CARMEL PEDIATRIC DENTISTRY

12188 A. N. Meridian St. Suite 365 Carmel, IN 46032

P: (317) 846-3496 F: (317) 846-4497

Child's Last Name: Child's First Name: MI:

☐ Male ☐ Female Date of Birth: _____

Whom may we thank for referring you to us? _____

Responsible Party Information:

Last Name: _____ First Name:_____ MI: _____

Date of Birth: _____ SS #_____ ☐ Male ☐ Female

Address:_____ Zip: _____

Home # _____ Work # _____ Cell # _____

E-mail Address: _____

Marital Status: ☐ M ☐ S ☐ D ☐ W

Other Parent's Information:

Last Name: _____ First Name: _____ MI:____

DATE OF BIRTH: _____ SSN# _____ MALE☐ FEMALE ☐

ADDRESS SAME AS ABOVE ☐

Address: _____Zip: _____

Home # _____ Work # _____ Cell # _____

E-mail Address: _____

Marital Status: ☐ M ☐ S ☐ D ☐ W

INSURANCE INFORMATION:

Insured's Relationship to patient: _____

Primary:

Name of Insured: _____ Insured's ID # _____

Insured's SS# _____ Insured's DOB: _____

Insurance Company: _____ Employer: _____

Insurance Company Address: _____ Group # _____

Insurance Phone # _____

Secondary (if Applicable)

Name of Insured: _____ Insured's ID # _____

Insured's SS# _____ Insured's DOB: _____

Insurance Company: _____ Employer:_____

Insurance Company Address: _____ Group # _____

Insurance Phone # _____

I affirm that the above information I have given is correct to the best of my knowledge. It will be held in confidence and it is my responsibility to inform this office of changes in the patient's information. I understand that Carmel Pediatric Dentistry may use and disclose pertinent health information and dental records to coordinate and manage dental care and related services to one or more health care providers or dental specialists. I authorize the release of all information necessary to secure benefits such as obtaining reimbursement for services, confirming coverage, bill or collection activities and utilization review. I understand that I am responsible for the full balance of the account regardless of my dental benefits and directly assign Carmel Pediatric Dentistry all insurance payments otherwise payable to me. Insurance is submitted as a courtesy and payment is due in full within 30 days of appointment. In case of default, I agree to pay all reasonable costs and fees associated with the collection of the account balance, including but not limited to third party collection fees, court filing fees and attorney fees. *Please be aware that the parent bringing the child in for care is the one legally responsible for payment of all fees*. I affirm that my signature represents my agreement to all of the terms mentioned above.

Signature _____ Relationship _____Date _____

APPOINTMENT INFORMATION

Which method would you prefer for having your appointment confirmed? You may select as many options as you'd like.

E-mail:_____

Text to Cellular Device: _____

Home or (Mobile) Phone Call:_____

Can we leave a message at the above listed contact numbers for appointment reminders? Yes ☐ No☐

Parental Consent

I, _____ (parent or guardian- please type name) do hereby state that in my absence the following individuals may bring my child, _____(Name of Minor Child) to any/all office visits at Carmel Pediatric Dentistry. I understand the named temporary guardian will be expected to provide identification at each visit. By signing this consent, I agree to give the named temporary guardian access to my child's dental and financial information, and permission to make dental/medical decisions as needed. I understand that this authorization will remain in effect until revoked by me in writing. (Include older siblings who will be driving younger siblings to appointments, nannies, grandparents or other relatives.)

1. _____ Relationship to patient _____
2. _____ Relationship to patient _____
3. _____ Relationship to patient _____

Guardian Signature _____ Date_____

CARMEL PEDIATRIC DENTISTRY

12188 A. N. Meridian St. Suite 365 Carmel, IN 46032

P: (317) 846-3496 F: (317) 846-4497

NAME DOB

DENTAL HISTORY

Dental Concerns

What is the primary reason for today's visit? ☐ Cleaning ☐Trauma/Dental Emergency ☐Consult for Decay

Has your child ever been to the dentist? ☐Yes ☐No

(If Yes) Previous/Present Dentist: _____

Any previous dental injuries? ☐ Yes No☐

Do you think your child will react well to treatment? Yes☐ No☐

Please describe any tip/tricks that will help our team provide a positive experience for your child's visit: Click here to enter text.

Dental Habits

☐ Suck Thumb/Finger ☐ Suck/Bite Lips ☐ Bite/Chew Nails ☐ Tongue Thrust

☐ Use Pacifier ☐ Tongue/Cheek Chew ☐ Clench/Grind Teeth ☐ Mouth Breather

MEDICAL HISTORY

Are immunizations current? ☐ Yes ☐ No

Child's Primary Care Physician: _____ Phone: _____

Date Last Exam: _____

Please list any other Specialists or Physicians involved in your child's care:

Physician Name: _____ Physician Name: _____

Phone: _____ Phone: _____

Current Medications: _____

_____

Allergies:

☐ Drug: Click here to enter text. ☐ Nuts ☐ Latex ☐ Seasonal

☐ Food: _____ ☐ Other (specify): _____

Caries Risk Assessment	YES	NO	DON'T KNOW
I brush my child's teeth with fluoridated toothpaste	☐	☐	☐
My child consumes fluoridated drinking water	☐	☐	☐
My child consumes >3 sugary beverages between meals per day	☐	☐	☐
My child takes a bottle or sippy cup to bed or nurses throughout the night	☐	☐	☐
Mother or primary care giver has a history of dental decay	☐	☐	☐
(Office to fill out)	Low ☐	Moderate ☐	High ☐

History of Hospitalizations / Operations / Emergency Room Care / Recent Illnesses (explain):_____

_____

Has your child been diagnosed and/or treated for any of the following (check all that apply)

☐ Blood Disorder / Anemia ☐ Tuberculosis (TB)

☐ Abnormal Bleeding / Hemophilia ☐ Asthma / Reactive Airway

☐ Immune Disorder / HIV / Aids ☐ Sleep Apnea / Snoring

☐ Cancer / Tumor / Leukemia ☐ Premature / Low Birth Weight

☐ Heart Murmur / Defect / Surgery ☐ Congenital Birth Defects

☐ Epilepsy / Seizures / Convulsions ☐ Cleft Lip / Palate

☐ Cerebral Palsy ☐ ADD / ADHD

☐ Cystic Fibrosis ☐ Autism Spectrum

☐ Kidney Problems ☐ Eating Disorder

☐ Liver Disease / Jaundice / Hepatitis ☐ Hearing Problems / Deaf

☐ Diabetes ☐ Speech Disorder

☐ Sickle Cell Trait ☐ Vision Problems

☐ Stomach / GI Disorders ☐ Mental / Cognitive / Social Delay

☐ Tonsillitis ☐ Syndromes: _____

Other conditions / diseases not listed (Specify): _____

Has anyone in your family traveled out of the United States in the last 21 days? ☐Yes☐No

(If Yes) please list travel locations: _____

Guardian Signature: _____ Date: _____

Before signing this document, verify that the content you are signing is correct. I affirm that the above information I have given is complete and accurate to the best of my knowledge. It will be held in confidence and it is my responsibility to inform Carmel Pediatric Dentistry of changes in the patient's dental and medical status.

Carmel Pediatric Dentistry

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 7/17/2013, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and terms of this notice at any time, provided such changes are permitted by applicable law, and to make new notice provisions effective for all protected health information that we maintain. When we make significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCOLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment: We may use and disclose your health information for your treatment. For example, we may disclose your health information 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, and insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.
Healthcare Options: We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training, and licensing activities.
Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative plans or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested, we may have to contact you using the information we have.
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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.
Right to Notification of a Breach: You will receive notifications of breaches of your unsecured protected health information as required by law.
Electronic Notice: You may receive a paper copy of this notice upon request, even if you have agreed to receive this notice electronically on our website or by electronic mail (e-mail).
Individuals Involved in Your Care or Payment of Your Care: We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.
Disaster Relief: We may use or disclose your health information to assist in disaster relief efforts.

Required by Law: We may use or disclose your health information when we are required to do so by law.
Public Health Activities: We may disclose your health information for public health activities, including disclosures to; 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 maybe have been exposed to a disease or condition, or notify the appropriate government authority if we believe a patient has been a 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. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody the protected health information of an inmate or patient.
Secretary of HHS: We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.
Worker's Compensation: 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 to law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order
Health Oversight Activities: We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and

credentialing, as necessary for licensure and for the government to monitor 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. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information request.

Research: We may disclose your PHI 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 the privacy of your information.

Coroners, Medical Examiner, and Funeral Directors: We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out duties.

Fundraising: We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

OTHER USES AND DISCLOSURES OF PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your authorization before using or disclosing your PHI for purposes other than those provided for in the notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on authorization.

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. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting: With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting to more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to additional requests.

Right to Request a Restriction: You have to right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure, or both, and (3) whom you want the limits to apply. 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.

QUESTIONS AND COMPLAINTS

If you want 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 if 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 using the contact information listed at the end 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 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 with the U.S. Department of Health and Human Services.

Contact Officer: Katherine Nichols, DDS, MSD
Telephone (317) 846-3496 Fax (317) 846-4497
Address: 12188-A N. Meridian St. Suite 365 Carmel, IN 46032

Carmel Pediatric Dentistry

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.

_____

(Signature)

_____

(Date)

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
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

Carmel Pediatric Dentistry

Katherine T. Nichols, DDS, MSD Lauren E. Long, DDS, MSD
12188-A N. Meridian Street, Suite #365
Carmel, IN 46032
(317) 846-3496

PHOTOGRAPH CONSENT FORM

Carmel Pediatric Dentistry loves to recognize your child's accomplishments including "A" brushing, great helpers, office activities, and contest winners. We may ask to photograph your child to positively reinforce their good brushing habits. We ask for written authorization to take your child's photograph for display in our office, on our website, or in social media. I understand my child's name and identity may be revealed in descriptive text or commentary in connection with the image(s) used. I authorize the use of these images without compensation to me. I hereby release and discharge Carmel Pediatric Dentistry, LLC from any and all claims or actions relating to the use or publication of such photos. I understand that this authorization will remain in effect until revoked by me in writing.

Child's Name (please print)

1._____

2._____

3._____

4._____

Parent/Guardian (print name) _____

Signature_____ **Date** _____

☐ **I DECLINE to allow Carmel Pediatric Dentistry to photograph my child.**

Parent/Guardian (print name) _____

Signature_____ **Date** _____

Carmel Pediatric Dentistry **Katherine Nichols, DDS, MSD Lauren E. Long, DDS, MSD**

Patient's Name _____

Office Use	CC _____
	Re-care_____

Our Office Policy Regarding Dental Insurance

We accept all types of dental insurance, however; we are in **NO** networks. 2 options are offered to our patients with dental insurance. In either case you must provide us with current insurance information.

Option 1: You may pay in full at time of service. We will then submit your insurance to reimburse you directly.

Option 2: You may leave a HSA or credit card number on file with us. We will then submit your insurance to pay us directly. Your signature below allows us to run your credit card for any balance on your account, and mail a statement and your credit card receipt to you.

Please circle your option of choice. Thank you for your cooperation.

**EFFECTIVE 10/21/2013 FOR ALL DELTA DENTAL SUBSCRIBERS WE WILL COLLECT PAYMENT AT TIME OF SERVICE WITH A 5% FEE COURTESY. DELTA DENTAL WILL THEN FORWARD PAYMENT WITHIN 7-10 BUSINESS DAYS DIRECTLY TO THE SUBSCRIBER.

THANK YOU FOR UNDERSTANDING.

Your Name: _____ Date: _____