HOMETOWN
children's
dentistry

Welcome to Hometown Children's Dentistry

Account No. _____ No. of New Patients _____

Insurance Co. _____ Date _____

We want to thank you in advance for taking a few moments to fill out our survey. The results will help us determine the best way to get our message of quality pediatric dental care out to the public and to help us better serve the needs of our patients.

How did you hear about us?

__ Sibling or Family Member who is or has been a patient

__ Friend – If so, who may we thank? _____

__ General Dentist Name: _____

__ Pediatrician/Doctor – Name: _____

__ Insurance Co. – Name: _____

__ Health Fair – Name of Fair: _____

__ Education Program School Name: _____

__ Newspaper __ Verizon Yellow Pages __ Yellow Book __ Magnet

__ Sign on building __ Website –www.hometownchildrensdentistry.com __ Sports Club

__ Other: _____

Have you seen our Website? ____ Yes ____ No

If yes, how did you get our website address? __ Yellow Pages __ Newspaper

__ Insurance __ Magnet __ Business Card __ Other: _____

What were the most important factors in your decision to use our services?

__ Insurance

__ Reputation of doctors

__ Friend's recommendation

__ Pediatric/Special Needs specialist

__ Convenient hours

__ Location

__ Doctor's referral

__ Community involvement

HOMETOWN
children's
dentistry

Release of Records Authorization:

Being able to see your child's previous dental records and x-rays allows our dental team to have a better understanding of their overall oral health as well as helping with deciding the right treatment for them!

By signing below, I consent for my previous child's dental treatment records and/or X-rays to be transferred by email to **team@hometownchildrensdentistry.com**

Parent/ Guardian signature:_____ Date:_____

Please provide the following information if your child is a new patient at Hometown Children's Dentistry and you consent to having their records sent to us from their previous provider:

Previous Dental Practice: _____

Previous Dentist's Name: _____

Previous Dentist's Email Address: _____

Previous Dentist's Phone Number:_____

Hometown Children's Dentistry

1120 Jacksonville Rd, Ivyland, PA 18974

Medical History Questionnaire:

***THESE QUESTIONS ARE OF GREAT VALUE IN AIDING US TO A BETTER UNDERSTANDING OF YOUR CHILD.**

CHILD'S FIRST NAME | CHILD'S LAST NAME | DATE OF BIRTH | MALE FEMALE

RESIDENCE ADDRESS (STREET) | PHONE

(TOWN) (ZIP)

SCHOOL | GRADE | REASON FOR VISIT

REFERRED TO THIS OFFICE BY (WE WISH TO THANK THEM).

MEDICAL HISTORY

CHILD'S PHYSICIAN | CITY | DATE LAST SAW PHYSICIAN MONTH / YEAR

	YES	NO
1. IS YOUR CHILD PRESENTLY UNDER THE CARE OF A PHYSICIAN FOR ANY MEDICAL PROBLEM? WHAT?	☐	☐
2. IS YOUR CHILD CURRENTLY TAKING ANY MEDICATION? WHAT?	☐	☐
3. HAS YOUR CHILD EVER BEEN HOSPITALIZED OR HAD SURGERY? FOR WHAT?	☐	☐
4. IS YOUR CHILD ALLERGIC TO ANY FOOD OR MEDICINE? WHAT?	☐	☐
5. IS YOUR CHILD PREGNANT?	☐	☐

DOES YOUR CHILD HAVE A HISTORY OF? (CHECK YES OR NO)

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	HEART MURMURS	☐	☐	HEARING PROBLEMS	☐	☐	PREGNANCY	☐	☐	CANCER/TUMORS
☐	☐	HEART TROUBLE	☐	☐	DIABETES	☐	☐	CONGENITAL BIRTH DEFECTS	☐	☐	CHEMO/RADIATION THERAPY
☐	☐	RHEUMATIC FEVER	☐	☐	ASTHMA	☐	☐	SPEECH PROBLEMS	☐	☐	LEUKEMIA
☐	☐	ALLERGIES _____	☐	☐	EPILEPSY	☐	☐	ANEMIA	☐	☐	HEPATITIS
☐	☐	ANESTHESIA-ALLERGIC/SENSITIVE	☐	☐	SEIZURES/CONVULSIONS	☐	☐	ADD/ADHD	☐	☐	BLEEDING PROBLEMS
☐	☐	DRUG SENSITIVITIES	☐	☐	RECURRENT HEADACHES	☐	☐	AUTISM/ASPERGER'S	☐	☐	BLOOD DISORDERS
☐	☐	HIGH TEMPERATURE	☐	☐	FRACTURED JAW	☐	☐	AIDS/ARC/HIV	☐	☐	HIGH BLOOD PRESSURE
☐	☐	BRAIN INJURY/CONCUSSION	☐	☐	LUNG TROUBLE/T.B.	☐	☐	KIDNEY/LIVER INVOLVEMENT	☐	☐	HISTORY OF BLOOD
☐	☐	VISION PROBLEMS	☐	☐	ARTIFICIAL PROSTHESIS	☐	☐	NERVOUS SYSTEM			TRANSFUSIONS & DATE
☐	☐	PREMATURE BIRTH									

Is there anything else regarding your child's physical, mental or EMOTIONAL health that you feel we should know? What?

DENTAL HISTORY

CHILD'S FIRST DENTAL VISIT? ☐ YES ☐ NO | PREVIOUS DENTIST | CITY | DATE LAST VISIT | X-RAY DATE

ANY INJURY TO YOUR CHILD'S TEETH OR JAWS? (FALLS, BLOWS, CHIPS, ETC.) ☐ YES ☐ NO

HISTORY OF? ☐ THUMBSUCKING ☐ LIP SUCKING ☐ FINGER SUCKING ☐ NAIL BITING ☐ PACIFIER

HAS YOUR CHILD EXPERIENCED ANY UNFAVORABLE REACTION FROM PREVIOUS MEDICAL OR DENTAL CARE? ☐ YES ☐ NO

EXPLAIN

HOW DO YOU THINK YOUR CHILD WILL ACT TOWARD THE DENTIST?

AGE OF CHILD WHEN DISCONTINUED BOTTLE OR NURSING.

NAME OF FAMILY DENTIST | CITY

PREVENTIVE DENTAL HISTORY

HOW OFTEN DOES YOUR CHILD BRUSH?

IS TOOTHBRUSHING SUPERVISED? ☐ YES ☐ NO

BY WHOM?

WHEN?

IS DENTAL FLOSS USED? ☐ YES ☐ NO

DOES YOUR CHILD RECEIVE (CHECK). ☐ FLUORIDE IN VITAMINS ☐ FLUORIDE TABLETS/DROPS ☐ FLUORIDATED WATER ☐ NONE ☐ HOW OFTEN?

By signing below, I am acknowledging that all of the information I've provided about my child's health/ medical history is correct to the best of my knowledge:

Parent/ Guardian Signature_____ Date:_____

CHILD'S INSURANCE INFORMATION

CHILD'S SOCIAL SECURITY NUMBER _____

CHILD'S INSURANCE CARRIER _____

CHILD'S IDENTIFICATION NUMBER (IF APPLICABLE) _____

AUTHORIZATION, FAMILY INFORMATION & FINANCIAL RESPONSIBILITY

RESIDENCE ADDRESS (STREET) (TOWN) (ZIP)		PHONE
PARENT/GUARDIAN'S FULL NAME SOC. SEC. NO. BIRTH DATE:	ADDRESS IF DIFFERENT	OCCUPATION
EMPLOYED BY	BUSINESS ADDRESS CITY	BUS. PHONE
NAME OF DENTAL INSURANCE CO.	GROUP NUMBER EMPLOYEE NUMBER	
PARENT/GUARDIAN'S FULL NAME SOC. SEC. NO. BIRTH DATE:	ADDRESS IF DIFFERENT	OCCUPATION
EMPLOYED BY	BUSINESS ADDRESS CITY	BUS. PHONE
NAME OF INSURANCE COMPANY	GROUP NUMBER EMPLOYEE NUMBER	

FIRST NAMES OF THE CHILD'S BROTHERS AND SISTERS AND THEIR AGES:

HAS ANY MEMBER OF YOUR FAMILY BEEN A PATIENT IN THIS OFFICE BEFORE? YES NO IF YES, NAME

IS YOUR CHILD ELIGIBLE FOR STATE/COUNTY AID? YES NO	NAME AND ADDRESS OF CLOSEST RELATIVE OR FRIEND & PHONE NO.

* IF THE FAMILY IS NOT LIVING TOGETHER, THE PARENT BRINGING THE CHILD IN IS RESPONSIBLE FOR THE CHILD'S ACCOUNT.

I hereby attest, that I am the legal, responsible parent or guardian of the aforementioned child and I hereby agree that I have read the above questions and have filled them out to the best of my ability. I hereby consent to such examinations, diagnostic, and curative treatment, x-rays, local anesthesia, inhalation and oral medication as is necessary upon_____ . If I have any objections to certain aspects of treatment, I have stated so in the space provided below. I will assume responsibility for fees associated with those procedures for my child.

SIGNATURE **X**	RELATIONSHIP TO CHILD	DATE
DOCTOR SIGNATURE	DATE	

PLEASE NOTE: PAYMENT IS EXPECTED FOR SERVICE RENDERED AT THE TIME OF THE FIRST VISIT. FINANCIAL ARRANGEMENTS FOR SUBSEQUENT TREATMENT MAY BE MADE FOLLOWING THE DIAGNOSIS. THANK YOU.

A CHARGE MAY BE MADE FOR BROKEN APPOINTMENTS UNLESS THE OFFICE IS NOTIFIED 24 HOURS BEFORE APPOINTMENT.

HOMETOWN
children's
dentistry

CLIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time (HIPAA).

1. Tell your provider if you do not understand this authorization, and the provider will explain it to you.

2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to the provider at the following address: 1120 Jacksonville Rd, Ivyland, PA 18974:

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, payment, enrollment or your eligibility for benefits. However, you may be required to complete this authorization form before receiving treatment if you have authorized your provider to disclose information about you to a third party. If you refuse to sign this authorization, and you have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a patient in their practice.

4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA. If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

5. You may inspect or copy the protected dental information to be used or disclosed under this authorization. You do not have the right of access to the following protected dental information: psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act (CUA) prohibits access or information held by certain research laboratories. In addition, our provider may deny access if the provider reasonably believes access could cause harm to you or another individual. If access is denied, you may request to have a licensed health care professional for a second opinion at your expense.

6. If this office initiated this authorization, you must receive a copy of the signed authorization.

7. Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes. HIPAA provides special protections to certain medical records known as Psychotherapy Notes. All Psychotherapy Notes recorded on any medium by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separately from the rest of the clients medical records to maintain a higher standard of protection. Psychotherapy Notes are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separate from the rest of the individuals medical records. Excluded from the Psychotherapy Notes definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. Except for limited circumstances set forth in HIPAA, in order for a medical provider to release Psychotherapy Notes to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other dental records.

8. You have a right to an accounting of the disclosures of your protected dental information by the provider or its business associates. The maximum disclosure accounting period is the six years immediately preceding the accounting request. The provider is not required to provide an accounting for disclosures: (a) for treatment, payment, or dental care operations; (b) to you or your personal representative; (c) for notification of or to persons involved in an individuals dental care or payment for dental care, for disaster relief, or for facility directories; (d) pursuant to an authorization; (e) of a limited data set; (f) for national security or intelligence purposes; (g) to correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody; or (h) incident to otherwise permitted or required uses or disclosures. Accounting for disclosures to dental oversight agencies and law enforcement officials must be temporarily suspended on their written representation that an accounting would likely impede their activities.

By signing this document I am acknowledging that I have reviewed my child's client rights and HIPPA authorization form:

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

HOMETOWN children's dentistry

Guardian Authorization Form

If your wish for a person other than your child's parent or legal guardian to bring them to their dental appointment, please sign and provide the following information:

Authorized Person's Name:_____

Authorized Person's Relation to Child:_____

By signing below I am giving this person authorization to accompany my child to their dental visit.

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

Please check the following treatments that you agree may be performed in your absence:

Dental Examination: _____

Dental X-rays: _____

Dental Cleaning: _____

Fluoride: _____

Dental Operative procedures deemed necessary by the dentist
(including all restorative procedures: fillings, crowns, extractions) _____

Nitrous Oxide _____

Emergency Treatment_____

By signing below I am agreeing that my child may receive these treatments while accompanied with the person that I have authorized

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

HOMETOWN
children's
dentistry

Consent for Dental Treatment:

As the parent and/ or legal guardian of the patient, I do hereby request and authorize Hometown Children's Dentistry and their staff to examine, clean, and provide dental treatment on my child. I further request and authorize the taking of dental x-rays as may be considered necessary to diagnose and/ or treat my childs dental problems. I will allow photographs to be taken of my child or my child's teeth for diagnostic and educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them understand the treatment inn terms appropriate for their age. We will provide an environment that will help your child learn to cooperate during treatment including praise, explanations, and demonstrations of procedures and instruments using a variable voice tone. The usual and most frequent risks or complications occurring from dental treatment include but are not limited to: the possibility of pain or discomfort during or after treatment, swelling, infection, bleeding, injury to adjacent teeth or surrounding tissue, allergic reactions, and jaw pain.

By signing below, I am agreeing that I understand the aforementioned risks that can occur with any dental treatment and agree for the dental professionals at Hometown Children's Dentistry to provide Oral Health Care for my child:

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

HOMETOWN children's dentistry

COMMUNICATION CONSENTS

Email Consent Form

PURPOSE: This form is used to obtain your consent to communicate with you by email regarding your Protected Health Information. Hometown Children's Dentistry offers patients the opportunity to communicate by email. Transmitting patient information by email has a number of risks that patients should consider before granting consent to use email for these purposes. Hometown Children's Dentistry will use reasonable means to protect the security and confidentiality of email information sent and received. However, Hometown Children's Dentistry cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email between Hometown Children's Dentistry and myself, and consent to the conditions outlined herein. Any questions I may have, have been answered by Hometown Children's Dentistry.

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

Text Message to Mobile Consent Form

PURPOSE: This form is used to obtain your consent to communicate with you by mobile text messaging regarding your Protected Health Information. Hometown Children's Dentistry offers patients the opportunity to communicate by mobile text messaging. Transmitting patient information by mobile text messaging has a number of risks that patients should consider before granting consent to use mobile text messaging for these purposes. Hometown Children's Dentistry will use reasonable means to protect the security and confidentiality of mobile text messaging communication and will not be liable for inadvertent disclourse of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of mobile text messaging between Hometown Children's Dentistry and myself, and consent to the conditions outlined herein. Any questions I may have, have been answered by Hometown Children's Dentistry

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

HOMETOWN children's dentistry

Financial Policy

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment; It is our hope that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choices related to your care.

Insurance:

Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services, including a pre-treatment estimate which we send to the insurance company at your request. It is physically impossible for us to have the knowledge and keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to hat benefits your employer has purchased for you. If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf.

Please be aware some or perhaps all the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion.

Payment:

Please understand that regardless of any insurance status you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to dental fees, operative procedures, tests, office procedures, medications and any other service not directly provided by the dentist.

FULL PAYMENT IS DUE at the time of service. If insurance benefits apply, estimated patient co-payments and deductibles are due at the time of service, unless other arrangements are made

ANY UNPAID BALANCE OVER 90 DAYS OLD will be subject to a monthly interest of 1.0% (APR 12%). If payment is delinquent, the patient will be responsible for payment of collection, attorney fees, and court costs associated with the recovery of the balance due on this account.

By signing below, I am acknowledging that I have read, understand, and agree to the terms and conditions previously outlined in this document

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

HOMETOWN children's dentistry

Missed Appointment Policy

If you must cancel an appointment, it is required that you call at least 24-hours prior to your scheduled appointment to avoid missed appointment fees. If your child is sick the night before, wakes up sick, or if you have an emergency situation, please call our office immediately and let our receptionist know or leave a message.

Any patient who misses an appointment without giving sufficient notice will be charged a 50$ missed appointment fee.

By signing this document you acknowledge that you have read, understand, and agree to this policy.

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

HOMETOWN
children's
dentistry

Photography Consent

I, _____, authorize Hometown Childrens Dentistry to take and/or reproduce photographs/videos of my child/children's teeth or face for publications, presentations, patient testimonials, smile gallery and marketing materials to be used online, social media and/or website.

CONSENT

I acknowledge I have read, and understand the above consent. I authorize the taking of clinical photographs and videos and their use for scientific and marketing purposes both in publications and presentations. By signing below, I understand and agree that photographs and videos may be taken of my child/children for educational and marketing purposes. I release Hometown Childrens Dentistry from any liability resulting from this production. I waive my rights to any royalties, fees and to inspect the finished production as well as advertising materials in conjunction with these photographs.

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

HOMETOWN
children's
dentistry

Social Media Consent

On occasion, our office will take pictures of patients being treated in our office and dental work that has been performed. The photos are used to promote services available in our practice, for patient education and to demonstrate before and after results of treatment. We would like your permission to use these photos of yourself and your child/children on our website and other social media outlets, in displays in our office and in newsletters.

Upon consent, Hometown Children's Dentistry and its representatives will be released from any claims, including but not limited to claims of invasion of privacy or defamation. It is also acknowledged and agreed that no sums whatsoever will be due as a result of the use of consented photographs or social media materials.

☐ YES, I give my permission for my/my child's photos and other media materials to be used in
displays in the office of Hometown Children's Dentistry
on the website for Hometown Children's Dentistry
on other social media outlets associated with Hometown Children's Dentistry.

☐ NO, I do not give permission for my/ my child's photo to be used on any media outlets

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