MP DENTISTRY
FOR CHILDREN

Patient Information

Date _____

Last Name_____ First Name _____Preferred Name_____

Age _____ Date of Birth _____ Sex: □ M □ F

Child's first language?_____Second language? _____

In the event of an emergency, whom should we contact?

Name _____ Relationship _____ Phone _____

How were you referred to our office? □ Our Website □ Insurance Website □ Google/Internet □ Facebook/Instagram

□ Friend / Relative_____□ Sibling _____□ Previous Patient _____

□ Other Doctor/Dentist_____ □Other _____

Parent/Guardian Information

□ Father □ Stepfather □ Guardian

Name _____ DOB _____ SS#_____ Employer _____

Home Address _____ City _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

E-Mail_____ *If email is provided, we may contact you for appointment reminders/account information

□ Mother □ Stepmother □ Guardian

Name _____ DOB _____ SS#_____ Employer _____

Home Address _____ City _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

E-Mail_____ *If email is provided, we may contact you for appointment reminders/account information

Insurance Information

PRIMARY COVERAGE

Name of Insured_____ DOB _____SS# _____

Employer: _____ Employer Phone_____

Insurance Co. Name _____ Insurance Phone_____

Insurance Address _____ City_____State_____Zip_____

Subscriber ID# _____Group/Policy #: _____

Dental History

Reason for this visit:

□ Checkup/Cleaning □ Dental Caries □ Mouth injury □ Toothache □ Crooked teeth □ Oral Habits

□ Others _____

Last Dental Visit and Reason _____Dentist's name _____

How do you think your child will behave during this visit: □ Friendly □ Happy □ Anxious □ Timid □ Afraid □ Resistant

Dental Habits- Does your child currently… (check all that apply)

□ Suck Thumb/Finger	☐ Suck/Bite Lips	☐ Bite/Chew Nails	☐ Tongue Thrust	☐ Bottle Feed
□ Use Pacifier	☐ Tongue/Cheek Chew	☐ Clench/Grind Teeth	☐ Mouth Breather	☐ Breast Feed

Hygiene Routine (check all that apply)

□ Fluoride Toothpaste ☐ Consume Fluoridated Water ☐ Brushing by Child:_____/ day ☐ Brushing by Parent:_____/day

□ Snack between Meals -- Type of Snacks:_____ ☐ Fluoride Mouthwash ☐ Dental Floss:_____/week

Medical History

Patient's Pediatrician _____ Phone _____

Is child under care of Physician now? - - - - - - □ No □Yes (explain) _____

Receiving any medications or drugs - - - - - - - □ No □Yes (explain) _____

Ever been hospitalized? - - - - - - - - - - - - - - - □ No □Yes (explain) _____

Ever had surgery? - - - - - - - - - - - - - - - - - □ No □Yes (explain) _____

Are there any Drug/Food/Metal/Latex allergies? - - □ No □Yes (explain) _____

HAS YOUR CHILD HAD ANY HISTORY OF:

□ Anemia	□ Cerebral Palsy	□ Heart disease	□ Premature baby
□ Asthma	□ Convulsions	□ Heart Murmur	□ Problems with anesthesia
□ Autism	□ Developmental Delay	□ Hearing Problems	□ Prolong bleeding when cut
□ ADHD	□ Diabetes	□ Hepatitis/Liver Disease	□ Rheumatic fever
□ AIDS/HIV	□ Down Syndrome	□ High/low blood pressure	□ Seasonal Allergies
□ Birth defect	□ Epilepsy	□ Kidney disease	□ Tuberculosis
□ Blood Disorder	□ Ear, eye, nose trouble	□ Lung disease	□ Thyroid Disease
□ Cancer	□ Gastric reflux	□ Pregnancy	□ Other

Comments: _____

_____

Acknowledgement of Patient Information/ Authorization for Initial Evaluation

The information I have given is correct to the best of my knowledge. I understand that all information is confidential, and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services to my child for an initial evaluation. Any other dental services required will be explained and authorize by me after the initial visit.

_____ _____

Signature of Parent/Guardian Date

Practice Financial Policy

We are committed to providing your child with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial and insurance policies is important to our professional relationship.

1.-VERIFYING INSURANCE: As a convenience to you, we will verify your insurance for eligibility benefits prior to your new patient appointment as well as any time that you notify us of a change in your coverage. The insurance companies do not guarantee payment based on the information that they provide us. You are ultimately responsible for knowing if there are any waiting periods for work to be performed. Any amounts on your treatment plans that are not covered by your insurance, are your financial responsibility. Please keep your insurance information current by notifying us of any changes in employment, insurance coverage, etc.

2.-PAYMENT: Payment is due at the time of service. The adult accompanying a minor and/or the parent (or guardian of the minor) is responsible for payment at the time of appointment. Additionally, if you have a balance following an insurance payment from a previous visit, you will be expected to pay that amount as well.

3.-CHANGES IN PERSONAL INFORMATION: Changes in your address or telephone numbers should be kept current with our office.

4.-BALANCES: If your account balance exceeds 60 days, you will receive a notice informing you that your account is overdue. If you do not pay your balance or arrange a payment plan within 10 days, your account will be turned over to a collections agency. If this happens, a collection fee (currently 39% of the balance) will be added to your account balance. The collection agency will report any unpaid balance to the major credit bureaus.

5.-INSURANCE: I certify that my child is covered by insurance and assign directly to Dr. Cho or Dr. Gaw for all insurance benefits, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not covered by dental insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

6.-CANCELLATIONS / FAILED APPOINTMENTS: We request **48-hour notice** if you are cancelling an appointment. In case of a second cancellation without 48 hours' notice or failed appointment ("no show"), there will be a **$25 fee** for cancellations made. The $25 will be posted to your account, and you will not be allowed to make any other appointments for your children until it is paid in full. If you cancel without 48 hours' notice for a hospital appointment, or sedation appointment, you will be charged a **$50 fee**. Additionally, if a patient is more than 20 minutes late without prior notice for a scheduled appointment, we will consider this a missed appointment and the $25.00 cancellation fee will be charged.

I have read and understand the Financial Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

_____ _____

Signature of Parent/Guardian Date

AGREEMENT TO RECEIVE ELECTRONIC COMMUNICATIONS

Email and Text Message Communication

I agree that Mangum Park Dentistry for Children may communicate with me electronically by email and/or text messages at the email address and cell phone number provided to the office. I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I understand text message charges from my cell phone provider may apply. I am responsible for providing Mangum Park Dentistry for Children with any updates to my email address and cell phone number. I can withdraw my consent to electronic communications in writing or by sending us an email with the request for withdraw.

Signature _____ Date _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- ☐ Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- ☐ Obtaining payment from third party payers (e.g. my insurance company);
- ☐ The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signature of Parent/Guardian _____ Date _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of the right to review and secure a copy of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- □ Individual refused to sign
- □ Communications barriers prohibited obtaining the acknowledgment
- □ An emergency situation prevented us from obtaining acknowledgment
- □ Other (Please Specify) _____

Name (Please Print)_____

Signature _____ Date _____

MP DENTISTRY
FOR CHILDREN

NOTICE OF PRIVACY PRACTICES

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 with your signature agreement, and will remain in effect until we replace it. You may request a copy of our Notice at any time.

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.
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.
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, 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 the 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 inference of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms for 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, or 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 authorize federal official's health information required to 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 access to 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. You must make a request in writing to obtain access to your health information. If you prefer, we will prepare a summary or an explanation of your health information for a fee.
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 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 of 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).

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, you may complain to us. You also may 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 upon request.
We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.