GREATER OWENSBORO
Pediatric Dentistry

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.

Patient Information

Last Name _____ First Name _____ Middle Initial _____ Preferred Name _____

Patient's Soc Sec # _____ Birthdate _____ Age _____ Gender ☐ M ☐ F

Hobbies _____

Referred by _____

Primary Language _____ Ethnicity _____ School Name _____

Select box if address and phone same for the entire family ☐

Address _____ City _____ State _____ Zip _____

Best Cell Phone for Texting _____ Best Email _____

Father's/Guardian's Information

Father/
Guardian's Name _____ Phone (If different) _____

Address
(if different from patient's) _____

Mother's/Guardian's Information

Mother/
Guardian's Name _____ Phone (If different) _____

Address
(if different from patient's) _____

Emergency Contacts

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Insurance Policy 1

Subscriber Name _____ Subscriber id _____

Subscriber 1 D/O/B _____ Subscriber 1 Soc Sec # _____

Insurance Company _____ Phone _____

Employer Name _____ Group Name _____ Group # _____

Insurance Policy 2

Subscriber Name _____ Subscriber id _____

Subscriber 2 D/O/B _____ Subscriber 2 Soc Sec # _____

Insurance Company _____ Phone _____

Employer Name _____ Group Name _____ Group # _____

Signature _____ Date _____

Medical History

Last Name: _____ First Name: _____ Birthdate: _____

Medical Doctor: _____ Doctor's Phone: _____

Date of last physical exam _____ Results _____

Y	N		Y	N	
☐	☐	Is patient under care of physician now?	☐	☐	Patient ever been hospitalized?
☐	☐	Receiving any medication or drugs?	☐	☐	Patient ever had surgery?
☐	☐	Excessive bleeding when cut?			

List all medications that patient is now taking:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Is patient allergic to any of the following?

Y	N		Y	N	
☐	☐	Anesthetic	☐	☐	Iodine
☐	☐	Antibiotics	☐	☐	Latex
☐	☐	Aspirin	☐	☐	Sulfa
☐	☐	Ibuprofen			

Does patient have any of the following medical conditions?

Y	N		Y	N	
☐	☐	AIDS/HIV	☐	☐	Epilepsy
☐	☐	Anemia	☐	☐	Hearing Problems
☐	☐	Asthma	☐	☐	Heart Problems
☐	☐	Autism	☐	☐	Hepatitis
☐	☐	Bleeding Problems	☐	☐	Kidney Disease
☐	☐	Cancer	☐	☐	Liver Problems
☐	☐	Cerebral Palsy	☐	☐	Rheumatic Fever
☐	☐	Diabetes	☐	☐	Sinus Problems
☐	☐	Other - Please explain _____			

Date of last visit to dentist? _____ For what service? _____

Name of former dentist _____ City/State _____

Y	N		Y	N	
☐	☐	Patient complained about dental problems?	☐	☐	Is fluoride taken in any form?
☐	☐	Does patient brush teeth daily?	☐	☐	Any injuries to mouth, teeth, head?
☐	☐	Does patient use floss every day?	☐	☐	Any unhappy dental experiences?
☐	☐	Any mouth habits - thumbsucking, nail biting, mouth breathing, sleeping with bottle, etc?			

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform the doctor if the patient has a change in health.

Date: _____

Signature _____

Greater Owensboro Pediatric Dentistry, Inc.
Patient Treatment and Financial Policies

Consent for Treatment

I am the parent, guardian, or personal representative of this patient and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services, including but not limited to x-rays and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

Financial Policy

Please Note: Payment is due when service is provided if not covered by insurance. The parent or legal guardian who has consented to treatment is responsible for payment.

The practice accepts cash, checks, MasterCard, Visa, and Discover. Additional fees may be applied for returned checks. If payment is not completed timely, I understand that the practice may be forced to turn my account over to a collection agency. I agree to pay all costs of collections including attorney fees, collection fees, and contingent fees to collection agencies up to 40%. Such contingency fees will be added and collected by the collection agency immediately upon referral of my account to the collection agency.

Insurance

As a courtesy, the practice will file dental insurance claims. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles, and maximums which are my responsibility. My insurance company and my plan benefits ultimately determine the amount paid by insurance. All charges incurred are my responsibility, regardless of insurance coverage. I realize my insurance policy is a contract between me and my insurance company.

The practice is committed to providing the best treatment for patients and charge what is usual and customary for our area. I understand I am responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Insurance payments are ordinarily received within 30-60 days from the time the claim is filed. The practice will cooperate with requests from insurance companies that may assist in claims being paid. If the practice contacts me because insurance has not made payment, I will contact my insurance company to make sure payment is expected. If payment is not received or the claim is denied, I will be responsible for paying the full amount at that time.

Insurance Assignment and Release

I certify that the patient is covered by the insurance carrier provided and assign directly to Greater Owensboro Pediatric Dentistry, Inc. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

This practice may use the patient's health care information and may disclose such information to the insurance company(ies) and their agents for the purpose of obtaining payment for services, determining eligibility, and estimating benefits payable for services.

Missed Appointment(s) and Cancellations

The practice's goal is to provide treatment in a timely manner with as few visits as necessary. In order to provide the best service to patients, we require at least a 48 hour notice for cancellations or for rescheduling appointments. We understand that unforeseen circumstances may arise, which may result in canceling or missing appointments. A charge may be assessed for multiple missed, short notice or canceled appointments. Failed appointments may result in being dismissed from the dental practice.

Communications

I authorize the practice to call or text me at any number I provide including mobile/cellular or similar devices for any lawful purpose. I agree to any fees or charges that I may incur for an incoming and/or outgoing call or text, to or from any such number, without reimbursement from the office. The practice or their agents may call by telephone regarding accounts. I agree that the practice may place such calls using an automatic dialing/announcing device.

By signing below, I authorize treatment of patient, assignment of insurance benefits, authorize mobile communications, and agree to the financial and missed appointment policies described above.

Signature Parent/Guardian _____Patient Name _____ D/O/B _____

Greater Owensboro Pediatric Dentistry, Inc.
Acknowledgement of Receipt of Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT THE PATIENT 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 medical and dental 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's parent/guardian, significant new rights to understand and control how the patient's 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 health information and how we may use and disclose the patient's health information.

- Without specific written authorization, we are permitted to use and disclose the patient's 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 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, the patient's confidential information may be used to remind you of an appointment (by phone, text, email 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 the patient's care or who assist in taking care of the patient. We will use and disclose protected information when we are required to do so by federal, state or local law. We may disclose 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 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 protected health information if requested by a law enforcement official for any circumstance required by law. We may release 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 the patient is an organ donor. We may use and disclose protected health information when necessary to reduce or prevent a serious threat to the patient's 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 protected health information if a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose protected health information to federal officials for intelligence and national security activities authorized by law.

We may disclose protected health information to correctional institutions or law enforcement HIPAA officials if patient is 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 patient, (b) for the safety and security of the institution, and/or (c) to protect patient's health and safety or the health and safety of other individuals or the public.

We may release 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 protected health information, which you can exercise by presenting a written request:

- 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 patient's protected health information.
- The right to request an amendment to patient's 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 protected health information and to provide you with notice of our legal duties and privacy practices.

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 the patient's privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint:

Greater Owensboro Pediatric Dentistry Inc.
3817 Fairview Drive
Owensboro, KY 42303
(270)683-7114

Effective Date 09/01/2023

By signing below, I acknowledge receipt of the Notice of Privacy Practices. I understand that it is my responsibility to inform the dentist if the patient has a change in health, and I agree that to the best of my knowledge, the information provided in these forms is complete and correct.

Signature Parent/Guardian _____Patient Name _____ D/O/B _____