



# florence pediatric dentistry

**Kimberly Elvington, DMD**

1505-A Heritage Lane

Florence, SC 29505

843.661.5700 ~ 843.661.5710 fax

**W**e are so excited to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we will be glad to assist you. We look forward to working with you in maintaining your child's dental health.

## PATIENT INFORMATION

Child's Name: \_\_\_\_\_

( ) Male      Last      First      Middle      Preferred Name  
( ) Female      Date of Birth      Hobbies: \_\_\_\_\_

Address: \_\_\_\_\_ City /State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Email Address: \_\_\_\_\_

How would you prefer us to contact you for confirming your child's appointments?

( ) Phone      ( ) Email      ( ) Text      ( ) Mail      ( ) Phone and Email

Whom may we thank for referring you to our office (how did you hear about us)? \_\_\_\_\_

## PARENTS' INFORMATION

( ) Mother      ( ) Stepmother      ( ) Guardian      Name: \_\_\_\_\_

Address (if different from above): \_\_\_\_\_

Home # (if different from above): \_\_\_\_\_ Work #: \_\_\_\_\_ Employer: \_\_\_\_\_

( ) Father      ( ) Stepfather      ( ) Guardian      Name: \_\_\_\_\_

Address (if different from above): \_\_\_\_\_

Home # (if different from above): \_\_\_\_\_ Work #: \_\_\_\_\_ Employer: \_\_\_\_\_

## INSURANCE INFORMATION

Policy Holder: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Policy Holder Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Insurance Co: \_\_\_\_\_ Employer: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ ID#: \_\_\_\_\_



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### **OFFICE POLICIES**

**Patient Name:** \_\_\_\_\_ **D.O.B.** \_\_\_\_\_ **Parent / Guardian:** \_\_\_\_\_

#### **FINANCIAL POLICY**

Our policy requires payment in full at the time of service.

For those families utilizing insurance benefits, we are happy to file your insurance claim as a courtesy. However, there is no direct relationship between our office and your insurance company. The type of plan chosen by you, and/or your employer, determines your insurance benefits. As such, we have no say in the selection of your insurance company, no control over the terms of your contract, the methods of reimbursement, or the determination of your insurance benefits. Reimbursement for covered services is subject to maximum allowable fees, deductibles, and copayments. Your estimated balance is due at the time of treatment. It is also your responsibility as a parent/guardian to pay any remaining balance on your account after any and all insurance benefits have been collected.

If your account is not paid within 60 days, you will be liable for all collection fees, legal fees, interest charges (1.5% per month), and any other expenses incurred while collecting your account.

I hereby authorize all insurance benefits, if any, to be assigned directly to Florence Pediatric Dentistry, otherwise payable to me for services rendered. I authorize the release of any information required to process insurance claims, including the use of my signature on all insurance submissions.

#### **MISSED APPOINTMENT POLICY**

We are dedicated to provide the best dental care possible for your child. We want to give your child the time and individual attention he/she deserves. Your child's appointment will be specifically reserved for your child. In an effort to acknowledge the importance of each parent's time and to remain on schedule, we ask that parents arrive on time for their children's appointments. If a patient is more than 15 minutes late, we cannot guarantee that all treatment will be completed, or we may need to reschedule the appointment. If an unforeseen circumstance arises, please give at least 24 hours notice if you must reschedule. Failure to comply with this policy may result in the dismissal of your child from our practice. If this happens, you will be notified in writing and we will continue to provide emergency dental care for your child for up to 30 days following the dismissal, as required by law.

**CONSENT FOR TREATMENT**

The information that I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform Florence Pediatric Dentistry’s dental staff of any changes in my child’s medical status. I authorize Dr. Elvington and/or associates to perform the necessary dental procedures, including, but not limited to, the use of nitrous oxide (laughing gas), local anesthetic (like Lidocaine), and any necessary x-rays needed on my child.

All procedures will be discussed with you prior to any dental treatment.

**ACKNOWLEDGEMENT OF HIPAA, FINANCIAL & MISSED APPOINTMENT POLICIES, & CONSENT**

I have read a copy of Dr. Kimberly C. Elvington’s Notice of Privacy Policies and I am aware that I am entitled to a copy upon request.

I understand the financial and missed appointment policies.

I hereby consent for treatment to be completed on my child.

I authorize Florence Pediatric Dentistry to file my insurance and for payments to be made to the office.

Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_



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Email: [info@florencepediatricdentistry.com](mailto:info@florencepediatricdentistry.com)

Effective date of notice: August 8, 2010

### **NOTICE OF PRIVACY PRACTICES**

Contact: Brice Elvington, Office Manager

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**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.**

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We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

#### **TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS**

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we will ask you for special written permission.

#### **USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION**

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

#### **APPOINTMENT REMINDERS**

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

## **OTHER USES AND DISCLOSURES**

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours. If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

## **YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION**

- The law gives you many rights regarding your health information. You can:
- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
  - ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
  - ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
  - ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
  - get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
  - get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

## **OUR NOTICE OF PRIVACY PRACTICES**

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

## **COMPLAINTS**

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

## **FOR MORE INFORMATION**

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown the beginning of this Notice.



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### AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

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Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

I authorize the professional office of my dentist named above to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1. Detailed description of the information to be released: Medical Concerns  
\_\_\_\_\_
2. To whom may the information be released [name(s) or class(es) of recipients]:  
\_\_\_\_\_
3. Expiration date or event relating to the individual or purpose for the release: \_\_\_\_\_
4. It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Date: \_\_\_\_\_

Parent / Legal Guardian: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**MEDICAL HISTORY**

Child's Pediatrician: \_\_\_\_\_ City/State: \_\_\_\_\_ Phone #: \_\_\_\_\_

Date of last physical exam: \_\_\_\_\_

Were there any difficulties during the pregnancy or delivery of your child? ( )Yes ( )No

If yes, please describe: \_\_\_\_\_

Has he/she ever been hospitalized or had surgery? ( )Yes ( )No

If yes, please describe: \_\_\_\_\_

Does your child have any history of the following medical concerns (Please check all that apply):

*General Conditions*

- \_\_\_\_\_ Arthritis
- \_\_\_\_\_ Asthma
- \_\_\_\_\_ Diabetes
- \_\_\_\_\_ Gastrointestinal Disorder
- \_\_\_\_\_ Heart Disease
- \_\_\_\_\_ Heart Murmur
- \_\_\_\_\_ Kidney Disease
- \_\_\_\_\_ Rheumatic Fever

*Behavior/Learning*

- \_\_\_\_\_ ADD/ADHD
- \_\_\_\_\_ Anxiousness/Nervousness
- \_\_\_\_\_ Autism
- \_\_\_\_\_ Asperger Syndrome
- \_\_\_\_\_ Behavioral Issues
- \_\_\_\_\_ Learning Disabilities
- \_\_\_\_\_ Psychiatric Disorder

*Developmental*

- \_\_\_\_\_ Blindness/Vision

*Brain Injury*

- \_\_\_\_\_ Cerebral Palsy
- \_\_\_\_\_ Cleft Lip/Palate
- \_\_\_\_\_ Developmental Delay
- \_\_\_\_\_ Feeding/Eating Problems
- \_\_\_\_\_ Growth Problems
- \_\_\_\_\_ Hearing Loss
- \_\_\_\_\_ Neuromuscular Defect
- \_\_\_\_\_ Orthopedic Problems
- \_\_\_\_\_ Seizures: Type \_\_\_\_\_
- \_\_\_\_\_ Speech Delay
- \_\_\_\_\_ Spina Bifida

*Hematological (Blood-related)*

- \_\_\_\_\_ Anemia
- \_\_\_\_\_ Bleeding Issues
- \_\_\_\_\_ Hemophilia
- \_\_\_\_\_ Sickle Cell Trait
- \_\_\_\_\_ Sickle Cell Disease
- \_\_\_\_\_ Blood Transfusion

*Infectious*

- \_\_\_\_\_ Hepatitis
- \_\_\_\_\_ HIV Infection
- \_\_\_\_\_ AIDS
- \_\_\_\_\_ Tuberculosis

*Other*

- \_\_\_\_\_ Adenoids
- \_\_\_\_\_ Cancer/Tumors
- \_\_\_\_\_ Fainting
- \_\_\_\_\_ Headaches
- \_\_\_\_\_ Leukemia
- \_\_\_\_\_ Skin Disorder
- \_\_\_\_\_ Sleep Apnea
- \_\_\_\_\_ Snoring
- \_\_\_\_\_ Thyroid
- \_\_\_\_\_ Tonsils
- \_\_\_\_\_ Tubes in ears
- \_\_\_\_\_ Other

If any checked, please describe further: \_\_\_\_\_

**MEDICATIONS**

Please list any medications your child is currently taking and the correlating diagnosis: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

### ALLERGIES

Has your child had any allergic reactions to the following:

Penicillin/Amoxicillin       Latex       Aspirin       Sulfa drugs       Local Anesthetic

Foods (Please list): \_\_\_\_\_

Other (Please list): \_\_\_\_\_

Have you ever been told your child requires antibiotic prophylaxis for dental treatment due to a medical condition (e.g., heart condition, shunt, etc)?     Yes     No

Physician following medical condition? \_\_\_\_\_

City/State: \_\_\_\_\_ Phone #: \_\_\_\_\_

### DENTAL HISTORY

Previous Dentist: \_\_\_\_\_ Last Dental Visit: \_\_\_\_\_

My child brushes his/her teeth \_\_\_\_\_ times a day.

Do you help your child brush his/her teeth?     Yes     No

Does your child floss every day?                     Yes     No

Is fluoride taken in any form?                       Yes     No

Is there a history of bad dental experiences?     Yes     No

Is your child experiencing any dental pain?     Yes     No

Any injuries to the mouth/teeth?                     Yes     No

Please describe and specify at what age: \_\_\_\_\_

Does your child have any mouth habits? (Please check all that apply)

Thumb/finger sucking                     Grinding during sleep                     Pacifier use

Sleeping with bottle/sippy cup     Mouth breathing                           Snoring

Is there anything else you would like to tell us regarding your child's dental health? \_\_\_\_\_

### AUTHORIZATION TO BRING MINOR FOR DENTAL TREATMENT

List anyone who may accompany your child (please specify relationship) to an appointment and has permission to make decisions concerning their dental treatment: \_\_\_\_\_

\_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_