# Jody Finazzo, DDS, MS
Child & Adolescent Dental Specialist


Dear Parent,

Welcome to our practice! We appreciate the trust you have shown in us by selecting our practice to provide your child's dental care. We are dedicated to providing the best dental care for children and adolescents in a happy and comfortable environment.

Many of our parents ask how to prepare their child for the first dental visit. We suggest you be very positive, stressing that a visit to the dentist will help your child keep a bright and healthy smile. You are welcome to visit our website at www.drjodydentist.com for further information regarding this or other dental topics you may want to explore.

During your child's first visit our primary goal is to develop a one-on-one relationship of trust and cooperation with your child. We will review and discuss your child's health history, perform a complete oral exam, cleaning of teeth, take x-rays if needed, and complete a fluoride treatment.

If your child's first visit with us is due to a referral from another dentist, please note that no dental treatment will be completed on the first visit. We will need to perform a complete exam and possible x-rays to determine the best course of treatment for your child. You should bring a copy of any x-rays that were taken at the referring dentist.

*A parent or legal guardian must be present at the time of the first visit. If this is not possible, please send legal documentation (a signed note from the parent or legal guardian giving consent for all dental treatment).*

Enclosed you will find a Medical and Dental History Form, an Insurance Authorization Form, and a Financial Policy Contract. Please complete all three forms and bring them with you to the first visit. The Financial Policy Contract must be signed by all responsible parties.

Please feel free to call our office with any concerns or questions prior to your visit.

We look forward to meeting you!

Sincerely,

Dr. Jody Finazzo

Dr. Jody Finazzo and Staff


12947 Northline Rd. · Southgate, MI 48195 · 734.285.8666 · Fax 734.285.8618
Making Kids Smile · www.drjodydentist.com

**Dr. Jody Finazzo DDS, LLC**

**PATIENT INFORMATION:**

Patient Name:______________________________________________________________
First MI Last Preferred Name

Child's Birthdate_______________Age_____ Sex (circle) M F

Child Lives With (circle) Both Parents Mother Father Guardian Grandparents

Child's Home Address_________________________City___________________Zip____________

Home Phone________________ Cell Phone_______________ Alternate Phone______________

Emergency Phone (Friend, neighbor, relative etc.)__________________________________________

Child's Physician or Pediatrician _______________________________Phone #_________________

Other members of family who are patients in our office_______________________________________

PARENT INFORMATION:

Mothers Name____________________________ Father's Name________________________

Mother's Employer_________________________ Father's Employer_____________________

Occupation_______________________________ Occupation__________________________

Social Security #__________________________ Social Security #______________________

Birthdate_______________________________ Birthdate____________________________

Email _________________________________ Email______________________________

DENTAL INSURANCE INFORMATION:

Insured Party's Name____________________________ Relationship to Child____________________

Employer_____________________________ Insurance Company______________________________

Group #_______________________________ Insured Party's Birthdate_________________________

IF MORE THAN ONE INSURANCE, PLEASE COMPLETE

Insured Party's Name____________________________ Relationship to Child____________________

Employer_____________________________ Insurance Company______________________________

Group #_______________________________ Insured Party's Birthdate_________________________

How did you hear about our office? ________________________________________________________

**PLEASE BE AS COMPLETE AS POSSIBLE**

## Medical History

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| AIDS or HIV Positive | __ | __ | Epilepsy | __ | __ |
| Allergies | __ | __ | Hearing Impaired | __ | __ |
| Artificial Prosthesis | __ | __ | Heart Disorder/Surgery | __ | __ |
| Asthma | __ | __ | Heart Murmur | __ | __ |
| Attention Deficit Disorder | __ | __ | Hepatitis/Liver Disorder | __ | __ |
| Anemia/Bleeding Disorder | __ | __ | Hyperactivity | __ | __ |
| Autism | __ | __ | Kidney Disorder | __ | __ |
| Blood Transfusion | __ | __ | Muscular Dystrophy | __ | __ |
| Brain/Nerve Damage | __ | __ | Motor Skills Delayed | __ | __ |
| Cerebral Palsy | __ | __ | Radiation Treatment | __ | __ |
| Chemotherapy | __ | __ | Rheumatic Fever | __ | __ |
| Counseling | __ | __ | Shunt | __ | __ |
| Cystic Fibrosis | __ | __ | Speech Delayed | __ | __ |
| Developmentally Impaired | __ | __ | Surgery | __ | __ |
| Diabetes | __ | __ | Vision Impaired | __ | __ |
| Eating Disorder | __ | __ | Other: ______________________________ | | |

Please explain any YES answers or other health problems: ________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

At the appropriate grade level for his/her age? (Circle) Yes No
If NO Please explain:______________________________________________________________________
__________________________________________________________________________________________

Is your child ALLERGIC to:

| | |
|---|---|
| __ Latex | __Penicillin |
| __ Food Coloring | __Clindamycin |
| __ Nuts | __Azithromycin (Z-pack) |
| __ Gluten | Other____________ |

Take any Medication now? (Circle) Yes No If yes, list medications and indicate reason for taking:

_______________ _____________________________________________________________________
_______________ _____________________________________________________________________
_______________ _____________________________________________________________________

Has your child had any injury to face, head or neck (Circle) Yes No
If YES Please explain______________________________________________________________________
__________________________________________________________________________________________

**Dr. Jody Finazzo DDS, LLC**

## DENTAL HISTORY

Any previous dental experience? __YES __ NO

Where?__________________________________ When?___________________________________________

What treatment was rendered (exam, cleaning, fillings, etc.)?_______________________________________________________

How did the child react? ___________________________________________________________________________________

Main dental concern currently? ____________________________________________________________________________

Mouth habits? (pacifier, thumb, finger, nail biting)________________________________________________________________

Does your child brush daily? __YES __NO How many times a day? ____________________________________

Do you help your child brush? __YES __NO Type of toothpaste? ________________________________________

Does your child floss daily? __YES __NO

Do you help with flossing? __YES __NO

Is your child currently being breastfed? __YES __NO

If YES, is your child breastfed on demand/or at naptime/bedtime __YES __NO

Please explain_________________________________________________________________________________________

Or does your child use a bottle or a sippy cup? __YES __NO

If YES, what is usually in the bottle or sippy cup? __________________________________________________________

If YES, does your take the bottle or sippy cup to bed/at naptime? __YES __NO

Does your child drink often between meals? __YES __NO

If YES, what is the usual liquid (i.e. milk, juice, water) ______________________________________________________

Does your child have set meal times? __YES __NO

Does your child snack often or between meals? __YES __NO

If YES, on what type of foods? (i.e. fruit, crackers, cheese)___________________________________________________

Does your child eat sweetened/sticky foods (i.e. fruit snacks, raisins, sticky candy, sticky granola bars) __YES __NO

If YES, on what sticky foods? ______________________________________________________________________

IF YES, how often (i.e. daily, few times a week)? __________________________________________________________

**Because your child is a minor, it is necessary to obtained signed permission from a parent or legal guardian. The above statements are, to the best of my knowledge, true and correct. I agree to report any health changes to the dentist before any treatment is performed. I hereby authorize Dr. Finazzo and her staff, to perform any examinations, x-rays, and procedures to diagnose oral and dental disease, and to provide any necessary dental treatment. This consent shall remain in full force and effect unless cancelled.**

**Patient Name**_____________________________________________________________________________________________

**Signature of Parent or Legal Guardian**___________________________________________________**Date**__________________________

**Jody Finazzo DDS, LLC**

**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.**

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## 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 (MM/DD/YR), 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.

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### 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.

**CONTINUE ON OTHER SIDE** →

**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).

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**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 $0.50 for each page, $15.00 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.

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**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 Service

Contact Officer: Rene Meeker Contact Phone: (734) 285-8666 Address: 12947 Northline Rd Southgate MI 48195

**Acknowledgement of Receipt of Notice of Privacy Practices**

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**Purpose**: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

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**Jody Finazzo DDS, LLC** **Acknowledgement of Receipt of Notice of Privacy Practices.** ***You may refuse to sign this acknowledgement.***

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

**Name (Print)_________________________________Signature_____________________________________Date_____________**

**OFFICE USE**

**We attempted to obtain written acknowledgement of our Notice of Privacy Practices, but acknowledgement could not be obtained because_________________________________________________________________________________________.**

# JODY A. FINAZZO DDS, MS

**Child and Adolescent Dental Specialist•12947 Northline Rd, Southgate, MI 48195**
**(734) 285-8666 fax (734) 285-8618**

## FINANCIAL POLICY CONTRACT PATIENT NAME_______________________________

***This policy is written so that you have a clear understanding of your financial obligation. We know that pediatric oral health is one of many family expenses and we will do our best to address your individual financial concerns.***
***We strive to always inform before we perform and to quote an approximate fee before services are rendered when at all possible. However, your actual cost may be greater than, or less than, the approximate fee.***

## *PLEASE INITIAL NEXT TO ITEM*

_______ **PAYMENT**

**Payment is due at the time of the treatment. Please come prepared to pay your portion. If the child is NOT accompanied by a parent, payment is still expected at time of service.** We accept the following payment options: Cash, check, credit card/debit (Visa and MasterCard) and Care Credit. We are a small business and do not extend credit. Payment is expected on the day of treatment. There is a $35 returned check fee. Should this happen, future payments will need to be made in cash, credit card, money order or certified funds.

All payments are to be made to: **Jody A. Finazzo, D.D.S., L.L.C., 12947 Northline Rd, Southgate Michigan 48195**

________ **DENTAL INSURANCE**

If dental insurance is involved, we will attempt to have the most current information ready for your initial visit. It is your responsibility to inform us of any changes in your insurance coverage prior to any dental appointment. Before your appointment, our business staff will attempt to directly contact your insurance company and verify:

- Current eligibility
- Benefits, yearly maximums, and effective dates
- Co-pay percentages and deductibles
- Any other important considerations

**PLEASE NOTE: ANY VERBAL OR WRITTEN INSURANCE INFORMATION/VERIFICATION THAT WE RECEIVE FROM YOUR INSURANCE COMPANY IS NOT A GUARANTEE OF PAYMENT OR EXACT PAYMENT FROM THEM.**
We know from experience that each insurance company is different and their schedule of benefits and payments can vary greatly. We will estimate the amount not covered by your insurance at the time of service, and will expect this amount to be paid. After all insurance moneys are received any portion that is not covered by your insurance carrier remains your responsibility. Any overpayment by the insurance company will be refunded if requested by your otherwise the credit will be left on your account. Please note that most insurance companies can request a refund to them of any overpayment by them at any time. If this occurs, any balance will be your responsibility. In addition, if we have difficulty in receiving payment from your insurance company, the responsibility of payment will be yours.

________ **NO SHOW/BROKEN APPOINTMENT/CANCELLATION POLICY**

***Since appointment times are reserved exclusively for each patient, we require a 24 hour advanced cancellation notice***. Dr. Finazzo's office reserves the right to or apply a no show or same day cancellation fee for each patient's broken appointment or require a monetary deposit before a missed appointment can be rescheduled (especially in the case of chronic broken appointments). **SPECIAL NOTE: If there is no 24 hour cancellation notification, we also reserve the right to terminate treatment and dismiss a patient.**

________ **RESPONSIBLE PARTY**

The party or parties who sign this contract is financially responsible for all charges incurred.

________ **PAST DUE ACCOUNTS**

Any account not kept current (30 days or over is not current) will be considered delinquent and any remaining balance becomes due immediately. All accounts delinquent over 90 days will be considered for the collection process. Adding to the balance due, you will be responsible for all actual legal and court fees and/or collection fees incurred in the collection process. All accounts past 90 days must be paid with certified funds, credit card, cash, or money order. This contract also authorizes Josephine (Jody) A. Finazzo DDS, LLC to obtain a credit report in the event that your account becomes delinquent and goes into the collection process.

***The above policies are subject to change at any time without notice.***

***Should you fail to abide by any of the terms or conditions set forth in this contract, it will be considered a material default of your agreement with us, and we reserve the right to terminate treatment.***

**I HEREBY CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE POLICIES AND AGREE TO THEM. IN ADDITION I UNDERSTAND IT IS REQUIRED TO PROVIDE ALL OF THE INFORMATION BELOW IN ORDER FOR MY CHILD TO BE ACCEPTED AS A PATIENT OF THE OFFICE.**

**Signature**_____________________________________________________________**Dated**_____________________

**Printed Name**_________________________________________________________________________________

**Social Security** _________/______/_________ **(OR) State ID/Driver's License #** ___________________________

**Signature**____________________________________________________________ **Dated**______________________

**Printed Name**__________________________________________________________________________________

**Social Security**________/______/__________ **(OR) State ID/Driver's License#**_____________________

**INSURANCE AUTHORIZATION**
(PRIMARY INSURANCE)

**Jody Finazzo DDS, MS**
**Child and Adolescent Dental Specialist**

**12947 Northline Rd**
**Southgate, MI 48195**

Print Patient's Name: ________________________________________________

Employee's Name: ___________________________________________________

Employee's ID # (if applicable): __________________________________________

Employee's Social Security #_______/________/________

Employer: ________________________________________________________

Dentist's Name: *Josephine (Jody) Finazzo DDS, LLC*

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care to third party payors and/or other health practitioners. I authorized request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered of the above named for whom I have authorized treatment

X______________________________________________________________

Parent or Legal Guardian Signature (if patient is a minor)

**INSURANCE AUTHORIZATION**
(SECONDARY INSURANCE)

**Jody Finazzo DDS, MS**
**Child and Adolescent Dental Specialist**

**12947 Northline Rd**
**Southgate, MI 48195**

Print Patient's Name: ________________________________________________

Employee's Name: ___________________________________________________

Employee's ID # (if applicable): __________________________________________

Employee's Social Security #_______/________/________

Employer: ________________________________________________________

Dentist's Name: *Josephine* (*Jody) Finazzo DDS, LLC*

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care to third party payors and/or other health practitioners. I authorized request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered of the above named for whom I have authorized treatment.

X______________________________________________________________

Parent or Legal Guardian Signature (if patient is minor)