CHILDREN'S Dental Specialists

2240 Livernois Rd.
Troy, MI 48083
Phone: (248) 528 - 0500
Fax: (248) 528 - 0555
Email: info@thechildrensdentalspecialists.com
Web: www.thechildrensdentalspecialists.com

PATIENT INFORMATION

Child's last name:	First:	Middle:

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Nick Name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Child's Social Security #:	Child's Home Phone #:	

Street Address and/or APT #:	City:	State:	ZIP Code:

Mother's Last Name/First Name/ Initial	Marital Status: Email Address:	Mother's Phone # ( )

Father's Last Name/First Name/ Initial	Marital Status: Email Address:	Father's Phone # ( )

Who may we thank for referring you? We would like to thank them: ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital
❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

INSURANCE INFORMATION

(Please give your insurance card or insurance info. to the receptionist.)

Person responsible for Bill:	Birth Date: / /	Address (if different):	Home phone # : ( )

Is this person present today? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone # : ( )

Please indicate primary insurance ❑ PPO ❑ HMO ❑ EPO ❑ State Medicaid

Subscriber's name:	Subscriber's S.S #:	Birth Date: / /	Group # :	Member ID # :

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group # :	Member ID # :

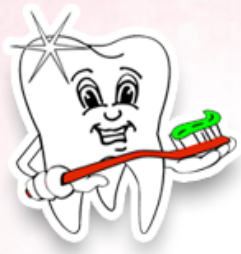
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

LANGUAGE

Languages Spoken by Patient/Family: ❑ English ❑ Spanish ❑ Arabic ❑ Other :

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the dental practice. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature *Today's Date*



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Dental/Medical Health History (Confidential)

Your child's overall health as well as any medications which your child takes could have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely.

How often does your child brush? _____

How often does your child floss? _____

Is your child's water fluoridated?	☐ Yes	☐ No
Does your child take fluoride supplements?	☐ Yes	☐ No

Does your child:

Suck Thumb/Finger	☐ Yes	☐ No
Suck/Bite Lip	☐ Yes	☐ No
Bite/Chew Nails	☐ Yes	☐ No
Chew Hard Objects (pencils, etc.)	☐ Yes	☐ No
Grind Teeth	☐ Yes	☐ No
Clench Jaws	☐ Yes	☐ No
Use A Pacifier	☐ Yes	☐ No

Date of Last Dental Visit _____

Previous Dentist _____

Has your child had difficulty with previous dental visits? ☐ Yes ☐ No

(If yes, please explain) _____

Has your child ever had any of the following:

ADD/ADHD	☐ Yes	☐ No
Allergies	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Autism	☐ Yes	☐ No
Learning or Developmental Disabilities	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No
Congenital Heart Defect	☐ Yes	☐ No
Abnormal Bleeding	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
Stomach, Liver or Kidney Problems	☐ Yes	☐ No
Convulsions/Epilepsy	☐ Yes	☐ No

Child's Physician _____ Phone # _____

Address _____ Immunization Status _____

Previous Hospitalizations/Surgeries/Serious Illnesses When?

_____ _____

_____ _____

Is your child currently taking any medications? ☐ Yes ☐ No (if yes, please list) _____

Does your child have a history of allergies/sensitivities/adverse reactions to any drugs or medications (Penicillin, Novocain, etc.)? ☐ Yes ☐ No

(if yes, please describe) _____

Please explain any medical problems that your child has: _____

Parent/Guardian Signature: _____ Date: _____

Reviewed By: _____ Date: _____

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CONSENT FOR TREATMENT

Because your child is a minor, signed permission is required from a parent, or legal guardian before any dental treatment can be rendered. I authorize Doctors at Children's Dental Specialists to perform a dental exam, including x-rays such as bitewings/periapical/panoramic/cephalometric/create models for teeth and photographs on my child. I also authorize Doctors to perform therapeutic dental procedures they deem necessary for my child. The Doctors are given permission to use local anesthetic and nitrous oxide analgesia as indicated by them. I understand that Doctors and the staff use behavior guidance techniques such as praise, voice control with variable voice tone to aid in cooperation of my child during treatment. I understand that, at any time, I have questions I may speak to the Doctor treating my child. I can ask questions until I have received satisfactory answers to my questions.

I have read and agreed to the Consent for Treatment.

Signature: _____ Date: _____

PRIVACY PRACTICES

Federal and state laws require the privacy of all health information. I acknowledge that I have received the Notice of Privacy Practices for my child.

Signature of Parent/Guardian: _____ Date: _____

Witness: _____ Date: _____

OFFICE POLICY/PAYMENT INFORMATION

The adult who brings the child to the office is financially responsible. Your appointment time will be reserved especially for your child. If you are unable to keep your appointment, we require 24 hour's notice; otherwise, it may be necessary to charge you at least twenty-five dollars per every thirty minutes for lost time.

Co-payments and behavior management fees must be paid in full before any treatment is provided. Payment is due at the time of service; we accept cash/debit and credit cards including Visa, MasterCard, Discover, and American Express. Balances over 90 days past due will be turned over to a collection agency. In this event, you will be responsible for all collection and legal fees.

I have read all of the information and completed this form. I certify that by signing this I am the minor's legal parent/guardian.

Signature: _____ Date: _____

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AUTHORIZATION FOR OTHERS TO CONSENT TO DENTAL CARE

I hereby give permission for the following person:

First and Last Name: _____

Relationship to Child: _____

To bring my child into Southfield Kids Dentist for dental care. This includes but is not limited to: examinations, dental cleanings, fluoride treatments, x-rays, and restorative care. He or she also has my authorization to make any decision based on Doctor's or their Associate's recommendation(s) regarding treatment in my absence. I agree to assume financial responsibility for his and/or her decisions at that time.

This consent is valid from date signed until revoked by parent or legal guardian.

This consent is valid for the children listed below:

Child's First and Last Name	Child's Date of Birth

Signature: _____ Date: _____

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THIRD PARTY FINANCIAL AGREEMENT

The charges for all dental treatment rendered by Doctors and/or Staff at Southfield Kids Dentist, PLLC are the responsibility of the parent/legal guardian of the patient.

As a courtesy to our parents, we will complete and file insurance forms relative to services rendered. We are obliging the parents of our patients by agreeing to wait up to ninety (90) days to receive payment from the insurance companies involved.

When determining your co-payments, we can only ESTIMATE the amount your insurance company will pay. If there is any balance remaining upon receipt of payment from the perspective insurance, it will become the responsibility of the parent/legal guardian.

I understand the above stated policy and agree to pay for any services provided to my child that are not covered by the insurance company(ies) involved.

Parent/Legal Guardian Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

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OFFICE POLICY

Dear Parents,

I would like to welcome you to my pediatric practice. We will strive to give you the best care possible. To do this, we will need you to be aware of the following:

- The practice is limited to the specialty of Pediatric Dentistry. We generally limit a child's first dental visit with us to: exams/prophylaxis (cleaning)/fluoride/x-rays (if necessary). Exams performed and x-rays taken are based on need and visual findings. School-time appointments are sometimes necessary, and we provide the appropriate documentation for excused absences.
- We have come to realize through years of experience that when dealing with children, they behave more independently when parents are not with them in the operatory while restorative work is being performed.
- PLEASE remember that your dental insurance policy is between you and your insurance company and not with the doctor and your insurance company.
- Behavior management fees are charged by all pediatric dental specialists, and may range from $50.00 to $200.00. Should your child need to be sedated, you will be assessed a fee, which may not always be covered by your dental insurance policy.
- We will strive to value your time and will be as punctual as possible. To evaluate and treat your child properly, we do not schedule anyone else in your child's time slot. If you are more than 15 minutes late, we will unfortunately need to reschedule. We try to remind parents by phone of appointments scheduled, however PLEASE DO NOT DEPEND ON THIS COURTESY. We require at least 24-hour cancellation notice or any time before the day of the appointment to avoid a $25.00 fee due before you can make another appointment.
- The more informed you are about your child's treatment, the more effective we can be.

We are honored that you have placed your trust in us to preserve your child's dental health. It is a pleasure to be of service to you and your child. -Dr. Ifechide Nwabueze

Parent Signature: _____ Date: _____

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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.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect this Notice takes effect (01/01/2015) 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 charges 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 charges. 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

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

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your 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 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 was 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.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your 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 care, of your location, your general condition, or death. 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 judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgement and our experience with common practice 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.

or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

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

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 and 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 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 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 info. You may obtain a form to request access by using the contact information listed at the beginning 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 beginning of this Notice. If you request copies, we will charge you $1.50 for each page, $25 per hour for staff time to 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 beginning 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 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.

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 an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means to alternative locations. (You must make this request in writing). Your request must specify the alternative means or location, and provide satisfactory explanation on how payments will be handled under the alternative means or location you request.

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: If you receive this Notice on our Web Site or by electronic mail (e-mail) you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you would like 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 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 by using the contact information listed at the beginning of this Notice. You may also 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 U.S. DHHS 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 U.S DHHS.

CONTACT: DR. IFECHIDE NWABUEZE, D.M.D

PHONE NUMBER: (248) 528 - 0500 EMAIL: info@thechildrensdentalspecialists.com

Parent/Guardian Signature: _____ Date: _____