We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

1 Tell Us About Your Child:

Today's Date: _____

CHILD'S NAME: _____

Nickname: _____ Birthdate: _____ Age: ____

❑ Male ❑ Female School : _____

Child's Home Address: _____

City, State & Zip Code: _____

Child's Home # : ( ) _____

2 Who Is Accompanying The Child Today?

Name: _____ Relation: _____

Do you have legal custody of this child? ❑Y ❑ N

Whom may we thank for referring you? _____

Other family members seen by us: _____

_____

Previous/Present Dentist: _____

Last Visit: _____ Last Cleaning: _____

3 Mother's Information: ❑Stepmother ❑Guardian

Name: _____ Birthdate: _____

Hm#( ) _____ Wk#( ) _____ Cell _____

Employer: _____

SS#: _____ DL#: _____

E-Mail _____

Father's Information : ❑Stepfather ❑Guardian

Name: _____ Birthdate: _____

Hm#( ) _____ Wk#( ) _____ Cell _____

Employer: _____

SS#: _____ DL#: _____

Parent's Marital Status: ❑Single ❑Widowed ❑Separated ❑Married ❑Divorced

4 Person Responsible For Account:

Name: _____ Relation: _____

Billing Address: _____

_____

How long at this address? _____ Hm# _____

Previous Address (if less than 3 yrs.) _____

_____

Employer: _____

Occupation _____ #Yrs Employed ___

Wk#( ) _____ Ext. ____ DL# _____

SS# _____ Birthdate: _____

Spouse's Name _____ Birthdate: _____

Employer: _____

Occupation: _____ #Yrs Employed _____

Wk#( ) _____ Ext: ___ SS# _____

5 Dental Insurance:

Policy Owner's Name: _____

Ins. Co. Name: _____

Ins. Co. Address: _____

Ins. Co. Phone # : ( ) _____

Group #: _____ SS#: _____

Relation to patient: _____ Birthdate: _____

Employer: _____

Do you have Secondary Coverage? ❑ Yes ❑ No

Policy Owner's Name: _____

Employer: _____

Ins. Co. Name: _____

Ins. Co. Phone # : ( ) _____

Group #: _____ SS#: _____

OVER PLEASE

6 Dental History:

Why did you bring the child to the dentist today? _____

Has the child ever had a serious / difficult problem associated with previous dental work?	❑ Yes	❑ No
Is the child's water fluoridated ? Or is the child taking fluoridated supplements ?	❑ Yes	❑ No
Has the child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD) ?	❑ Yes	❑ No
Does the child brush his / her teeth daily ? ❑ Yes ❑ No Floss his / her teeth daily?	❑ Yes	❑ No
Does / did the child have any of the following habits? Lip sucking/biting	❑ Yes	❑ No
Nursing Bottle Habits	❑ Yes	❑ No
Nail Biting	❑ Yes	❑ No
Thumb / Finger Sucking	❑ Yes	❑ No

Previous / Present Dentist : _____ Last visit date: _____

Last cleaning appt. : _____

7 Medical History :

Has the child had any of the following medical problems ?

Abnormal Bleeding	Yes❑	No❑	Handicaps / Disabilities	Yes❑	No❑
Allergies to any drugs	Yes❑	No❑	Hearing Impairment	Yes❑	No❑
Any Hospital Stays	Yes❑	No❑	Heart Murmur	Yes❑	No❑
Any Operations	Yes❑	No❑	Hemophilia	Yes❑	No❑
Asthma	Yes❑	No❑	Hepatitis	Yes❑	No❑
Cancer	Yes❑	No❑	HIV+ / AIDS	Yes❑	No❑
Congenital Heart Defect	Yes❑	No❑	Kidney / Liver Problems	Yes❑	No❑
Convulsions / Epilepsy	Yes❑	No❑	Rheumatic / Scarlet Fever	Yes❑	No❑
Diabetes	Yes❑	No❑	Tuberculosis (TB)	Yes❑	No❑

Child's Physician : _____ Phone : _____

Is the child currently under the care of a physician ? ❑ Yes ❑ No Date of Last Visit: _____

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

_____

Please list all drugs that the child is allergic to : _____

_____

Please discuss any serious medical problems that the child has had : _____

_____

_____

_____

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I understand that the information that I have given is correct to the best of my knowledge, 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 my child may need. I understand that where appropriate, credit bureau reports may be obtained.

Signature of parent or guardian: _____ Date: _____

Financial Agreement

To our patients with dental insurance:

As a courtesy, we will be happy to assist you by completing your claim forms. In addition to filing the claim, we will initially ask you for your *estimated portion.* Please understand this is only an estimate.

The financial obligation for dental treatment is between you and our office. The insurance company is **responsible to you, and not our office.** Once your carrier has paid the claim, any difference will be due upon receipt of our statement. If for any reason, we have not received your insurance carrier's payment with **60 days** after the claim, the remaining balance will be due and payable by you.

Additional Terms and Obligations:

Past due balances are subject to a finance charge of 1.5% per month from the date of the treatment, and in the event unpaid balances are turned over for collection, you agree to pay reasonable attorney's fees and expense, whether the same be collected or secured by suit otherwise.

Signature: _____
Printed Name: _____
Date: _____

Drs. Thomas and Moore
801-B University Blvd. S
1059 Snow Rd S.
Mobile, AL
251-345-1717

Drs. Thomas & Moore

PEDIATRIC DENTISTRY

801-B UNIVERSITY BOULEVARD SOUTH

MOBILE, ALABAMA 36609-2997

(251) 345-1717

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect October 1, 2013 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

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 if 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.

Our Privacy Official: Penny Spurlock

Telephone: 251-345-1717 Fax: 251-343-0835

Address: 801 - B University Blvd. South, Mobile, AL 36609

E-Mail: Universityblvd@aol.com

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I have received and reviewed a copy of our dental practice's privacy, security and breach notification polices and procedures.

I understand that I should ask our dental practice's Privacy Official if I have any questions about these policies and procedures.

Print Name: _____

Signature: _____

Date: _____

Appointment Policy

We do our best to schedule appointments at your convenience. Preschool children are best seen in the morning because they are refreshed from a good night's sleep. School aged children who may require longer appointments may also benefit from a morning appointment. Dental appointments are an excused absence at all schools. Missing school can be kept to a minimum when regular dental care is continued. After school appointments are VERY popular, so we recommend scheduling your next six month recall appointment at the time of your visit.

We ask that you respect the appointment times by keeping them. Please note, we kindly request at least a 24-hour notice to change an appointment. **No-show appointments and appointments cancelled with less than a 24-hour notice will be subject to a $20 fee per child.**

It is understandable that sometimes cancellations cannot be helped due to illness or emergency. We will take all valid circumstances into account.

We make every effort by phone, text messages or email to contact you to confirm your appointments a day or two before the appointment. We can only do this if we have current contact information from you. Please keep us informed of any changes to your contact information.

I have read and understand the above policy.

Signature: _____ Date: _____