Children's Dental Health of Lynchburg

Specializing in Children, Teens, and Young Adults

Shannon M. Sawyer DMD **Summer Sawyer DMD**

We at Childrens Dental Health of Lynchburg know how valuable your time is and we hope you feel the same about us. Consequently, we have a policy to protect our appointment schedule:

Cancellation Policy

If you must cancel an appointment, we would appreciate a call at least 24-hours prior to your scheduled visit, so that we have an opportunity to replace your child's visit with another patient. If your child is sick the night before or awakens sick in the morning of the appointment, or if you have an emergency situation, please call our office immediately and leave a message with our answering service.

Missed Appointments

A missed appointment is quite simply the failure to notify this office when your child has an appointment but does not show and no one notifies us beforehand.

We recognize that we all have busy schedules and can occasionally forget something as important as a dental appointment. We will accept only two missed appointments in a calendar year. Regrettably, if a second appointment is missed during this same 12-month period, we will not see your child. When your child misses an appointment, we will count back 12 months to see if this qualifies as a third missed appointment.

By signing this paper you acknowledge that you have read our policy, understand it, accept it, and also you will share this policy with all persons who are responsible for bringing your child to his/her visits.

Signature: ______________________________ Child's Name :________________________

Relationship to child: ________________________ ________________________

Date: __________ ________________________

Signature of Front Desk Receptionist: ________________________

HIPAA CONSENT FORM

From the office of: Children's Dental Health of Lynchburg

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent by requesting a copy from the receptionist. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information (PHI) may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the use of their information, but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon execution of this Consent

Below is a list of ways the office may contact you. Checking a box will give permission to leave, as thorough of a message as needed, from your dental office. This will include, but not limited to, appointments day, time and treatment scheduled, documents to be signed, financial and collection concerns or pre and post treatment directions. Any source other than the USPS, example: cell phones, email and fax lines, are not considered 100% secure. Contact information will be verified by patient.

Please check all that apply, and write in appropriate information needed for contact.

__ Home Phone ______________________ __ Cell Phone ______________________
__ Home Email ______________________ __ Work Phone ______________________
__ Emergency Contact Name ____
__Emergency Contact Phone ______________________ __ Cell Phone ______________________
__Interpreter Contact Name ______________________ __ Phone ______________________

List names of who can have access to your dental/medical chart information:

This access will include : Financial, Treatment, Health history, is allowed to be disclosed or copied

______________________ **Full Access/ Relation to Patient** ______________________
______________________ **Full Access/ Relation to Patient** ______________________
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______________________ **Full Access/ Relation to Patient** ______________________

_____ Patient gives office permission to forward any verified contact information and PHI to patients specialists. Office may discuss pertinent patient chart information, including PHI, with labs, and product representatives involved in patient's case through verified unsecured, unencrypted means. The Privacy Rule allows those doctors, nurses, hospitals, laboratory technicians, and other health care providers that are covered entities to use or disclose protected health information, such as X-rays, laboratory and pathology reports, diagnoses, and other medical information for treatment purposes without the patient's authorization. This includes sharing the information to consult with other providers, including providers who are not covered entities, to treat a different patient, or to refer the patient. See 45 CFR 164.506. Any source other than your Healthcare Providers, will sign a Business Associate Agreement. Patient understands if permission is not granted, USPS, is the only means of communication with those involved in patients case, which is considered HIPAA compliant. Treatment may take considerably longer in this case. This office will not be held responsible for any delay in mail which then causes an increase in treatment time or treatment costs. Patients or approved contacts may request and pick up copies of PHI to be hand delivered.

Print Patient's Name: ______________________ **Date** __________

Print Legal Guardian's Name: ______________________ **Date** __________

Signature of Patient or Legal Guardian: ______________________ **Date** __________

____Patient refused to sign HIPAA Consent. Patient has the right to refuse. USPS or patient pick up will be used for PHI transfer.

Office Staff Signature______________ **Printed Name**______________ **Date** ________

DENTAL HISTORY

YES NO

____ ____ 1.) Is this your child's first dental visit?

a.) How do you think your child will respond in the dental chair? ____________________

b.) Describe your child's temperament. ____________________

c.) Does your child have a toothache or any dental problems? ____________________

____ ____ 2.) My child is a mouth breather?
____ ____ 3.) My child sucks his or her thumb?
____ ____ 4.) My child sucks his or her fingers?
____ ____ 5.) My child has a tongue habit?
____ ____ 6.) My child has other habits affecting his or her teeth? Explain ____________________
____ ____ 7.) Does your child brush their own teeth? How many times per day? ____________________
____ ____ 8.) What brand of toothpaste does your child use? ____________________
____ ____ 9.) Does your water have fluoride in it?
____ ____ 10.) Does your child take any type of fluoride supplement?
____ ____ 11.) Have any dental x-rays ever been taken of your child's teeth?
If yes, when ____________________
____ ____ 12.) Do you have any objection to taking diagnostic x-rays of your child's teeth?
If yes, please explain. ____________________
____ ____ 13.) Who is your family dentist? ____________________

Father's Name: ____________________ Work Phone: ____________ Cell Phone: ____________
Father's SSN: ____________________ Employer: ____________________
Mother's Name: ____________________ Work Phone: ____________ Cell Phone: ____________
Mother's SSN: ____________________ Employer: ____________________
Does your child have medical insurance? Yes / No Dental insurance? Yes / No
Please list your dental insurance carrier: ____________________ Ins. SSN: ____________

In order to keep our fees reasonable we do not bill for services rendered. Our policy is that you pay as services are rendered. Please check appropriate payment plan you wish to use:

CASH______ CHECK______ CHARGE______ MEDICAID______ (MUST HAVE CARD FOR ALL VISITS)

CONSENT:

Your child is a minor, therefore, it is necessary that a signed consent be obtained from a parent or guardian before any necessary dental service can be started. I grant Children's Dental Health of Lynchburg permission to provide my child's dental exam and treatment, and I will be responsible for the cost of this dental care.

Signed: ____________________
(parent or guardian) Date

By signing this agreement, I understand that I am responsible for ALL fees incurred by services performed by Children's Dental Health of Lynchburg. I also understand that if my account balance becomes delinquent at any time, the outstanding amount can/will be transferred at a collection agency/attorney for recovery of this debt. If that occurs, I understand I will be charged interest in the amount of 24% annually, collection and/or reasonable attorney fees and any court cost fees which may occur with the collection of this amount due.

Signed: ____________________ Witness: ____________________

Children's Dental Health of Lynchburg

NEW PATIENT QUESTIONNAIRE & CONSENT

❑ M
❑ F

CHILD'S NAME: ____________________ NICKNAME: __________

CHILD'S DATE OF BIRTH: ___/___/___ AGE: ___ SSN#: __________

HOME ADDRESS: ____________________ HOME/CELL PHONE: __________
STREET CITY STATE ZIP

Names and ages of brothers and/or sisters, if any: ____________________

Hobbies: __________ Interests: __________ Pets: __________

CHILD'S PHYSICIAN: __________ DATE LAST PHYSICAL: __________

Is your child taking any medication? Yes / No If Yes please list them. __________

Is your child being treated for any medical problems at this time? Yes / No If Yes, please explain. __________

ALLERGIC REACTIONS: Is your child *allergic* to any *medicine* or *anesthetic*? Yes / No

If Yes, please explain. __________

Does your child have any of the following diseases or problems? (Circle appropriate answer)

HEART DISEASE	YES	NO	DIABETES	YES	NO
HEART MURMUR	YES	NO	ARTHRITIS	YES	NO
RHEUMATIC FEVER	YES	NO	LOSS OF CONSCIOUSNESS	YES	NO
KIDNEY PROBLEMS	YES	NO	FAINTING	YES	NO
LIVER DISEASE	YES	NO	SEIZURES	YES	NO
HEPATITIS	YES	NO	EMOTIONAL PROBLEMS	YES	NO
HIV (AIDS) virus	YES	NO	CEREBRAL PALSY	YES	NO
MALABSORPTION SYNDROME	YES	NO	MENTAL RETARDATION	YES	NO
PROLONGED BLEEDING or BRUISING	YES	NO	SPEECH DIFFICULTIES	YES	NO
ASTHMA/BRONCHITIS	YES	NO	ADD/ADHD	YES	NO
RESPIRATORY PROBLEMS	YES	NO	AUTISIM	YES	NO
GLANDULAR PROBLEMS	YES	NO	OTHER		

Has your child ever been hospitalized? Yes / No If yes, please explain __________

Were there any complications during pregnancy? Yes / No If yes, please explain __________