Welcome to Clark Pediatric Dental Group. Our staff would like to welcome you and your child to our dental office. We strive to provide a fun and educational experience for your child while also maintaining the highest level of excellence in your child's care and treatment. Our ultimate goal is teaching good oral hygiene that will enable our patients to maintain beautiful smiles for a lifetime!

Patient Information

Patient's name: _____ Nickname: _____

Home address: _____ ☐Male ☐Female

City: _____ State: _____ Zip Code: _____

Date of Birth: _____Age: _____ How did you hear about us? _____

Legal Guardian Information

Mother's Information: ☐Mother ☐Step Mother ☐Legal Guardian ☐Grandmother

Name: _____Date of Birth: _____ Social Security #: _____

Email: _____ Cell: _____ Work: _____ Prefer: _____

Father's Information: ☐Father ☐Step Father ☐Legal Guardian ☐Grandfather

Name: _____Date of Birth: _____ Social Security #: _____

Email: _____ Cell: _____ Work: _____ Prefer: _____

Dental Insurance Information

Primary Dental Insurance: _____ Phone: _____

Subscriber Name: _____ ID/SSN Number: _____ DOB: _____

Employer: _____ Phone Number: _____

Secondary Dental Insurance: _____ Phone: _____

Subscriber Name: _____ ID/SSN Number: _____ DOB: _____

Employer: _____ Phone Number: _____

Emergency Contact Information

In case of an emergency where either the parent or legal guardian cannot be reached, please identify the following information for the next closest relative not living with the patient.

Name: _____ Phone: _____ Relationship to patient: _____

Medical History

Please list the name and phone number of any physicians that are currently treating your child. When was your child's last medical check-up with his/her primary care physician?

_____

Please list **all medications** patient is currently taking? _____

Please list **all allergies (food/medications)**? _____

State Law Requires that we ask has your child ever had any of the following conditions?

- ☐ Heart Murmur (innocent or Pathologic)
- ☐ Bleeding Disorders/ Hemophilia/ Sickle Cell
- ☐ Heart Condition
- ☐ Hepatitis Type: _____
- ☐ Immunologic Disorder, HIV, AIDS
- ☐ Liver Disease or Transplantation
- ☐ Anemia
- ☐ Kidney Disease of Transplantation
- ☐ Rheumatic Fever
- ☐ Tuberculosis or Positive Test Result
- ☐ Cancer, Malignancy, Leukemia, or Lymphoma
- ☐ Congenital Birth Defects/ Syndromes
- ☐ Neurological Disorder (Hydrocephaly, Microcephaly)
- ☐ Cleft Lip/Palate (bilateral/unilateral)
- ☐ Diabetes Mellitus
- ☐ Asthma or Lung Problems (Inhaler, Nebulizer)
- ☐ Eye Problems (right, left or both)
- ☐ Hearing Impairment (right, left or both)
- ☐ Seasonal Allergies, Hay Fever, etc.
- ☐ Seizure Disorder, Epilepsy
- ☐ Febrile Seizure, Fainting Spells
- ☐ Psychiatric Problems
- ☐ Physical or Emotional Abuse
- ☐ Autism
- ☐ ADD, ADHD or Hyperactivity
- ☐ Emotional or Behavioral Problems
- ☐ Learning Disabilities

Dental History

Is this your child's first dental visit? ☐ Yes ☐ No Date of last dental visit? _____ Were X-rays Taken? ☐ Yes ☐ No

Has your child had an unfavorable experience in a dental office? ☐ Yes ☐ No Explain: _____

Has your child ever experienced any unfavorable reaction to local anesthetic or laughing gas? ☐ Yes ☐ No

Does tour child suck his/her thumb, finger, pacifier or blanket? ☐ Yes ☐ No _____

Does your child brush/floss his/her teeth? ☐ Yes ☐ No Do you assist? _____ How often? _____

Has your child been prescribed fluoride supplements? ☐ Yes ☐ No Water source? ☐ Private Well ☐ Public System

How would you predict your child's behavior to be today? ☐ Cooperative ☐ Nervous ☐ Defiant ☐ Don't Know

Has your child ever suffered from any of the following dental related problems?

Yes	No		Yes	No	
☐	☐	Bad breath/Halitosis	☐	☐	Stained or Discolored teeth
☐	☐	Missing or extra teeth	☐	☐	Pain from teeth
☐	☐	Cavities	☐	☐	Previous injury or trauma to teeth, mouth or face

Authorization for Signature on File

I (name of insured), _____, hereby authorize Clark Pediatric Dental Group to affix my name to any and all claims or documents as related to any and all health benefits due my dependents through my insurer. I hereby authorize payment of dental benefits otherwise payable to me directly to the office above. I agree to be responsible for all charges for dental services whether or not paid by my insurance. I authorize the release of any information relating to this claim to obtain payment. I authorize the use of this signature on all insurance submissions.

Financial Policy

_____ Initials On your first visit we expect you to supply our office with your insurance information and a photo ID. If any changes should occur during the time you are a patient, it is your responsibility to inform our office with any changes. Our office will not be responsible for claims submitted to insurance companies by which you are no longer covered.

_____ Initials As a **courtesy**, we will gladly bill your insurance. While we accept most insurance plans, and are happy to aid in submission of your claims, it is your responsibility to read your policy and understand that this is a contract between your employer, your insurance company and yourself. Please be aware of some and perhaps all of the services rendered may be not covered by your individual plan and you are ultimately responsible for the payment on the account.

_____ Initials We cannot accept responsibility for collecting an insurance claim after 90 days or for negotiating a disputed claim. If non-payment is received on an account after two monthly statements our office will make every effort to contact the responsible party. If the party responsible cannot be reached, a third bill will be sent indicating that **"This will be the final notice for payment"**. If the party fails to contact our office after receiving such notice, the account will be sent to a collection agency. Should this occur, it is agreed that the financially responsible party listed below shall pay all finance charges, collection cost, attorney fees and any other costs that may be incurred to enforce collection of any amount outstanding. In addition, a 35% collection fee based on the balance of the account will be added.

_____ Initials We ask that you either pay your estimated patient portion of the bill at the time of service, or that a suitable written financial arrangement be reached at the time of service. We accept cash, all major credit cards, personal checks, and financing from Care Credit. For all checks returned due to **non-sufficient funds**, there will be a $35 fee added to your account.

_____ Initials If an insurance company pays more than anticipated creating a credit for the patient, we are happy to either refund the patient or leave the credit on the account to be applied toward future treatment.

_____ Initials The original dental record, including but not limited to treatment notes, x-rays, study models are the property of Clark Pediatric Dental Group. These originals will not be released to patients or other healthcare providers, without written request. I understand that a $25 fee may be applied to my account for duplication of my dental records and x-rays.

Failed or Cancelled Appointments

If an appointment has been reserved for you, we kindly ask that patients give us 24 hours' notice for cancellations; otherwise, we reserve the right to charge a minimum of $25 per hour of scheduled appointment will be assessed to the patient's account (I.E. 1hr or less appointment= $25 charge, 2hr appointment= $50, etc.). **We will not offer appointments to patients who fail two appointments without having given us proper notice.**

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. I confirm that I have read and understand this form or it was read to me and all of my questions have been answered to my satisfaction.

Patients Name Print	Print Parent/Legal Guardian Name	Signature Parent/Legal Guardian	Date

Print Name of Treating Dentist	Signature of Treating Dentist	Date

Informed Consent

Permission for Dental Examination and/or Treatment of a Minor

I am the parent or guardian of _____ who is a minor child, and I do hereby authorize and consent to any x-ray, examination, anesthetic, sedative, or dental treatment rendered under the general, direct, or indirect supervision of Dr. _____ and his/her associates, staff members, or agents, as he/she may deem necessary.

This authorization will remain in effect until cancelled in writing by me.

Parent Signature _____ Date _____

Witness _____

How would you like us to communicate with you?

Our dental office sends appointment reminders, information about treatment, payment and insurance, and other communications. Please tell us how you would like us to communicate with you.

Your name: _____ Today's Date: _____

Check or complete all that apply (please print clearly):

☐ Contact me by U.S. Mail at the following address: _____
☐ Contact me by email at the following email address: _____

For Phone and Text Communications:

This form is optional. You are not required to sign this form, and you do not need to sign it to receive care in our dental office.

Phone Number: _____

☐ **By checking this box, I consent to the following**: The dental practice or its service provider may contact me to provide health care information such as appointment reminders and information about treatment, payment, my account or insurance, using artificial or prerecorded voice or telephone equipment that may be capable of automatic dialing. The dental practice may:

☐ Call me
☐ Text me
☐ Call me and text me

Signature: _____ Date: _____

Please call the dental office right away if you get a new telephone number!

For Office Use Only:
☐ Consent revoked. Date/Initials: _____/_____ ☐ Possible reassigned number. Date/Initials: _____/_____ ☐ Confirmed accurate. Date/Initials: _____/_____ Date/Initials: _____/__

SOCIAL MEDIA / PHOTO CONSENT FORM

Clark Pediatric Dental Group would like your permission to use images taken of you/ your child to showcase extraordinary before and after smiles and/or testimonials for marketing purposes on our website, Facebook page, Instagram and office bulletin board.

Please indicate below the following areas where you consent to the use of you/ your child's picture.

Please check all that apply.

__ Clark Pediatric Dental Group Website
__ Clark Pediatric Dental Group Facebook Page
__ Clark Pediatric Dental Group Instagram Page
__ Full face can be shown
__ Teeth-only can be shown
__ First name can be used

Authorization:
I authorize the use and disclosure of my name and/or my child's name, photographic/video images, and/or testimonial for marketing purposes by our practice. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPPA privacy regulations.

Purpose:
The photographic/video images will be used for: Social Media and/or Advertising.

Revocability:
I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by our practice via registered mail. Revocation affects disclosure moving forward and this is not retroactive.

Date: ___/___/____
Patient Name: _____
Parents/ Guardian Name: _____

Signature of Parent/Guardian: _____

CONSENTIMIENTO PARA FOTOGRAFIAS/ REDES SOCIALES

Clark Pediatric Dental Group gustaría de su permiso para usar imágenes tomadas de usted / su hijo para mostrar su extraordinario antes y después de sonrisas y / o testimonios con fines de mercadeo en nuestro sitio web, página de Facebook, Instagram y tablón de anuncios de la oficina.

Por favor, indique a continuación las siguientes áreas en las que usted autoriza el uso de fotos de usted/ su hijo.

Por favor marque lo que corresponda.

__ Página Web de Clark Pediatric Dental Group.
__ Página de Facebook de Clark Pediatric Dental Group.
__ Página de Instagram de Clark Pediatric Dental Group.
__ Puede mostrar cara completa.
__ Solo los dientes pueden ser mostrados.
__ Puede ser utilizado el primer nombre

Autorización:
Yo autorizo el uso y divulgación de mi nombre y / o el nombre de mi hijo, imágenes fotográficas/vídeo, y / o testimonial para fines de marketing por nuestra práctica. Entiendo que la información divulgada de acuerdo con esta autorización puede estar sujeta a una nueva divulgación y ya no estar protegida por las regulaciones de privacidad de HIPPA.

Propósito:
Las imágenes fotográficas / vídeo serán utilizados para: Medios de Comunicación Social y / o Publicidad.

revocabilidad:
Entiendo que puedo revocar esta autorización en cualquier momento, pero tal revocación debe ser por escrito y recibida por nuestra práctica a través de correo certificado. La revocación afecta a la divulgación de seguir adelante y esto no es retroactiva.

Fecha: ___/___/____
Nombre del Paciente: _____
Nombre del Padre/ Tutor: _____

Firma del Padre/Tutor: _____

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you 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 (HIPPA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information.

As required by HIPPA, we have prepared this explanation of how we required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

 Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
 Payment means such activities as obtaining reimbursement for services, confirming coverage billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
 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.
We will not, however, use your medical information for marketing communications with your written consent. An example would be an internal quality assessment review.

We may also create and distribute de-identifiable health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

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 the following rights with respect to your protected health information, which you can exercise by presenting a written request to the privacy officer:

 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 to 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 reasonable requests to receive confidential information of protected health information from use by alternative means or at alternative locations.

 The right to inspect and copy your protected health information. We reserve the right to charge a cost-based fee for duplicating postage.

 The right to amend your protected health information.

 The right to receive an accounting of disclosures of protected health information.

 The right to obtain a paper of this notice form us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with the notice of our legal duties and privacy practices with respect to protected health information. This notice is effective as of April 14, 2003 and 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 we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office. You have recourse if you feel your privacy protections have been violated. You have the right to file a written complaint with our office or with the Department of Health and Human Services, Office of Civil Rights, about violations of provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a claim.

Please contact us for more information:

Clark Pediatric Dental Group
1813 Eastchester Dr. Suite 100
High Point, NC 27265
336-882-0345

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.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

Additional individuals we can contact or release information to: _____

_____

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)

_____

_____

_____