Carmel Dental Group
FAMILY & COSMETIC DENTISTRY

715 WEST CARMEL DRIVE, SUITE 103
CARMEL, INDIANA 46032
317 . 844 . 0022
CARMELDENTALGROUP.COM

PATIENT INFORMATION

Child's Full Name: _____

Male ☐ Female ☐ Age: _____ Birthdate: _____

Nickname: _____

Hobbies: _____

Siblings:

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Child's Home Address: _____

Child's Mailing Address: _____

Person Financially Responsible: _____

Parent Contact Number: (_____) _____

Parent Email: _____

Would you like to confirm appointments via email? Yes ☐ No ☐

Whom may we thank for referring you?:

_____

GUARDIAN INFORMATION

(Both Parent/Guardian information is required.)

Father's Name: _____

Father's Address:

Street: _____

City: _____ State: ____ Zip: _____

Father's Phone Number: (_____) _____

Father's Employer: _____

Father's Soc. Sec. #: _____ - _____ - _____

Father's Birthdate: _____

Does Father Have Insurance Coverage for Child? Yes ☐ No ☐

Mother's Name: _____

Mother's Address: _____

Mother's Phone Number: (_____) _____

Mother's Employer: _____

Mother's Soc. Sec. #: _____ - _____ - _____

Mother's Birthdate: _____

Does Mother Have Insurance Coverage for Child? Yes No ☐

INSURANCE INFORMATION

(Please Fill Out All Information Directly From Your Insurance Card)

Father's Insurance Plan Name: _____

Father's Insurance Card Phone Number: (____) _____

Father's Insurance Card Address: _____

Father's Insurance ID Number: _____

Father's Group ID Number: _____

Mother's Insurance Plan Name: _____

Mother's Insurance Card Phone Number: (____) _____

Mother's Insurance Card Address: _____

Mother's Insurance ID Number: _____

Mother's Group ID Number: _____

EMERGENCY CONTACT

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

Name: _____

Relationship: _____

Phone Number: (_____) _____

DENTAL HISTORY

Date of last visit to a dentist: _____

For what service: _____

Has your child been complaining about any dental problems?:

Yes ☐ No☐

Does your child brush their teeth daily? Yes ☐ No ☐

Does your child use floss daily? Yes ☐ No ☐

Does your child take fluoride in any form? Yes ☐ No ☐

Does your child have any injuries to mouth, teeth or head?

Yes ☐ No ☐

Any unhappy dental experiences? Yes ☐ No ☐

Any mouth habits - thumbsucking, nail biting, mouth breathing, pacifier,sleeping with bottle, etc.?

Yes ☐ No ☐

MEDICAL HISTORY

Child's Physician:_____

City: _____ State: _____

Physician's Phone Number: (____) _____

Date of last physical examination: _____

Results: _____

Is Minor/Child under the care of a physician now ? Yes ☐ No ☐

Receiving any medication or drugs? Yes ☐ No ☐

List: _____

Ever been hospitalized? Yes ☐ No ☐

Reason:_____

Ever had surgery? Yes ☐ No ☐

Reason: _____

Is there excessive bleeding when cut? Yes ☐ No ☐

Medications: _____

Allergies: _____

Allergies to Latex? Yes ☐ No ☐ Sulfa? Yes ☐ No ☐

Acrylic? Yes ☐ No ☐ Nickel? Yes ☐ No ☐

Dental Anesthetics? Yes ☐ No ☐

HAS THE MINOR/CHILD HAD ANY HISTORY OR DIFFICULTY WITH ANY OF THE FOLLOWING? IF SO, PLEASE CHECK:

☐ ADHD / ADD	☐ AIDS / HIV
☐ Anemia	☐ Aspergers Syndrome
☐ Asthma	☐ Arthritis Autism
☐ Autism	☐ Bladder Problems
☐ Cancer	☐ Chemotherapy/Radiation
☐ Chicken Pox	☐ Cerebral Palsy
☐ Cold Sores	☐ Convulsions
☐ Drug / Alcohol Abuse	☐ Diabetes
☐ Fainting	☐ Epilepsy
☐ Heart Murmur	☐ Hearing / Ear Problems
☐ Heart Valve Disorder	☐ Heart Problems
☐ Hepatitis	☐ Herpes
☐ Hyposensory	☐ Hypersensory
☐ Liver Disease	☐ Kidney Disease
☐ Mononucleosis	☐ Measles
☐ Rheumatic Fever	☐ Mumps
☐ Thyroid Disease	☐ Sinus Problems
☐ Other:	☐ Tuberculosis

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, 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 for my child/minor, including but not limited to x-rays, and the administration of anesthetics which are deemed necessary by the doctor, whether or not I am present at the actual appointment when treatment is rendered. I also understand that the use of anesthetic agents embodies a certain risk. I also authorize the use of nitrous oxide with my child in cases where the doctor feels would be appropriate or beneficial.

It is our policy that patients pay the portion of their balance that is not covered by insurance in full at the time of service. It is also our policy to request the legal guardian of the patient to prior-authorize a credit card on file for the following 30 days post receipt of a processed claim (or explanation of benefits) for any completed dental service that has not been paid. This is usually requested for moderate to larger procedures following preventative work. As a second option, you may pay with a check in the form of a deposit in the estimated amount if a credit card is not owned.

If your insurance company does not remit payment to our office within five (5) weeks post date of service, a statement for the balance will be sent to you and will be your responsibility. Any insurance payment received in overage from your payment would then be refunded.

I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable, at the time services are rendered. I further understand that a 1.5% finance charge (18% annually) will be added to balances over 60 days. In the event of default, I (we) agree to pay interest on the indebtedness, together with reasonable attorney fees and an additional 50% of balance added for the collection costs as will be required to effect collection of this account.

$25 will be charged for collection letters, returned check, appointment no show, and/or appointment cancellation with less than 48 hours notice.

I, _____ hereby acknowledge and agree that I am financially responsible for all services rendered by Dr. Cami L. Hovda. I understand that I am liable for all charges whether or not paid by insurance. Insurance estimates will be noted at time of service, please remember that this is only an estimate and please be prepared to pay all discrepancies once insurance has remitted payment to our office. I authorize the doctor to release all information necessary to secure a payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature _____ ☐ Parent ☐ Guardian Date: _____

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☐ Parent ☐ Guardian Date: _____

Signature _____

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Cami Hovda, DDS, PC

Carmel Dental Group

715 West Carmel Dr. Suite 103, Carmel, IN 46032 (317)844-0022

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: (_____) _____ E-mail: _____

Patient Number: _____ Social Security Number: _____ - _____ - _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Kim
Telephone: (317) 844-0022 Fax: (317) 844-0021
Address: 715 West Carmel Dr Suite 103, Carmel IN, 46032

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, 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 heath care operations.

Signature:_____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.
I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature:_____ Date: _____

Notice of Privacy Practices

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices. {Note: this form may need to be changed to reflect the dental practice's particular privacy policies and/or stricter state laws.}

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

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 January 1, 2010, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

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. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

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. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

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, your 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 a 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 inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of 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 authorized federal officials health information required for 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 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. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.25 for each page, $10.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

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, for the last 6 years, but not before April 14, 2003. 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 or 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).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation 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.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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 complain to us using the contact information listed at the end of this Notice. 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.

Contact Officer: Kim Ransom

Telephone: 317-844-0022 Fax: 317-844-0021

E-mail: info@carmeldentalgroup.com

Address: 715 West Carmel Drive Suite 103, Carmel, IN 46032

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT****

Cami Hovda, DDS, PC

Carmel Dental Group

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

Name: _____

Signature: _____

Date: _____

FOR OFFICE USE ONLY

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

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

_____

_____

_____

_____