PATIENT REGISTRATION

PATIENT INFORMATION

Patient name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Birthdate: _____ SSN: _____

School patient attends: _____

Whom may we thank for referring you or how did you hear about us? _____

RESPONSIBLE PARTY

Name of person responsible for this account: _____

Address: _____

City: _____ State: _____ ZIP: _____

Employer: _____

Business Address: _____

City: _____ State: _____ ZIP: _____

Relationship to patient: _____ Home phone: _____

Work phone: _____ Cellphone: _____

Responsible party's birthdate: _____ SSN: _____

INSURANCE INFORMATION

PRIMARY INSURANCE

Name of insured: _____

Relationship to patient: _____

Primary dental insurance company, including address:

_____

_____

Insurance phone: _____

Group name/number: _____

Insured date of birth: _____

SSN of insured: _____

ADDITIONAL/SECONDARY INSURANCE

Name of insured: _____

Relationship to patient: _____

Primary dental insurance company, including address:

_____

_____

Insurance phone: _____

Group name/number: _____

Insured date of birth: _____

SSN of insured: _____

MEDICAL HISTORY

PATIENT NAME: _____

PATIENT MEDICAL HISTORY

Physician Name: _____ Physician Phone: _____

Routine Exams ❍ Yes ❍ No Is your child under medical treatment now? ❍ Yes ❍ No

Has your child been hospitalized for surgery or serious illness? ❍ Yes ❍ No

If yes, please explain: _____

DOES YOUR CHILD HAVE OR HAS HE/SHE HAD ANY OF THE FOLLOWING? (Please mark all with a yes or no)

Problems at Birth	❍ Yes ❍ No	Eye Problems	❍ Yes ❍ No	GERD	❍ Yes ❍ No	Speech Problems	❍ Yes ❍ No
Heart Murmur	❍ Yes ❍ No	AIDS/HIV	❍ Yes ❍ No	Seizures	❍ Yes ❍ No		
Heart Disease	❍ Yes ❍ No	Tuberculosis	❍ Yes ❍ No	Autism	❍ Yes ❍ No	Additional Concerns (please list)	
Rheumatic Heart Disease	❍ Yes ❍ No	Liver Disease	❍ Yes ❍ No	ADD/ADHD	❍ Yes ❍ No		
Anemia/SCA	❍ Yes ❍ No	Kidney Disease	❍ Yes ❍ No	Behavior Problems	❍ Yes ❍ No		
Bleeding/Hemophilia	❍ Yes ❍ No	Diabetes	❍ Yes ❍ No	Tobacco/Drug Use	❍ Yes ❍ No		
Blood Transfusion	❍ Yes ❍ No	Arthritis	❍ Yes ❍ No	Respiratory Problems	❍ Yes ❍ No		
Hepatitis	❍ Yes ❍ No	Cancer	❍ Yes ❍ No	Asthma	❍ Yes ❍ No		
Sleep Problems	❍ Yes ❍ No	Cerebral Palsy	❍ Yes ❍ No	Eczema	❍ Yes ❍ No		
Cleft Lip/Palate	❍ Yes ❍ No	Skin Problems	❍ Yes ❍ No	Tonsile/Adenoid Issues	❍ Yes ❍ No		

IS YOUR CHILD ALLERGIC TO ANY OF THE FOLLOWING?

❍ Medication ❍ Environmental ❍ Food ❍ Latex

❍ Other (please explain): _____

_____

PLEASE LIST ALL CURRENT MEDICATIONS (Incuding herbal/non-pres)

_____

_____

_____

If your child has asthma, when was his/her last episode? _____

ER Visits: _____ Last Hospitalization: _____ Last Albuterol Use: _____

Has your child ever had dental x-rays? ❍ Yes ❍ No

Has your child ever had problems with dental anesthetic? ❍ Yes ❍ No

Do you expect your child to be a cooperative dental patient? ❍ Yes ❍ No

What are you looking for in a new dental practice for your child? _____

RATE YOUR CHILD'S COMFORT LEVEL WITH DENTAL TREATMENT:

Unknown_____ No Problem_____ Slightly Anxious_____

Moderately Anxious_____ Fearful_____

NOTE PROBLEM YOUR CHILD HAS HAD WITH PAST DENTAL EXPERIENCES:

_____

_____

DOES YOUR CHILD HAVE OR HAS HE/SHE HAD ANY OF THE FOLLOWING?

Thumb Sucking	❍ Yes ❍ No	How Long? _____	Still Active? ❍ Yes ❍ No
Finger Habit	❍ Yes ❍ No	How Long? _____	Still Active? ❍ Yes ❍ No
Pacifier	❍ Yes ❍ No	How Long? _____	Still Active? ❍ Yes ❍ No
Sippy Cup	❍ Yes ❍ No	How Long? _____	Still Active? ❍ Yes ❍ No

CHILD'S BRUSHING/DENTAL CARE HABITS:

How often does your child brush? _____ How often does your child floss? _____

Is toothbrushing supervised? _____ By whom? _____

Does your child receive: Fluoridated water ❍ Yes ❍ No Bottled Water ❍ Yes ❍ No

Well water ❍ Yes ❍ No Fluoride in vitamins ❍ Yes ❍ No Fluoride tablets/drops ❍ Yes ❍ No

REASON FOR TODAY'S VISIT:

Routine	_____
Behavior	_____
Orthodontics	_____
Emergency	_____
Physical/Developmental	_____
Cosmetic	_____
Decay	_____
Habit	_____
Other	_____

Notice of Privacy Practices Acknowledgement

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

I, _____ have received a copy of Hines Little Smiles, LLC's Notice of Privacy Practices.

Patient's Name: _____

Signature of Parent or Guardian: _____

Date: _____

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

Personal Representative's Name: _____

Relationship to Patient: _____

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 acknowledgment

❍ An emergency situation prevented us from obtaining acknowledgement

❍ Other (Please specify_____

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

Our Legal Duty

Federal and state laws require us to maintain the privacy of your health information. We are also required to provide this Notice about our office's privacy practices, our legal duties, and your rights regarding your health information. We are required to follow the practices that are outlined in this Notice while it is in effect. This Notice takes effect _____ 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 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 additional copies of this Notice, please contact us using the information listed at the end of this Notice.

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 is 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you without authorization for the following purposes:

Treatment: We disclose medical information to our employees and others who are involved in providing the care you need. We may use or disclose your health information to another dentist or other healthcare provider providing treatment which we do not provide. We may also share your health information with a pharmacist in order to provide you with a prescription, or with a laboratory that performs tests or fabricates dental prostheses or orthodontic appliances.

Payment: We may use and disclose your health information to obtain payment for services we provide you, unless you request that we restrict such disclosure to your health plan when you have paid out-of-pocket and in full for services rendered.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include, but are not limited to, quality assessment and improvement activities, reviewing the competence or qualification of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. You have the right to request restrictions on disclosure to family members, other relatives, close personal friends, or any other person identified by you.

Unsecured Email: We will not send you unsecured emails pertaining to your health information without your prior authorization. If you do authorize communications via unsecured email, you have the right to revoke the authorization at any time.

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 both. 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 practise 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.

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

Marketing Health-Related Services: We may contact you about products or services related to your treatment, case management or care coordination, or to propose other treatments or health-related benefits and services in which you may be interested. We may also encourage you to purchase a product or service when you visit our office. If you are currently an enrollee of a dental plan, we may receive payment for communications to you in relation to our provision, coordination, or management of your dental care, including our coordination or management of your health care with a third party, our consultation with other health care providers relating to your care, or if we refer you for health care. We will not otherwise use or disclose your health information for marketing purposes without your written authorization. We will disclose whether we receive payments for marketing activity you have authorized.

Change of Ownership: If this dental practice is sold or merged with another practice or organization, your health records will become the property of the new owner. However, you may request that copies of your health information be transferred to another dental practice.

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

Public Health: We may, and are sometimes legally obligated, to disclose your health information to public health agencies for purposes related to preventing or controlling disease, injury or disability; reporting abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. Upon reporting suspected elder or dependent adult abuse or domestic violence, we will promptly inform you or your personal representative unless we believe the notification would place you at risk of harm or would require informing a personal representative we believe is responsible for the abuse or harm.

Notice of Privacy Practices

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 institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Appointment Reminders: We may contact you to provide you with appointment reminders via voicemail, postcards, or letters. We may also leave a message with the person answering the phone if you are not available.

Sign In Sheet and Announcement: Upon arriving at our office, we may use and disclose medical information about you by asking that you sign an intake sheet at our front desk. We may also announce your name when we are ready to see you.

Decedents: We may disclose health information about a decedent as authorized or required by law.

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 contacting our office. 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. If you request copies, there may be a charge for time spent. If you request an alternate 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 for a full explanation of our fee structure.

Disclosure Accounting: You have a right to receive a list of instances in which we disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities for the last six years. 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 certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). We must comply with a request to restrict the disclosure of protected health information to a health plan for purposes of carrying out payment or health care operations (as defined by HIPAA) if the protected health information pertains solely to a health care item or service for which we have been paid out-of-pocket in full.

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 mush specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.

Breach Notification: In the event your unsecured protected health information is breached, we will notify you as required by law. In some situations, you may be notified by our business associates.

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: You may receive a paper copy of this notice upon request, even if you have agreed to receive this notice electronically on our website or by electronic mail (Email).

Research: Your health information may be disclosed to researchers for research purposes. In this situation written authorization is not required as approved by an Institutional Review Board or privacy board.

Fundraising: We may use or disclose demographic information and dates of treatment in order to contact you for fundraising activities. If you no longer wish to receive these communications, notify us at the contact information provided below and we will stop sending further fundraising information.

Questions and Complaints:

If you want more information about our privacy practices, or have questions or concerns, please contact Alyssa Spandikow at (614) 475-5439. You may also fax your questions or concerns to (614) 476-8558, email to mhines@hineslittlesmiles.com or mail to 5715 N. Hamilton Rd., Columbus, OH 43230.

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 send a written complaint to our office or to the U.S. Department of Health and Human Services, Office of Civil Rights. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We will not retaliate against you for filing a complaint.

Office Policies Consent Form

OFFICE POLICY & CONSENT FORM

Please remember that we are here to serve you in a comfortable and professional atmosphere.
Our goal is to provide you with the very best quality of dental care.

INSURANCE & PAYMENT POLICIES:

- **FEES FOR SERVICE AT OUR OFFICE WILL BE REQUESTED AT THE TIME OF YOUR VISIT.** For treatment involving fees above $500.00, special financial arrangements may be discussed with our office manager.
- For patients with dental insurance: **We will file your claim for you at no charge, however, we ask that your deductibles and your estimated portions (20-60%) be paid as services are rendered. Your dental insurance is designed to be an assistance to you, and will not always cover all dental expenses. Although we gladly file dental insurance claims, any and all account balances are ultimately your responsibility.**

  All insurance benefits are assigned to the Doctor, unless services are paid-in-full the day of treatment.
- Please Note: For your convenience, we accept VISA, MasterCard, Discover, Care Credit, checks and cash.

OFFICE POLICIES:

- Your appointment time is set aside especially for you. We ask for courtesy to the Doctor and to other patients that you keep your scheduled appointments. **If you must change or miss an appointment, we would appreciate a two-business day notice. Repeated cancellations or failures to keep your appointment could result in a broken appointment charge of $35 or no re-appointment.**
- We realize that many families are in a state of change. **The policy in our office is that the parent who requests treatment for a child is responsible to us for all fees incurred.**
- We will be fair in working out special finances with you, but please also be fair to us with your commitments. **A 1.5% finance charge will be assessed monthly on all overdue balances.**

CONSENT:

I have read and understand the above information. The undersigned hereby authorizes the Doctor to perform those diagnostic and treatment procedures, including local anesthesia and sedation, deemed necessary. If I ever have any change in my health or change in my medication, I will inform the Doctor at the next appointment. For insured patients, my signature below authorizes assignment of insurance benefits to the Doctor and authorizes the release of dental records to my insurance company.

Signature:_____ Date: _____

OPERATIVE & HYGIENE APPOINTMENTS:

Hines Little Smiles is very excited at the opportunity to provide quality oral heath care to your child. We would like for you to know that we are going to try our very best to make your child's visit a positive one. If your child will not cooperate for their visit, a 10 minute time-frame begins where you will have the opportunity to give your child a pep-talk in hopes of alleviating any fears they are experiencing. If after 10 minutes your child still will not cooperate, his or her appointment will end. At that point, options for sedation will be presented to you and you will be able to choose which option best suits you and your child.

We understand that failed treatment appointments are very frustrating, not only for parents but for our office as well. Your child's safety is our biggest concern and sometimes sedation dentistry may be the less traumatic and safest option for your child. But, you never know until you try, and we are always willing to try treatment in the office first.

Hines Little Smiles: Keeping Little Smiles Happy!

Signature:_____ Date: _____