to teach children good oral habits which will help them keep their smiles beautiful for a lifetime.**

***How did you hear about us?*** Phone Book a Friend Family Doctor (referral)_____
Coupon Book Other _____

## About Your Child

Child's Name _____
Nickname _____ Gender_____
Birthdate _____ Age _____
School_____ Grade_____
Child's Home Address _____
City, State, Zip _____

## Mother Stepmother Guardian

Name _____
Email _____
Home Phone _____
Cell Phone _____
Work Phone (optional)_____
Social Security #_____
Employer _____
Occupation _____

## Father Stepfather Guardian

Name _____
E-mail _____
Home Phone (if different than above)_____
Cell Phone _____
Work Phone (optional)_____
Social Security #_____
Employer_____
Occupation _____

## Parents' Marital Status

Single Married Divorced Separated Widowed

## Who is accompanying this child today?

Name _____
Relationship _____
Phone _____
Best time to call _____

## Primary Dental Insurance

Insured's Name _____
Relationship _____
Birthdate _____ Soc. Sec.#_____
Employer _____ Date Employed _____
Occupation _____
Insurance Company _____
Group #_____ Emp. No. _____
Ins. Company Address _____
Deductible _____ Max. Annual Benefit _____
Orthodontic Coverage? Yes No

## Additional Insurance

Insured's Name _____
Relationship _____
Birthdate _____ Soc. Sec.#_____
Employer _____ Date Employed _____
Occupation _____
Insurance Company _____
Group #_____ Emp. No. _____
Ins. Company Address _____
Deductible _____ Max. Annual Benefit _____
Orthodontic Coverage? Yes No

## Account Information of Responsible Party

Name_____ Relation to child _____ Phone#_____
Billing Address (if different from above) _____
Payment Method: Cash/Check VISA MasterCard

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for all services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.
Initials

# Health History (Confidential)

## Medical History

Has your child ever had any of the following:

| | | |
|---|---|---|
| Heart Murmur | Yes | No |
| Surgeries/Operations | Yes | No |
| Cancer/Tumors | Yes | No |
| Hyper Active/ADD | Yes | No |
| Respiratory Problems | Yes | No |
| Asthma/Difficulty Breathing | Yes | No |
| Hemophilia | Yes | No |
| Abnormal Bleeding | Yes | No |
| Fainting/Seizures/Epilepsy | Yes | No |
| Cleft Lip/Palate | Yes | No |
| Tuberculosis TB | Yes | No |
| Psychiatric Problems | Yes | No |
| Cerebral Palsy | Yes | No |
| HIV+/AIDS/ARC | Yes | No |

Other_____

Please explain any medical problems that your Child has _____

_____

Does child require pre-medication? Yes No

Is your child currently taking any medications?

Yes No (if yes, please list)_____

_____

Is your child allergic to: Latex Tetracycline Penicillin/Amoxicillin Aspirin Food allergies Dental Anesthetics

Other:_____

## Child's Habits

How often does your child brush? _____

How often does your child floss? _____

Date of last dental visit _____

Previous Dentist _____

Child's Physician _____

Phone Number _____

Address _____

Is your child's water fluoridated? Yes No

Does your child take fluoride supplements?

Yes No

Does your child:

| | | |
|---|---|---|
| Suck thumb/finger | Yes | No |
| Suck/bite lips | Yes | No |
| Heavy Snoring | Yes | No |
| Grind teeth | Yes | No |
| Chew hard objects (pencils, etc.) | Yes | No |

## Emergency Visit Only:

How long has child been in pain? _____

Explain the problem(s): _____

_____

_____

What type(s) of pain medication has child been taking? _____

_____

## Authorization and Release:

☺ We invite you to discuss with us any questions regarding our services. The best Dental Health services are based on a friendly, mutual understanding between provider and patient.

☺ Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with our financial coordinator. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, billing and interest charges, and any other expenses incurred in collecting your account.

☺ We ask all our patients to show up on time to their appointments. Please give us at least 48 hour cancellation notice prior to your scheduled appointment to avoid any no-show fee charges.

☺ I authorized the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

☺ I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

_____

Please sign and print your name here Date

UPDATE: _____ _____/_____/_____ _____ _____/_____/_____ _____ _____/_____/_____

Initials Date Initials Date Initials Date


# The Shoebox Pediatric Dentistry

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**PRIVACY POLICY & INFORMATION PRACTICES PATIENT RIGHTS STATEMENT**

***Patient Acknowledgement of Receipt***

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I, _____, *have received a copy of The Shoebox Pediatric*
Please Print Name
*Dentistry's Privacy Policy and Information Practices*.

_____
Signature

_____
Date

_____
Witnessed

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**For Office Use Only**

We attempted to obtain the written acknowledgement of receipt of our Patient Rights Notice regarding our office Privacy Policy & Information Practices. Acknowledgement was not obtained because:

____ Individual refused to sign

____ Communications barriers prohibited us to obtain a signature

____ There was an emergent situation that prevented us from obtaining a signature

____ Minor Patient was not accompanied by an adult to this appointment

*Steps taken to deliver our written Patient Rights Notice:*

_____

_____

_____

_____ Staff Initials/Date

Revised on 2/4/04

# The Shoebox Pediatric Dentistry

## A NOTICE TO OUR PATIENTS ABOUT OUR PRIVACY POLICY & INFORMATION PRACTICES

*Dr. Richard Hsu and his staff* are committed to maintaining the confidentiality of your personal, financial, and health information. State and Federal law requires us to inform you of our policy and practices as long as we provide you services.

**HOW WE PROTECT YOUR PERSONAL INFORMATION:**
We authorize individuals to access your personal information only to the extent necessary to conduct our business of serving you, such as making and confirming dental appointments, submitting insurance claims, securing insurance benefit information, and submitting applications for third party payment arrangements per your request. We take steps to secure our building, patient files, and electronic systems from unauthorized access. Our employees are trained regarding confidentiality and are held to strict Office Policy and Procedures regarding your personal and health information both written and verbal. All employees are subject to discipline if they violate these procedures.

**INFORMATION WE COLLECT:**
Examples of your personal information include: your name, Social Security Number, Address, telephone number, employment, medical history, health records, claim information, and driver's license number.

**INFORMATION WE SHARE:**
We may share your personal or health information with other third parties with or without prior authorization *for our normal business functions*. Examples of our normal business functions include:

- Submission of Dental Claims
- Referrals to Specialist
- Request from other healthcare providers
- Request to or from pharmacy's
- Processing transactions that you request
- Appointment notification via postcards, voice messages, or other written or verbal means

**PATIENT RIGHTS:**
We honor your right to request access to your personal information. To do so, you must submit a written request describing the information you are requesting. There will be a $5 charge for staff time to retrieve and copy the requested information plus postage. If we are able to located and retrieve the information within 30 days from your request we will:

- Inform you of the nature and substance of the personal information either in writing or by telephone.
- Permit you to see and copy, in person the requested information or to obtain a copy by mail, whichever you prefer.
- Disclose the persons to whom we've shared your personal information within the last six years, from April 11, 2003, or if not available the names of organizations or persons to whom the information is normally disclosed.
- Provide a summary of the procedures by which you may request correction, amendment or deletion of personal information.

If you request a correction, amendment or deletion of personal information, we will correct, amend or delete your personal information or will notify you of our refusal. You may submit a statement telling us what you believe to be relevant or fair information and the reasons that you disagree with our decision. Your statements will be filed with your personal information.

# The Shoebox Pediatric Dentistry

## Use and Disclosure of Health Information Consent Form

**Consent:** By signing this form, you do consent to our use and disclosure of your personal health information to carry our treatment, payment activities and other healthcare operations required by this office. You acknowledge you are aware of our need to share your protected personal health information and have received your patient rights notification explaining in detail our office Privacy Policy and Information sharing Policy.

**Right to revoke**: You have the right to revoke this Consent at any time by giving us written notice. We will honor the request as of the day receive your written notice. Please understand it will not affect any action taken before we received your revocation and we may decline to treat you or to continue treating you if you revoke this Consent.

**Changes to Privacy Practices**: We reserve the right to change our privacy practices described in our Patient Rights Privacy Policy and information Practices. If we change our practices we will issue a revised Patient Rights Privacy Policy and Information Practice statement.

**Patient Responsibility**: We request timely notification of any changes to your personal information we maintain for you, such as but not limited to, health history information, address, telephone number, active insurance policy, and change in employer.

***I, _____, have read and understand the above information. I understand that by signing this form I am giving my consent to use and disclose my protected health information to carry out treatment, payment activities and health care operations.***

Signature: _____ Date: _____

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**Consenting Patient Information:**

Name: _____ Date of Birth _____

Address: _____
Street City State Zip

Telephone: (____) _____ (____) _____ (____) _____
Home Work Cell

***Minor children also covered by this consent:***

Name: _____ Date of Birth _____

Name: _____ Date of Birth _____

Name: _____ Date of Birth _____

Name: _____ Date of Birth _____