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Patient's Name _____ Preferred Name _____

Age ____ Date of Birth _____ Patient's Social Security Number _____

Sex: M F

Home Address _____

Phone (home) _____ Parent or Guardian Email Address _____

Have we previously seen other family members? __ Yes __ No

If Yes, please provide names: _____

Please list your child's hobbies/interests: _____

Do parents live together? __ Yes __ No If no, with whom does child live? _____

Who has legal custody of the patient? _____

PLEASE LIST FULL NAMES OF ALL FAMILY MEMBERS BEING SEEN AS PATIENTS FOR WHOM THIS INFO APPLIES:

_____

_____

_____

_____

****If siblings have different parent/guardian or insurance information, please complete separate forms for each individual patient.**

PARENT OR GUARDIAN INFORMATION ___Mother ___ Stepmother ___ Guardian

Name _____ DOB _____ Occupation _____

Home Address _____

Employer _____ SS # _____ Work Phone _____ Cell _____

P**ARENT OR GUARDIAN INFORMATION** ___Father ___ Stepfather ___ Guardian

Name _____ DOB _____ Occupation _____

Home Address _____

Employer _____ SS # _____ Work Phone _____ Cell _____

PRIMARY DENTAL INSURANCE

Subscriber's Name _____ Relationship to Patient _____

Birthdate _____ Social Security # _____

Employer _____ Insurance Co. _____

Group # _____ Member ID _____

Insurance Co. Phone # _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

LKNPD Medical History

Patient's Name: _____ DOB: _____

Child's Physician:_____

Physician's Phone #: (_____)_____ Date of last visit: _____

Physician's Address: _____
Street City State Zip

Is the child currently under the care of a physician? □ Yes □ No

If yes, please explain:_____

Please describe the child's current physical health: □ Good □ Fair □ Poor

Are Immunizations Current? □ Yes □ No

Please list all medications that the child is currently taking:_____

Please list all medications/foods/other that cause the child allergic reactions: _____

Has the child been diagnosed with or treated for any of the following:

Y N Abnormal Bleeding
Y N AIDS/HIV+
Y N Anemia
Y N Any Hospital Stays/Surgeries
Y N Asthma
Y N Autism Spectrum
Y N Blood Transfusion
Y N Cancer
Y N Cerebral Palsy
Y N Chromosomal Abnormalities
Y N Cleft Palate / Lip
Y N Diabetes
Y N Epilepsy / Seizures
Y N Handicaps / Disabilities
Y N Hearing / Speech
Y N Heart Disease
Y N Heart Murmur
Y N Hemophilia Type ____
Y N Hepatitis Type ____
Y N High / Low Blood Pressure
Y N Hives
Y N Kidney Problems
Y N Liver Problems
Y N Rheumatic Fever
Y N Sickle Cell Anemia
Y N Tuberculosis (TB)

Please provide explanation for any "Yes" answers above and any other medical issues the child has/had: _____
_____

Does the child require pre-medication for dental appointments? □ Yes □ No Explain: _____

Do you consider your child to be: □ Progressing normally in the learning process □ Slow in the learning process

Dental History

What is the ***primary*** reason for today's visit? _____

Is your child currently having problems with any of the following?

□ Cavities □ Toothache □ Sensitive Teeth □ Trauma
□ Gum Infection □ Color of Teeth □ Tooth Alignment □ Other _____

Has the child experienced problems with previous dental work? □ Yes □ No Explain: _____

Is the child's home water supply fluoridated (city/county water)? □ Yes □ No

Does the child brush his/her teeth daily? □ Yes □ No # of times per day: ___ Using fluoride toothpaste? □ Yes □ No

Do you give the child any other form of fluoride? □ Yes □ No If yes, what? _____

Does the child floss his/her teeth daily? □ Yes □ No

Was your child bottle/breast-fed? □ Yes □ No If yes, what age was it completely stopped? _____

Does your child suck a finger / thumb / pacifier / or exhibit any other habits? _____

Previous/Present (circle) Dentist: _____ Date of last Visit: _____

What did you like most about any dentist you have seen?_____

Least?_____

Signature _____ Date _____

Relationship to Child_____

Reservation and Cancellation Policy

We strive to provide high quality dental care in the most efficient manner possible for your children. We value your time and reserve a place for your child to see the hygienist and doctor. Your reservation helps us ensure we utilize your time most effectively and ensures that other patients receive the same quality care that you receive. We ask that you review our reservation and cancellation policy and acknowledge this policy with your signature below.

- With your permission, the practice will communicate reservation reminders via text messaging, email, and/or telephone calls.
- We ask that all new patients arrive at least fifteen (15) minutes prior to your reservation time in order to allow for completion of necessary new patient forms.
- We ask that reservation cancellations be made at least 24 hours ahead of the scheduled reservation time.
- The practice understands that emergencies can sometimes arise. Therefore, we will work with you to reschedule your reservation if you must cancel less than 24 hours prior.
- If two reservations are missed without notice, you will be placed on a short-call list and may only be scheduled on short notice if an appointment becomes available. If a third appointment is missed without notice, you will be dismissed from the practice. This decision may be appealed by speaking with our office manager.
- A fee of $25 will be charged for appointments missed without 24 hours notice.
- The practice reserves the right to cancel your reservation if you are more than ten minutes late for any service.
- The practice reserves the right to modify this policy at any time in the future.

_____ _____

Responsible Party Signature Date

_____

Relationship to Patient(s)

Financial Policy

Please take a moment to review this policy, and acknowledge it with your signature.

- Payment for dental care is expected at the time of service.
- We will strive to verify your insurance benefits prior to treatment. However, your insurance carrier only provides us an estimate of benefits. Any remaining balance becomes your financial responsibility. Any payment not received from your insurance company after 60 days from the treatment date will be due in full from you. Thereafter, you will need to seek reimbursement directly from your insurance company.
- As a courtesy to insured patients, we are happy to help file dental claims on your behalf. However, please remember that **your dental insurance policy is a contract between you, your employer, and the insurance company**. Although we agree to charge reduced fees to you based on your insurance fee schedule, we are not a party to your insurance contract.
- Law requires that this practice collect your copay for dental care received.
- We accept cash or credit card: Visa, MasterCard, American Express, and Discover.
- Account balances greater than 90 days are subject to being forwarded to a collection agency.
- The practice reserves the right to modify this policy at any time in the future.

_____ _____

Responsible Party Signature Date

_____

Relationship to Patient

Photo/Video Consent Form

I, _____, give consent for Lake Norman Pediatric Dentistry to obtain and
Parent/Guardian Name

use photos of my child(ren) _____
Patient Name(s)

for marketing and/or social media purposes on the following media sources:

--Lake Norman Pediatric Dentistry's official Facebook Business page. (https://www.facebook.com/lknpediatricdentistry/)

--Lake Norman Pediatric Dentistry's official Instagram page. (@lknpedatricdentistry)

--www.lknpediatricdentistry.com

I ___ would or ___ would not like to be "tagged" in this photo. If you would like to be tagged, please include your Facebook name and/or Instagram handle below.

Facebook: _____

Instagram: _____

I understand this photo will include identifiable features of my child but WILL NOT include any protected health information or personal information, other than my personal "tag" if I wish.

_____ _____
Parent/Guardian Signature Today's Date

_____
Relationship to Patient

Lake Norman Pediatric Dentistry
Authorization for Release of Information – Compound Release

Please list the names and birth dates of all children you make health care decisions for at our office:

Patient:_____ DOB: _____
Patient:_____ DOB: _____
Patient:_____ DOB: _____
Patient:_____ DOB: _____
Patient:_____ DOB: _____
Patient:_____ DOB: _____

Lake Norman Pediatric Dentistry is authorized to release PHI about the above named patients in the following manner and/or to selected persons.

CHECK EACH PERSON/ENTITY APPROVED TO RECEIVE INFORMATION.	CHECK TYPE OF INFORMATION THAT CAN BE GIVEN TO PERSON/ENTITY ON THE LEFT IN THE SAME SECTION.
☐ Voice Mail	☐ Appointment Reminders
☐ Other person(s)(provide name(s) and phone number(s)):	☐ Financial ☐ Treatment ☐ May bring patient(s) to appointments
☐ Email communication-Provide email address* _____ *For email communication to occur, please accept the disclosure below:	☐ Financial ☐ Treatment ☐ Appointment reminders ☐ Breach notification
☐ Text communication – Provide number * _____ *For text communication to occur, accept the disclosure below:	☐ Appointment reminder ☐ Other: _____

☐ For **email and/or text communication** I understand that if information is *not* sent in an encrypted (secure) manner, there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.

- I have the right to revoke this authorization at any time by contacting this office.

- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

Signature of Patient or Guardian: _____ Date: _____

Relationship to Patient: _____(attach necessary documentation)

☐ Revoked by patient or personal representative on _____.
DATE

How revoked: ♦ orally (in person or via phone) ♦ in writing (place copy in patient's file)

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*** You May Refuse to Sign This Acknowledgment****

I, _____, have been offered a copy of this office's Notice of Privacy Practices.

_____

Please Print Name

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices but acknowledgment could not be obtained because:

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

Notice of Privacy Practices

This notice describes how medical information about you may be used, disclosed, and how you can obtain this information. Please review it carefully.

If you have any questions about this notice please contact our Privacy Officer.

We are committed to protect the privacy of your personal health information (PHI).

This Notice of Privacy Practices describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, to obtain payment, or other healthcare operations. We may also share your information for other purposes that are permitted or required by law. This notice also describes your rights to access and control your PHI.

We are required by law to maintain the privacy of your PHI. We will follow the terms outlined in this notice.

We may change our notice at any time. Any changes will apply to all your PHI. Upon request we will provide you with any revised notice by:

1. Posting the new notice in our office.
2. If requested, making copies of the new notice available in office or by mail.
3. Posting the revised notice on our website: www.lknpediatricdentistry.com

Usage and Disclosures of Protected Health Information

W**e may use or disclose your PHI to provide health care treatment for you.**

Your PHI may be used and disclosed by your physician, our staff, and others outside of our office that are involved in your care and treatment for the purpose of providing healthcare services to you.

EXAMPLE: Your PHI may be provided to a physician to whom you have been referred for evaluation to ensure that the physician has the necessary information to diagnose or treat you. We may also share your PHI from time to time to another physician or healthcare provider (e.g. a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your healthcare diagnosis or treatment to your physician.

We may also share your PHI with people outside of our practice that may provide medical care for you such as home health agencies.

We may use and disclose your PHI to obtain payment for service. We may provide PHI to others in order to bill or collect payment for services. There may be services which we share with your health plan to determine if the service will be paid for.

PHI may be shared with the following:

1. Billing companies
2. Insurance companies, health plans
3. Government agencies in order to assist with qualification of benefits.
4. Collection agencies

EXAMPLE: You are seen at our practice for a procedure. We will need to provide a listing of services such as x-rays to your insurance company in order to obtain payment for the procedures performed. We may at times contact your healthcare plan to obtain approval PRIOR to performing certain procedures to insure the services will be paid for. This will require sharing your PHI.

We may use or disclose, as needed, your PHI in order to support the business activities of the practice, which are called healthcare operations.

Examples:
1. Training students, other healthcare providers, and ancillary staff such as billing personnel to help them learn or improve their skills.
2. Quality improvement processes which look at delivery of healthcare and improvements which will provide safer, more effective care for you.
3. Use of information to assist in resolving problems or complaints within the practice.

We may use and disclose your PHI in other situations without your permission:

1. If required by law: The use and disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. For example: we may be required to report gunshot wounds, or suspected abuse or neglect.
2. Public heath activities: The disclosure will be made for the purpose of controlling disease, injury, or disability. This type of information will be disclosed only to public health authorities permitted by law to collect or receive this type of information. We may also notify individuals who may have been exposed to a disease or may be at risk of contraction and spreading a disease or condition.
3. Health Oversight Agencies: We may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee healthcare systems, government benefit programs, other government regulatory programs and civil rights laws.
4. Legal Procedures: to assist in any legal proceedings or in response to a court order, in certain circumstances in response to a subpoena, or other law processes.
5. Police and Other Law Enforcement Agencies: The release of PHI will meet all applicable legal requirements for release.
6. Coroners/Funeral Directors: We may disclose PHI to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner to perform other duties authorized by law.
7. Medical Research: We may disclose your PHI to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI.
8. Social Government Purposes: Information may be shares for national security purposes or if you are a member of military. When PHI is release to military it will be under limited circumstances.
9. Correctional Institutions: Information may be shares if you are inmate or under custody of law which is necessary for your health or the health and safety of others.
10. Worker's Compensation: Your PHI may be disclosed by us as authorized to comply with workers compensation laws and other similar legally established programs.

Other uses and disclosures of your PHI:

1. Business Associated: Some services are provided through the use of contracted entities called "business associates". We will always only release the minimum amount of PHI necessary so that the business associate can perform the identified services. We require the business associate(s) to appropriately safeguard your information. Examples of business associates include companies or

transcription services.
2. Health Information Exchange: We may make you PHI available electronically to other healthcare providers outside of our facility who are involved in your care.
3. Fundraising Activities: We may contact you in effort to raise money. You may opt out of receiving such communications.
4. Treatment Alternatives: We may provide you notice of treatment options or other healthcare related services that may improve your overall health.
5. Appointment Reminders: We may contact you as a reminder about upcoming appointments or treatment.

We may use or disclose your PHI in the following situations UNLESS you object.

1. We may share your PHI with friends or family members, or other persons directly identified by you at the level they are involved in your care and payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgement will determine if it is in your best interest to share the information. For example: we may discuss post procedure instructions with the person who drove you to the facility unless you tell us specifically not to share the information.
2. We may use or disclose your PHI to notify or assist in notifying a family member, personal representative, or any other person that is responsible for your care, of your location, general condition, or death.
3. We may use or disclose you PHI to an authorized public or private entity to assist in disaster relief efforts.

The following uses and disclosure of PHI require your written consent:

1. Marketing
2. Disclosure for any purpose which require the sale of your information.
3. Release of psychotherapy notes: Psychotherapy notes by a mental Health professional for the purpose of documenting a conversation during a private session. This session could be with an individual or with a group. These notes are kept separate from the rest of the medical records and do not include: medications and how they affect you, start and stop time of counseling sessions, types of treatments, provided, results of test, diagnosis, treatment plans, symptoms, prognosis.

All other uses and disclosures not recorded in this notice will require a written authorization from you or your personal representative.

Written authorization simply explains how you want your information used and disclosed. Your written authorization may be revoked at any time, in writing. Except to the extent that your doctor or this practice has used or released information based on the direction provided in the authorization, no further use or disclosure will occur.

Your Privacy Rights

You have certain rights related to your PHI. All request to exercise these rights must be made in writing to the office of Julie Spivey, DMD, ATTN: Privacy Officer.

You have the right to see and obtain a copy of your PHI.

This means you may inspect and obtain a copy of PHI about you that is contained in a designated record set for as long as we maintain the PHI. If you request we will provide a copy of your records in an electronic format. We may charge you a reasonable cost based fee for a copy of records.

You have the right to request a restriction of your PHI.

You may you may request for this practice not to use or disclose any part of your PHI for the purpose of treatment,

payment, or healthcare operations. We are not required to agree with these request. If we agree to a restriction request we will honor the restriction request unless information is needed to provide emergency treatment.

There is one exception: *We must accept a restriction request to restrict disclosure of information to a health plan if you pay out of pocket in full for a service or product unless it is otherwise required by law.*

You have the right to request for us to communicate in different ways or in different locations.

We will agree to reasonable request. We may also request an alternative address or other methods of contact such as mailing information to a post office box. We will not ask for an explanation from you about the request.

You may have the right to request an amendment of your PHI.

You may request an amendment of your health information if you feel that the information is not correct along with an explanation of the reason for the request. In certain cases, we may deny your request for an amendment at which time you will have an opportunity to disagree.

You have the right to a list of people or organizations who have received your health information from us.

This right applies to disclosures for purposes other than treatment, payment, or healthcare operations. You have the right to obtain a listing of these disclosures that occurred after April 14, 2003. You may request them for the previous six years or a shorter time frame. If you request more than one list within a 12 month period you may be charged a reasonable fee.

Additional Privacy Rights:

1. You have the right to obtain paper copy of this notice from us, upon request. We will provide you a copy of this notices the first day we treat you at our facility. In an emergency situation we will give you this notice as soon as possible.
2. You have a right to receive notification of any breach of your PHI.

Complaints:

If you think we have violated your rights or you have a complaint about our privacy practices you can contact our Privacy officer:

Joan Foschi
lknpediatricdentistry@gmail.com
(704) 966-1919
407 NC 16 Business Hwy
Denver, N.C. 28037

You may also submit complaints to the United Stated Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

If you file a complaint we will not retaliate against you for filing a complaint.
This notice was published and becomes effective December 17, 2018.