

**NEW LONDON PEDIATRIC DENTISTRY**

**Child's Registration and History**

**PLEASE COMPLETE THE FIRST TWO SHEETS AND MAIL BACK. THANK YOU!**

**DATE** \_\_\_\_\_

CHILD'S NAME \_\_\_\_\_ AGE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

NICKNAME \_\_\_\_\_ GENDER \_\_\_\_\_

SCHOOL \_\_\_\_\_ GRADE \_\_\_\_\_

LEGAL GUARDIAN \_\_\_\_\_ LEGAL GUARDIAN \_\_\_\_\_

ADDRESS \_\_\_\_\_ ADDRESS \_\_\_\_\_

HOME PHONE \_\_\_\_\_ HOME PHONE \_\_\_\_\_

CELL PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

WORK PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

EMAIL \_\_\_\_\_ EMAIL \_\_\_\_\_

EMPLOYER \_\_\_\_\_ EMPLOYER \_\_\_\_\_

OCCUPATION \_\_\_\_\_ OCCUPATION \_\_\_\_\_

PERSON FINANCIALLY RESPONSIBLE (IF OTHER THAN GUARDIAN) \_\_\_\_\_ RELATIONSHIP TO CHILD \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ PHONE \_\_\_\_\_

DENTAL INSURANCE \_\_\_\_\_

SUBSCRIBER NAME \_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING YOU \_\_\_\_\_

CHILD'S FAVORITE : ACTIVITY \_\_\_\_\_ TOY \_\_\_\_\_

HOBBY \_\_\_\_\_ PERSON \_\_\_\_\_ FICTION CHARACTER \_\_\_\_\_

**DENTAL HISTORY**

YES NO

Date of last dental visit \_\_\_\_\_ Any unusual speech habits \_\_\_\_\_

For what Service \_\_\_\_\_

\_\_\_\_\_ Any lost teeth \_\_\_\_\_

Child's attitude toward dentist \_\_\_\_\_ Orthodontic appliance worn now or ever \_\_\_\_\_

\_\_\_\_\_ YES NO \_\_\_\_\_

Any unhappy dental experiences \_\_\_\_\_   Does your child brush teeth daily \_\_\_\_\_

\_\_\_\_\_ Do you assist child with tooth brushing \_\_\_\_\_

Has child complained about dental problems \_\_\_\_\_   How often \_\_\_\_\_

\_\_\_\_\_ Is dental floss used \_\_\_\_\_

Any injury to mouth – teeth – head \_\_\_\_\_   How often \_\_\_\_\_

\_\_\_\_\_ Is fluoride taken in any form \_\_\_\_\_

Any mouth habits – mouth breathing, thumb sucking, nail biting, nursing, bottle habits, pacifier, etc. \_\_\_\_\_   Do you desire complete dental service for the child

\_\_\_\_\_ If no, please explain your expectations: \_\_\_\_\_

## HEALTH HISTORY

Child's Physician \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Date of last physical examination \_\_\_\_\_ Results \_\_\_\_\_

YES NO

YES NO

Is child under care of physician now \_\_\_\_\_   Is there an allergy to penicillin or other drugs \_\_\_\_\_    
\_\_\_\_\_

Is child receiving any medication or drugs \_\_\_\_\_   Are there other allergies: food, pollen, animals, dust, \_\_\_\_\_    
\_\_\_\_\_ other \_\_\_\_\_

Is there any excessive bleeding when cut \_\_\_\_\_   Does child have good physical coordination \_\_\_\_\_    
\_\_\_\_\_ Are there any behavioral or emotional issues - please \_\_\_\_\_

Has child ever been hospitalized \_\_\_\_\_   explain \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has child ever had surgery \_\_\_\_\_   Females of reproductive age: Are you pregnant or using \_\_\_\_\_    
\_\_\_\_\_ oral contraceptives \_\_\_\_\_

DOES THE CHILD HAVE DIFFICULTY WITH OR A HISTORY OF ANY OF THE FOLLOWING:

- |                     |                          |               |                      |                       |
|---------------------|--------------------------|---------------|----------------------|-----------------------|
| ___ Anemia          | ___ Cerebral Palsy       | ___ Fainting  | ___ Kidney           | ___ Rheumatic Fever   |
| ___ Asthma          | ___ Chicken Pox          | ___ Hearing   | ___ Liver            | ___ Seizures/Epilepsy |
| ___ Autism          | ___ Chronic Sinus        | ___ Heart     | ___ Malignancies     | ___ Thyroid           |
| ___ Bladder         | ___ Developmental Delays | ___ Hepatitis | ___ Measles or Mumps | ___ Tuberculosis      |
| ___ Bleeding Issues | ___ Diabetes             | ___ HIV+/AIDS | ___ Mononucleosis    | ___ Other             |

SUMMARY: (for doctor's use)

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information we should be aware of that we have not discussed.

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Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_ Relation to Child \_\_\_\_\_

ROGER A. ACHONG, DMD  
PATRICK F. CAPOZZI, DDS  
DANIELLE C. HINTON, DMD  
ELLIOT C. CHIU, DMD  
RACHEL S. DAVIS, DDS

## NEW LONDON PEDIATRIC DENTISTRY

299 Main Street  
New London, New Hampshire 03257  
TEL. (603) 877-0069

SPECIALIZING IN  
PEDIATRIC DENTISTRY

### FINANCIAL UNDERSTANDING

**Payment Policy:** Since we request payment at the time dental care is delivered, we have provided the following information to help avoid confusion.

**If You Have Dental Insurance:** We can submit your dental claims to **most** insurance companies. A copy of your insurance card and a completed dental claim form are required. If a prior approval is required by your insurance company then **you** are responsible for informing us before we start services. We will gladly discuss your proposed treatment and answer any questions that you might have to the best of our ability. You must realize, however, that:

1. Your insurance contract is between you, your employer and the insurance company. We are not a party to that contract. As dental care providers, our relationship is with you, not your insurance company. Neither we nor you had a part in those negotiations and the benefits you may receive from your insurance have nothing at all to do with you receiving a high quality result. We have found the interests of insurance companies to be sometimes incompatible with our stated goal of delivering excellence in pediatric dental care.  
While filing the insurance claims is a courtesy we extend to our patients, should a dispute arise over coverage or benefits, we ask that you pay us the disputed amount and request direct reimbursement from your insurance company or employer.
2. **When you entrust your pediatric dental care to us, we are working for you and you alone. We do not work for any insurance companies and we do not allow insurance companies to determine what is the best possible treatment for your pediatric dental needs.**
3. Insurance deductibles and co-payments are the parent/legal guardian's responsibility at time of service.
4. This office allows six weeks for payment from the insurance company; if not received, then parent/legal guardian is responsible for payment. A rebilling charge of \$10.00 per month will be assessed after the 1<sup>st</sup> statement. This charge is to help cover the administrative expense of producing the invoice, mailing the invoices and the staff time in responding to patient inquiries that invariably accompany any invoices for over due accounts.

**If You Do Not Have Dental Insurance:**

**Full (100%) payment at the time of service.** You may make payment with a personal check, cash, MC/VISA/DISCOVER or debit card.

**Missed Appointments:**

We feel it is your responsibility to remember scheduled appointment times. If contact cannot be established and an appointment is missed, or less than 24 business hours notice given for a cancellation, a charge of \$50.00 per child/appointment will be assessed. No further (non emergency) appointments will be made until this is paid. This fee is partly to recover the fixed cost incurred for the unused time, but more importantly, to act as a deterrent to missed appointments that often result in compromised treatment outcomes.

Again, we thank you for selecting our Pediatric Dental Specialty Office. Please do not hesitate to ask questions regarding treatment, fees, or services. We will make every effort to avoid any misunderstanding and to preserve our good relations. It is our goal to deliver quality pediatric dental care, and we want you to feel comfortable with the investment you are making in your child's oral health.

I, the undersigned, have read, understand and agree to the above policies.

\_\_\_\_\_  
Parent/Legal Guardian (Print Name)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signed

Rev 10/10

**NEW LONDON PEDIATRIC DENTISTRY**

**CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION**

Child's Name: \_\_\_\_\_ Child's Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

**PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.**

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your child's protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your child's protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your child's protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting: Jamie C. Young, 16 Foundry St. Suite 101, Concord, NH 03301, (603) 224-3339.

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat your child or to continue treating your child if you revoke this Consent.

**SIGNATURE FOR CONSENT**

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my child's protected health information to carry out treatment, payment activities and health care operations.

Parent or Legal Guardian Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.**

**REVOCACTION OF CONSENT**

I revoke my Consent for your use and disclosure of my child's protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat my child after I have revoked my Consent.

Parent or Legal Guardian Name:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

NEW LONDON PEDIATRIC DENTISTRY

NOTICE OF PRIVACY PRACTICES

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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.  
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

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**OUR LEGAL DUTY**

We are required by applicable federal and state law to maintain the privacy of your child's health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your child's health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/14/03, 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 the 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 for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

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**USES AND DISCLOSURES OF HEALTH INFORMATION**

We use and disclose health information about your child for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your child's health information to a physician or other healthcare provider providing treatment to your child.

**Payment:** We may use and disclose your child's health information to obtain payment for services we provide to your child.

**Healthcare Operations:** We may use and disclose your child's health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your child's health information for treatment, payment or healthcare operations, you may give us written authorization to use your child's 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 was in effect. Unless you give us a written authorization, we cannot use or disclose your child's health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your child's health information to you, as described in the Patient Rights section of this Notice. We may disclose your child's health information to a family member, friend or other person to the extent necessary to help with your child's healthcare or with payment for your child's healthcare, but only if you agree that we may do so.

**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 child's care, of your child's location, your child's general condition, or death. If you are present, then prior to use or disclosure of your child's health information, we will provide you with an opportunity to object to such uses or disclosure. 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 child's healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your child's best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Service:** We will not use your child's health information for marketing communications without your written authorization.

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

**Abuse or Neglect:** We may disclose your child's health information to appropriate authorities if we reasonably believe that your child is a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your child's health information to the extent necessary to avert a serious threat to your child's 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 institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

**Appointment Reminders:** We may use or disclose your child's health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

## **PATIENT RIGHTS**

**Access:** You have the right to look at our copies of your child's 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 child's health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. 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 to the address at the end of this Notice. If you request copies, we will charge you \$0.50 for each page, \$15.00 per hour for staff time to locate and copy your health information and postage if you want the copies mailed to you. If you request an alternative 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 using the information listed at the end of this Notice for a full explanation of our fee structure.)

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your child's health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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.

**Restrictions:** You have the right to request that we place additional restrictions on our use or disclosure of your child's health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communications:** You have the right to request that we communicate with you about your child's health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your child's 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:** If you receive this Notice on our Web site by electronic mail (e-mail), you are entitled to receive this Notice in written form.

## **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 disagree with a decision we made about access to your child's health information or in response to a request you made to amend or restrict the use or disclosure of your child's 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 child's 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.

Contact officer: Jamie C. Young, 16 Foundry St. Suite 101, Concord, NH, 03301, (603) 224-3339