Children's Dental Office
Dr. Casper and Associates

Date_____

Patient Information

Patients Name _____ _____**M / F**
Last First Middle Nick Name Sex

Who is Accompanying the Child Today?
Name_____ **Relationship**_____**Custody yes/no**

Address_____
Street City State Zip

Mailing Address _____
Street City State Zip

Home Phone _____**Birthdate**_____**age**_____**Social Security #**_____

Patient's Physician_____**Phone Number**_____**Referred by** _____

Other Family members in treatment_____

Responsible Party Information

Name _____ _____**M / F**
Last First Middle Marital Status Sex

Address_____
Street City State Zip

Mailing Address _____ _____
Street City State Zip

Relationship to Patient_____ _____**Birthdate**_____**Social Security #**_____

Email_____**Phone**_____**Work Phone**_____**Cell Phone**_____

Employer_____**Occupation**_____**No of Years** _____

Spouse's Name_____ _____
Last First Middle

Relationship to Patient_____**Birthdate**_____**Social Security #**_____

Email_____**Phone**_____**Work Phone**_____**Cell Phone**_____

Employer_____**Occupation**_____**No of Years** _____

Dental Insurance Information

Policy Holders Name _____**Birthdate**_____**Insured Social Security No.**_____

Insurance Company_____**Group No.**_____**Local No.**_____

Insurance Company Address _____

Employer_____ _____**Insurance Co Phone NO.**_____

Do you have dual coverage? Yes ☐ **NO** ☐ **if Yes:**

Policy Holders Name _____**Birthdate**_____**Insured Social Security No.**_____

Insurance Company_____**Group No.**_____**Local No.**_____

Insurance Company Address _____

Employer_____ _____**Insurance Co Phone NO.**_____

Medical History

Dental History

Is this your child's first visit to the dentist? _____

If not, how long since the last visit to the dentist? _____

Were any X-rays taken at previous dental visits? _____

Have there been any injuries to the teeth, face or mouth? _____
If yes please explain: _____
_____
_____

Why did you bring the child to the dentist today_____
_____
_____

Does the child have any of the following habits:

Y N Lip Sucking/Biting Y N Nail Biting

Y N Nursing Bottle Habits Y N Thumb/Finger Sucking

Has the child ever had a serious or difficult problem associated with previous dental work? Y N

If yes, please explain
_____
_____
_____

Is the child's water fluoridated? Yes No

Is the child taking fluoride supplements? Yes No

Has the child ever had any pain or 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

Please list all drugs the child is currently taking_____
_____

Please list all drugs the child is allergic to_____
_____

Child's Physician_____
Phone# _____
Is the child currently under the care of a physician Yes NO

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

Health History

Has the child ever had any of the following problems:

Abnormal Bleeding	Yes	No
Allergies to any drugs	Yes	No
Any Hospital Stays	Yes	No
Any Operations	Yes	No
Asthma	Yes	No
Cancer	Yes	No
Congenital Heart Disease	Yes	No
Convulsions/Epilepsy	Yes	No
Pregnancy	Yes	No
Handicaps/Disabilities	Yes	No
Hearing Impairment	Yes	No
Heart Murmur	Yes	No
Hemophilia	Yes	No
Hepatitis	Yes	No
Hiv = / Aids	Yes	No
Kidney/Liver Problems	Yes	No
Rheumatic/Scarlet Fever	Yes	No
Allergies to Latex Products	Yes	No

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

I understand that the information 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.

_____
Signature of parent or guardian Date

_____
Relationship to Patient

Children's Dental Office and Orthodontics
Office Financial Policy

Welcome to our office and thank you for choosing us as your dental care provider. We take that responsibility very seriously and we are committed to providing you with the best possible care. **Please understand that payment is considered part of your treatment**. The following is our Financial Policy which we require you to read and sign prior to any treatment. Before seeing the doctor, you are required to complete the information/medical history form.

Regarding Payment

Payment for services is due at the time of service; (see below if insurance applies). We accept the following forms of payment: Cash, Check, Visa, MasterCard, Discover and American Express. For more extensive treatment we offer payment through Care Credit. Please ask about this program. Returned checks will have a fee of $30.00 added to the amount of the returned check.

The parent that accompanies the minor child/children to the appointment is responsible for any payment due. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized before the appointment date or arrangements have been made with the Office Administrator.

Regarding Insurance

Your insurance policy is a contract between you and your insurance company and/or employer. We are not a party to that contract. As an office courtesy we will submit a claim to your insurance company. In the event we do accept assignment of benefits and your insurance company has not paid your account in full within 45 days, the balance will be transferred to your account. Please be aware that some, and perhaps all, of the services provided may be non-covered services under the terms of your insurance policy. **IT IS YOUR RESPONSIBILITY, AS THE INSURED, TO KNOW YOUR BENEFITS**. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of an insurance company's arbitrary determination of usual and customary rates.

In the event we DO NOT participate with your insurance, we expect all fees to be paid at the time of service and as a courtesy we will submit a claim to your insurance company, and they will send any reimbursement directly to you.

Your complete insurance information must be presented at the time services are provided. Insurance claims cannot be backdated. All insurance co-pays and deductible must be paid at the time of service.

Cancellation Policy

Please help us serve all our patients needs better by keeping scheduled appointments. Please note that, unless appointments are cancelled **24 hours** in advance, you will be charged for a missed appointment at the rate of **$50.00** for scheduled hygiene appointments and **$100.00** for scheduled procedures. Please call the office as soon as possible if you have to reschedule.

Agreement

We would be happy to discuss our charges and how they relate to your particular situation. Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read, understand and agree to this Financial Policy.

_____

Signature / Date

Notice of Privacy Practices

April 2, 2003

Jerome S. Casper Childrens Dental Office, P.A.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include crowns, fillings, teeth cleaning services, etc.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your dental plan for your dental services.
- **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services including release of information to friends and family members that are directly involved in your care or who assist in taking care of you. We will use and disclose your protected when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the

dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We will release your PROTECTED HEALTH INFORMATION if requested by a law enforcement official for any circumstance required by law. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs. We may release PROTECTED HEALTH INFORMATION to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your PROTECTED HEALTH INFORMATION if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your protected health information TO FEDERAL OFFICIALS FOR INTELLIGENCE AND NATIONAL SECURITY ACTIVITIES AUTHORIZED BY LAW. We may disclose PROTECTED HEALTH INFORMATION to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations. We may disclose your PROTECTED HEALTH INFORMATION to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you; (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public. We may release your PROTECTED HEALTH INFORMATION for workers' compensation and similar programs.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.
- The right to access, inspect and copy your PROTECTED HEALTH INFORMATION.

- The right to request an amendment to your PROTECTED HEALTH INFORMATION.
- The right to receive an accounting of disclosures of PROTECTED HEALTH INFORMATION outside of treatment, payment and health care operations.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:

HIPAA Official, Carol Hart
Jerome S. Casper Childrens Dental Office, P.A.
2923-D Olney Sandy Spring Road, Olney MD 20832
301-924-5500

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
877-696-6775 (toll-free)

Acknowledgement of Receipt of Privacy Practices

I, _____ have received a copy of **Jerome S. Casper Children's Dental Office, P.A**.'s Notice of Privacy Practices with an effective date of April 2, 2003.

Name of Patient

Address of Patient

Signature of Parent/Guardian _____ Date _____ (or Patient if 18 or older)

Name of Witness _____

Signature of Witness _____ Date _____

Children's Dental Office and Orthodontics
Authorization and Consent

Permit for Dental Services Upon A Minor

Thank you for choosing our office to serve your child's dental needs. Each child who comes to us is special, and we try hard to provide quality work and service. Also, we constantly seek new ways to serve you better. Please let us know if there is any way you think we can better serve you. It may not be possible to act upon every request, but all comments are respectfully appreciated and considered. If you like the care your child is receiving here, please tell your friends about us. We welcome new patients.

I, being the parent or legal guardian of the child named on this form, do hereby authorize and request the performance of dental services upon this patient and do authorize emergency procedures that the judgment of the doctor may determine to be necessary during treatment. I agree to services necessary for the care of my child.

Patient Name:_____ Parent/Guardian:_____
Please Print
Relationship:_____
*I have the legal authority to sign this on behalf of above named patient*_____
Signature

Consent to use of records

I hereby give my permission for the use of records, including photographs made in the process of examinations, treatment and care for purposes of professional consultations, research, education or publication in professional journals and internal or external marketing initiatives.

_____ _____
Signature Date

Authorization for release of patient information

I hereby authorize Children's Dental Office to release complete dental records and/or any x-rays concerning the overall dental care and treatment as deemed appropriate. I understand that once released, the above doctor(s) and staff has (have) no responsibility for any further release by the individual receiving this information.

_____ _____
Signature Date

Witness_____ Date_____