Today's Date: _____

Patient Registration

Note: The parent or Guardian who accompanies the child is responsible for payment at the time of service.

Child's Name: First_____ Last _____ Mi._____

Nickname_____ Child's Birthdate _____/_____/_____ Age _____

Child's Home Address _____

City _____ State _____ Zip_____ Child's Home Ph# _____

School _____ Grade _____

MOTHER'S INFORMATION ___Mother ____Stepmother ___Guardian

Name: First _____ Last _____ Mi._____

Address _____ (if different than child)

Home _____ Cell _____ Work _____

Employer _____ SSN _____ Birth date _____

FATHER'S INFORMATION ___Father ____Stepfather ___Guardian

Name: First _____ Last _____ Mi._____

Address _____ (if different than child)

Home _____ Cell _____ Work _____

Employer _____ SSN _____ Birth date _____

WHO IS ACCOMPANYING THE CHILD TODAY?

Name: First _____ Last _____ Mi._____

Email _____

Relationship _____ Do you have legal custody of the child? Yes or No

PERSON RESPONSIBLE FOR ACCOUNT

Name: First _____ Last _____ Mi._____

Billing Address _____

City/State/Zip_____ Home# _____

Work#_____ Cell# _____ Relationship _____

Email _____

PRIMARY DENTAL INSURANCE

Insurance Company _____ Phone _____

Policy Holder Name _____ Birth date _____ SSN _____

Employer _____ Relationship to Patient _____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

_____

DENTALSAURUS
Pediatric Dental Specialist

Date _____

Has the patient received dental care previously? Yes or No
Reason for bringing the child to the dentist (chief complaint) _____

___Y ___N Is your child currently being treated by a physician?
Physician Name:_____Phone: _____

___Y ___N Has your child ever been hospitalized? If yes, for what and when
_____

___Y ___N Has your child ever received general anesthesia? If yes, were there any complications?_____

___Y ___N Has any family member had a complication with general anesthesia? If yes, explain:_____
___Y ___N Is your child allergic to any foods, medications or latex?
_____

___Y ___N Is your child taking any medications at this time? If yes, what:
_____
Are your child's immunizations up to date? _____
Was your child born premature or with low birth weight? _____
Has your child taken any medications for a long period of time? _____

Has your child ever been diagnosed with any of the following conditions?

__Y __N Anemia	__Y __N ADHD	__Y __N Arthritis
__Y __N Jaundice	__Y __N Asthma	__Y __N Leukemia
__Y __N Jaundice at Birth	__Y __N Measles	__Y __N Bleeding problems
__Y __N Mental Retardation	__Y __N Cancer	__Y __N Orthopaedicproblems
__Y __N Cerebral Palsy	__Y __N Otitis (earinfection)	__Y __N Convulsions/Seizures
__Y __N Pnemonia	__Y __N Cystic Fibrosis	__Y __N Pregnancy
__Y __N DelvelopmentalDelay	__Y __N RheumaticFever	__Y __N Diabetes
__Y __N ScarletFever	__Y __N EyeProblems	__Y __N SickleCell Anemia
__Y __N HearingLoss	__Y __N SpinaBifida	__Y __N HeartMurmur
__Y __N Hepatitis	__Y __N Whooping Cough	__Y __N High Blood Pressure
__Y __N HIV (AIDS)	__Y __N Down Syndrome	__Y __N Brain Surgery

Has your child been seen by a dentist before? If yes, when_____
Has your child had any accidents involving his/her teeth? _____
Does your child have a dental condition that runs in the family? _____
Does your child brush regularly? _____ How many times and when? _____
Does the water in your community contain fluoride? _____
Has your child ever take fluoride vitamins/gels/rinses? _____
What type of toothpaste does your child use? _____
Does your child use dental floss? _____How often and when? _____
How do you expect your child to react to dental treatment? Very Well__ Moderately Well __Not Well __
Why? _____
Does your child play any sports? _____
Does your child have any oral habits (thumb sucking, nail biting, etc.) _____
Any additional information that you would like to discuss? _____

_____

DENTALSAURUS
PEDIATRIC DENTAL SPECIALIST

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. 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_/_1_/_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 will notify you of any changes. We will provide copies upon request. You may request a copy of our Notice at any time.

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.

Treatment: Example: 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. Example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations: Example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment: We may disclose information to your family, friends or any other individual identified by you. Additionally, we may disclose information to a patient representative. **Disaster Relief:** Example: To assist in disaster relief efforts.

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

Public Health Activities:. Example:

- 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. To authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. To correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS: (The Secretary of the U.S. Department of Health and Human Services) When required to investigate or determine compliance with HIPAA.

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. 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.

Research. 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 privacy of your information.

Coroners, Medical Examiners, and Funeral Directors: Example, to identify a deceased person or determine the cause of death.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law.

_____**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. If you request information that we maintain on paper, we provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying. 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.

You will receive notifications of breaches of your unsecured protected health information as required by law.

Patient Acknowledgment

I hereby acknowledge that I have read the Privacy Policy for Dentalsaurus

Parent/Guardian_____ Patient:_____

SIGNATURE_____ DATE_____

Dentalsaurus
2500 W. William Cannon, Ste 507
Austin, Texas 78745

Patient Policies

Welcome and thank you for choosing our office. We truly appreciate you entrusting us with your oral dental health. As an office and staff we pride ourselves on delivering top-quality dentistry with a commitment to superior customer service. It is important that you understand these so we can serve you and all our patients to the best of our ability.

Financial Policy and Responsibility

_____We gladly submit the insurance claim to your providing insurance company as a courteous to you. Your insurance policy is a contract between you, your employer, and your insurance company. It is the responsibility of the patient to notify this office any changes to name, address, employer or policy. Payment is required at the time of the services for all charges not covered by insurance company including co-pay and deductibles. (Financial policy to all patients/insurance. Please ask front desk representative for more information.)

I agree that I will be responsible to pay for any of the charges that are not covered by the insurance I have provided. Pay any required co-pay or deductible at the time of the visit. If I fail to pay the outstanding insurance balance within 30 days of receiving a statement form or office. (When Dentalsaurus receives an explanation of benefits (EOB) from your insurance company; any amounts that you need to pay will be billed to you).

I understand that my obligation may be referred to a third-party collection agency and that I will be responsible for any collection fees, interested, and other expensed necessary to collect on my account, including court cost, should legal action be instated against me.

Appointment Policy: An appointment in our office is reserved specialty for you and the doctor or hygienist. If you are unable to make your reserved time, we ask you to call our office during business hours at least 1 business day (24) hours in advanced.

- A "no-show" appointment is where a patient does not call our office or leave a message 24 hours prior to appointment date. A no-Show appointment will be charged a cancellation fee of $35.
- After two no-show appointments you will be charged a second cancellation fee of $35.
- If you are running late for an appointment, we ask you to call to keep us informed. This will allow our schedule to flow as smoothly as possible. We will do all we can to adjust our schedule to get you in for your service our schedule coordinator will work with you as needed

Returned Check Policy

If a payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF), Account Closed (AC), or Refer to Maker (RTM), the patient or the Patient's Responsible Party will be responsible for the original check amount in addition to a $45.00 Service Charge. Once notice is received of the returned check, Dentalsaurus will send out a letter to notify the Responsible Party of the returned check. If a response is not made within 15 days from the letter date by the Patient or the Responsible Party, the account may be turned over to our collection agency and a collection fee will be added to the outstanding balance – in addition to the $45.00 Check Service Charge.

By signing below, you agree to accept full financial responsibility as a patient who is receiving dental services or as the responsible party for minor patients. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

Patients Name: _____

Responsible Party Name: _____

Responsible Party Signature: _____ Date: _____