Tooth Town Pediatric Dentistry • Stephen M. Ghezzi, DDS
26018 Pontiac Trail • South Lyon, MI 48178 •248-486-4030 • DrSteve@toothtownsmiles.com

Today's Date_____

PARENT/GUARDIAN INFORMATION

With whom do the children reside? ___Father___Mother ___Legal Guardian ___Other (relationship)_____

Parents' Marital Status: __ Married __Divorced __Single __Widowed __Separated

MOTHER_____ **Date of Birth**_____ **Social Security**_____

Street Address_____City_____Zip_____

Home#_____Cell#_____Email_____

Employer_____Work#_____

Dental Insurance Carrier_____Group_____Subscriber ID_____

FATHER_____ **Date of Birth**_____ **Social Security**_____

Street Address_____City_____Zip_____

Home#_____Cell#_____Email_____

Employer_____Work#_____

Dental Insurance Carrier_____Group_____Subscriber ID_____

GUARDIAN_____ **Date of Birth**_____ **Social Security**_____

(If other than parent)

Street Address_____City_____Zip_____

Home#_____Cell#_____Email_____

Employer_____Work#_____

Dental Insurance Carrier_____Group_____Subscriber ID_____

CHILDREN

Name _____ Date of Birth _____Age_____Sex____

Name _____ Date of Birth _____Age_____Sex____

Name _____ Date of Birth _____Age_____Sex____

Name _____ Date of Birth _____Age_____Sex____

How did you hear about our office? _____

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Child's Name (First, Middle, Last) _____ Nickname_____

Date of Birth_____ Age_____ Sex_____ School_____

Insurance Carrier: _____ ID: _____ Group: _____
* If different from responsible party

MEDICAL HISTORY

Primary Care Physician_____ Location_____ Phone_____

Pharmacy_____ Location_____ Phone_____

List all medications your child is currently taking (including dose & frequency) _____

Has your child ever been hospitalized, had surgery or any serious illness (please explain)?_____

Does your child have any allergies? _____

Does your child require an antibiotic prior to dental treatment (please explain)?_____

Does your child have a history of any of the following? (check all that apply)

- ☐ ADD (Attention Deficit Disorder)
- ☐ ADHD (Attention Deficit Hyperactive Disorder)
- ☐ AIDS (HIV)
- ☐ Anemia
- ☐ Asthma
- ☐ Autism
- ☐ Blood Pressure Concerns
- ☐ Blood Transfusion (explain)
- ☐ Bruises Easily
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Convulsions/Epilepsy/Seizures
- ☐ Depression
- ☐ Diabetes
- ☐ Eating Disorder (explain)
- ☐ Fainting Spells
- ☐ Hearing Impairment
- ☐ Heart Condition (explain)
- ☐ Hepatitis-Type:_____
- ☐ Hives or skin rash
- ☐ Liver Disease
- ☐ Malignancies
- ☐ Mastoid
- ☐ Measles
- ☐ Mumps
- ☐ Nervousness
- ☐ Persistent Cough or Coughing up Blood
- ☐ Physical, emotional or mental impairment
- ☐ Rheumatic Fever
- ☐ Surgery or radiation treatment for tumor, growth, or condition of the head or neck
- ☐ Thyroid
- ☐ Tuberculosis
- ☐ Venereal Disease

Other (please explain):_____

DENTAL HISTORY

Reason for today's Visit_____

Referring or Previous Dentist_____ Location_____

Date of last dental visit_____ Type of Service _____

Has your child complained of any dental problems? _____

Are there any problems associated with previous dental treatment?_____

How do YOU think your child will act with the dentist? _____

Past Dental History (check all that apply)

- ☐ Cavity
- ☐ Teeth Cleaning
- ☐ Tooth Extraction
- ☐ Toothache
- ☐ Dental X-ray
- ☐ Prolonged bleeding after extraction
- ☐ Gum Swelling
- ☐ Local Anesthesia
- ☐ Braces (Orthodontic Treatment)
- ☐ Injury to Teeth/Face
- ☐ Filling (s)
- ☐ Other (explain)

Has brushing teeth been easy at home? _____ How often and when? _____

Current Daily Oral Hygiene, Diet and Mouth Habits (check all that apply now)

- ☐ Thumb/Finger Sucking
- ☐ Pacifier
- ☐ Use Toothpaste with Fluoride
- ☐ Adult Assisting
- ☐ Floss
- ☐ Fluoride Supplement
- ☐ Sugary/Starchy snacks more than 3/day
- ☐ Frequent Juice/Sports/Soft Drinks
- ☐ Bottle Fed
- ☐ Baby Bottle at Bedtime
- ☐ Breast Fed

Comments: _____

May we request release of your child's medical or dental records for our reference? _____YES _____NO

By signing here, I certify that I have completed the requested information on this form to the best of my knowledge:

Signature_____ Relationship to Child_____ Date_____

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FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We are committed to your child's treatment being successful. Please understand that payment of your bill is considered a part of your child's treatment. Our main concern is that your child receives the proper and optimal treatment needed to restore and maintain his or her dental health. We have developed the following financial policies to clarify our billing practices and expectations. Prior to your child's appointment, please review, ask any questions you may have and sign. A copy will be provided to you upon request.

1. Payment is due at the time services are rendered. We accept Cash, Check, Visa, MasterCard, Discover, American Express or Care Credit.
2. We participate in many insurance plans and whenever possible will bill your insurance company as a courtesy to you. When we submit an insurance claim on your behalf, you must understand that:
    a. All deductibles and co-payments are payable at the time service is rendered. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud.
    b. Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. In general, our relationship is with you, NOT your insurance company.
    c. It is your responsibility to know your insurance coverage and benefits, including frequencies and limitations on procedures. This information can normally be obtained through your employer's benefits office or the insurance carrier.
    d. All charges are your responsibility whether your insurance company pays or not. Not all services are a covered benefit and some insurance companies arbitrarily select certain services they will not cover.
    e. Our fees are considered usual, customary and reasonable by most insurance companies and, therefore, provide reimbursement to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse on an arbitrary schedule of fees.
    f. If your insurance carrier has not paid on a claim within forty five (45) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance.
    g. A statement will be sent for any balance remaining after insurance payment is received. Unless other arrangements are approved by us in writing, the balance is due and payable when the statement is issued, and is past-due if not paid within thirty (30) days.
3. A fee of $25 will be charged for any checks returned by the bank.
4. Returned checks and balances older than ninety (90) days may be turned over to our attorney and collection agency. Additional collection fees of up to 50% will be applied to your account.
5. In the case of divorce or separation, the party responsible for the account is the parent authorizing treatment for the child. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the responsibility of the authorizing parent to collect from the other parent.
6. Please call as soon as possible if you need to reschedule your child's appointment. Appointments that are missed or cancelled with less than 24 hours notice may be charged a missed appointment fee of $50.00 per hour of appointment time scheduled.
7. We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems immediately so that we can assist you in the management of your account.

I understand I am financially responsible, WHETHER OR NOT MY INSURANCE COMPANY PAYS, for all charges incurred by me. I hereby assign my dental insurance benefits to Stephen M. Ghezzi, DDS and Tooth Town Pediatric Dentistry. I authorize the release of any protected health information required to secure payment.

Parent or Guardian 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 July 19, 2011, 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 changes in our privacy practices with any new terms of our Notice, effective for all health information that we maintain; including health information we created or received before we made any change. Before we make a significant change in our privacy practices, we will amend 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 beginning 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.
Persons Involved In Care: We must disclose your health information to you as described in the Patient Rights section of this Notice. Under certain circumstances, we may disclose health information to family members, other relatives, or close personal friends or others that you identify, to the extent it is directly relevant to their involvement with your care or payment related to your care; or to notify them of your location, general condition, or death. If you are present, you may object to such uses or disclosures. However, in the event of your incapacity or emergency situation, we will disclose health information based upon a determination using our professional judgment and our experience with common practice to make reasonable inferences of your best interest.
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 or 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 (via telephone, telephone answering machine, voicemail, email or letter).

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 information. You may obtain a form to request access by contacting our office directly or by sending us a letter to the address at the top of this notice. We may charge you a reasonable cost-based fee for expenses (such as copies, staff time and postage). If you request an alternative format, we will assess a cost-based fee for providing your healthcare in that format.
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 six years, but not before April 14, 2003. You are entitled to one such list per year without charge. Additional requests may be subject to a cost-based fee.
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 situation).
Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or locations. Your request must be made in writing and must specify the alternative means or location, and provide satisfactory explanation 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.
Additional Notice Copies: Regardless of whether you received this Notice electronically or in paper form; you are entitled to additional paper copies (via written request).

QUESTION AND/OR COMPLAINTS

If you want more information about our privacy practices or have a question and/or concern, please contact us.

If you are concerned that we have not properly respected the privacy of your health information, you are free to complain to us or to the U.S. Department of Health and Human Services (address provided, upon request). We will not retaliate in any way if you choose to file a complaint.

We support your right to the privacy of your health information.

Patient Acknowledgement and Consent Form

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPPA") requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPPA's requirements, we are giving you a copy of our Notice of Privacy Practices. This notice of Privacy Practices contains the information that HIPPA requires us to disclose regarding our privacy practices.

Existing Michigan Law requires (in addition to our attempt to obtain your written acknowledgment, discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with a defense to a claim challenging our professional competence; a review entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Patient Acknowledgement

Please sign this form below under the heading "acknowledgement" to acknowledge that you have today received a copy of our notice of privacy practices.

I acknowledge that I have today received a copy of the Notice of Privacy Practices.

_____ _____

Patient Signature Patient Name (please print)

Date: _____

Patient Consent

Please sign this form below under the heading "consent" to consent to our disclosures of your information that we deem necessary in order to provide you with proper treatment.

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

_____ _____

Patient Signature Patient Name (please print)

Date: _____

For office use only

Patient Refused to Sign

The following circumstances prohibited the patient from signing the Acknowledgement

_____

An emergency situation prevented the patient from signing the Acknowledgement.

_____ _____

Office Personnel (signature) Office Personnel (print name)

Date: _____