Thank you for choosing Children's Dentistry!

To expedite your check in, please complete the forms in this packet and bring with you to your appointment. You may also FAX these forms to the office where your child will be seen.

Broomall Patients ONLY may send forms via email to: Carly@childrens-dentistry.com

All forms are required except as noted:

1. New Patient Registration Form
2. Dental History Form
3. Medical History Form
4. Guardian Form (if necessary)
5. HIPAA – Privacy Form
6. Dental Insurance Claim Form (if applicable)

ALLENTOWN	3057 College Heights Blvd.	Allentown, PA 18104	Tel: (610) 433-2357	Fax: (610) 433-9133
ARDMORE	233 E. Lancaster Avenue	Ardmore, PA 19003	Tel: (610) 896-8300	Fax: (610) 896-5425
BETHLEHEM	2299 Brodhead Rd. Suite C-1	Bethlehem, PA 18020	Tel: (610) 954-5400	Fax: (610) 954-9008
BROOMALL	1220 West Chester Pike	Havertown, PA 19083	Tel: (484) 454-3230	Fax: (484) 455-7186
HIGHPOINT	1600 Horizon Drive; Suite #101	Chalfont, PA 18914	Tel: (215) 822-4042	Fax: (215) 822-0744
UPPER MERION	357 South Gulph Rd.	King of Prussia, PA 19406	Tel: (610) 337-2325	Fax: (610) 337-3863

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New Patient Registration Form

Mother's Name Or Guardian		**Home Tel#**	
Address			
Email		**Cell #**	
Mother's DOB		**Mother's SS#**	
Employer		**Work Tel#**	
Work Address			
Father's Name or Guardian		**Home Tel#**	
Address			
Email		**Cell #**	
Father's DOB		**Father's SS#**	
Employer		**Work Tel#**	
Work Address			
Who is accompanying the child today?			
Name		**Relationship to Child**	

Emergency Contact Person & Tel #			
Do you have legal custody of this child?	**Yes**	**No**	
Whom may we thank for referring you?			
Enter Names/Ages of other Children			

Dental Insurance Information			
Primary Insurance Co.		**Group #**	
Employee		**ID#**	
Secondary Insurance Co.		**Group #**	
Employee		**ID#**	

I hereby authorize payment directly to the dentists of _____ of the group insurance benefits otherwise payable to me.

X_____*(Insured's Signature)*

It is the policy of our office that the parent or guardian who accompanies the child and requests treatment is responsible for payment of all fees at the time of service unless prior arrangements have been approved. In case of default of this account, I agree to pay collection costs on the outstanding balance.

X_____*(Signature of Parent/Guardian)*

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Dental History Form

Patient's Name				**Today's Date**	
Previous Dentist Name & Address					
Is this his/her 1st Dental Visit?	**Y or N**	**Date of last dental visit?**		**Would you like us to request previous dental records?**	
Reason for your child's visit today?					
Has the child ever had a serious/difficult problem with previous dental treatment? If YES, explain					

Please answer the following (Yes or No) questions

Question	Y/N	Comments
Does child brush daily?		Do You Help? Yes or No
Does child floss daily?		Do You Help? Yes or No
Does child take a fluoride supplement?		
Does child thumb or finger suck?		
Is child still breast feeding or bottle fed?		
Does child breathe out of his/her mouth?		
Does child lip suck or bite nails?		
Does child use a pacifier?		
Does child grind his/her teeth?		
Has child had a tooth extracted?		
Has child had any injuries to the face, mouth or teeth?		
Does child require an antibiotic prior to dental treatment? If YES, please call us BEFORE the appointment.		
Is there a family history of missing or extra teeth?		
Does child have braces or orthodontics? If YES, please enter Orthodontist's name and location.		

children's dentistry

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Medical History Form

Patient's Name		**Birth Date**		**Age**	
Child's Physician & Phone #					

Has the child ever had one of the following (Yes or No) Please explain YES answers

Condition	Y/N	Explain "yes"
Artificial joints or valve replacements		
Asthma		
Autism / PDD Spectrum		
Behavior Problems		
Cancer		
Cleft Lip/Palate or Facial Disorder		
Congenital Birth Defects		
Convulsions / Epilepsy / Brain Injury		
Diabetes		
Growth Problems		
Handicaps or Disabilities – what type?		
Hearing/Ear Problems		
Heart Murmur or other Heart Problems		
Hemophilia or Abnormal Bleeding		
Hepatitis		
High Fevers		
HIV+ / AIDS		
Hyperactivity, ADD or ADHD		
Kidney or Liver Problems		
LATEX Allergy?		
Learning Disability or Mental Retardation		
Rheumatic Fever		
Speech Problems		
Tuberculosis		
Vision/Eye Problems		

Describe child's learning process for his/her age: *Circle one*: **Advanced Average Slow**	**Do mother and father live together? Y or N**
List all Drug or other ALLERGIES	
List all DRUGS child is currently taking	
Any serious medical problems, operations, or hospital stays? Explain.	

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 the office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need.

X_____**/date:**_____

Thank you for filling out this form completely. It will enable us to give your child the best dental care possible.

Office USE Only - Reviewed by: **(Initials & Date)** _____, _____, _____ , _____ Updated 06-12

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Dear Parents:

In order to treat your child we require a parent or guardian's written permission. If you need to send a family member or child care giver with your child, please sign this form giving us permission to go ahead with treatment. Also include a phone number where we can contact you directly if necessary.

Child's name	
Name of person bringing child	
Relationship to child	
Parent's Signature:	
Phone # where parent can be reached at time of appointment:	

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NOTICE OF PRIVACY PRACTICES

Updated 12/15/14

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 9/23/2013, 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

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

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

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

Prevent or control disease, injury or disability;
Report child abuse or neglect;
Report reactions to medications or problems with products or devices;
Notify a person of a recall, repair, or replacement of products or devices;
Notify a person who may have been exposed to a disease or condition; or
Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

OTHER USES AND DISCLOSURES OF PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

YOUR HEALTH INFORMATION RIGHTS

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure. If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

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 Web site or by electronic mail (e-mail).

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 if 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 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 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.

Our Privacy Official: LYNN OHARE Telephone: 610-337-2325 Fax: 610-337-3863
357 South Gulph Road, Suite 100 King of Prussia, PA 19406 E-mail: lynn@childrens-dentistry.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement
I have received a copy of this office's Notice of Privacy Practices.

Patient's Name: _____

Signature: _____

Date: _____

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 acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (Please Specify)_____

_____

Upper Merion Dental Associates / Broomall Pediatric Dentistry & Orthodontics / Highpoint Pediatric Dental Associates/ Allentown-Bethlehem Pediatric Dental Associates / Ardmore Pediatric Dental Associates