Lancaster Pediatric Dental Associates PC

1875 Lititz Pike • Lancaster, PA 17601 • 717-560-9002
info@lpdakids.com • www.lpdakids.com

PATIENT REGISTRATION

TODAY'S DATE_____ **REFERRED BY:**_____

PATIENT'S NAME_____ **Preferred Name:**_____
Last First MI

DATE OF BIRTH _____/_____/_____ **AGE** _____ ☐ **MALE** ☐ **FEMALE**

FATHER'S NAME_____ **MOTHER'S NAME**_____

ADDRESS_____
Number and Street City State Zip

HOME TELEPHONE_____ **E-MAIL**_____

NAME OF CHILD'S PRIMARY PHYSICIAN_____ **TELEPHONE**_____

FAMILY DENTIST_____ **TELEPHONE**_____

FATHER'S EMPLOYER_____ **MOTHER'S EMPLOYER**_____

FATHER'S WORK NUMBER_____ **MOTHER'S WORK NUMBER**_____

FATHER'S CELL NUMBER_____ **MOTHER'S CELL NUMBER**_____

DO WE HAVE YOUR PERMISSION TO CONTACT YOU AT YOUR WORK NUMBER IF NECESSARY? ☐ **YES** ☐ **NO**

BILLING INFORMATION

Responsible Party_____ **DATE OF BIRTH**_____/_____/_____

Home Address_____ **Home Phone(**____**)**_____

Employer_____ **Work Phone(**____**)**_____ **Occupation**_____

Relationship to Patient_____ **Marital Status (circle one):** **Single** **Married** **Divorced** **Widowed**

INSURANCE INFORMATION – PRIMARY

Name of Insured:_____

Dental Insurance_____

Address_____

Group #_____ **Phone #**_____

Relationship to Patient_____

SSN_____ **Insured's DOB**_____/_____/_____

Occupation_____

Marital Status: Single Married Partner Other Divorced Widowed
(circle one)

INSURANCE INFORMATION – SECONDARY

Name of Insured:_____

Dental Insurance_____

Address_____

Group #_____ **Phone#**_____

Relationship to Patient_____

SSN_____ **Insured's DOB**_____/_____/_____

Occupation_____

Marital Status: Single Married Partner Other Divorced Widowed
(circle one)

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize any dentist, physician, hospital, pharmacy, insurance company, employer or insuring organization to release any information regarding my child's dental history, treatment or benefits payable for this claim for the purpose of validating and determining benefits payable in connection with this claim. This authorization or copy of the original shall be valid for the duration of the patient's relationship with this practice or until the information contained within changes.

AUTHORIZATION TO PAY BENEFITS TO THE DENTIST: I hereby certify to the above statements. I hereby authorize payment directly to the above named dentist of the group benefits otherwise payable to me.

_____ _____
Parent's Signature **Date**

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Your child's oral health is integral to his/her overall health. Simply put, that means your child cannot be healthy without good oral health and oral health means more than healthy teeth. New research is pointing to association between chronic oral infections in adults and heart and lung diseases, stroke, low birth-weight and premature births. Association between periodontal disease and diabetes has long been noted. Tooth decay is currently the single most common chronic childhood disease – five (5) times more common than asthma and seven (7) times more common than hay fever.

The mouth reflects general health and well-being. The American Academy of Pediatric Dentistry states one of their core values as "oral health is an inseparable part of the overall health and welfare of the infant, child and adolescent." Our practice supports these values and philosophies. It is important that we are aware of and understand your child's overall health history. Please provide the most complete and accurate information as possible when completing your child's health history information. This information is invaluable as we provide the best dental care and treatment to your child.

HEALTH HISTORY & PATIENT INFORMATION

Child's Name:_____ **Date:**_____

Reason for bringing your child to the dentist:_____

HEALTH HISTORY:	**YES**	**NO**	**Reviewer Comments**
1. Is your child being treated by a physician at this time?	☐	☐	
2. Has your child ever been a patient in a hospital?	☐	☐	
3. Has your child ever received general anesthesia?	☐	☐	
4. Has your child ever been seriously ill?	☐	☐	
5. Has your child ever had surgery?	☐	☐	
If yes, describe:_____			
6. Is your child allergic to anything? (medicine, food)	☐	☐	
If yes, what?_____			
7. Is your child taking any medicines at this time?	☐	☐	
If yes, what?_____			
8. Has your child ever been seen by a dentist before?	☐	☐	
9. Has your child ever received fluoride in any form?	☐	☐	
If yes, what form? _____			
10. Does your child suck his/her thumb, finger or pacifier?	☐	☐	
11. Does your child brush his/her teeth daily?	☐	☐	
How many times/day?_____			
12. Does your child snore?	☐	☐	
13. What type of toothpaste does your child use?_____			
14. At what age did your child stop bottle/breast feeding?_____			

Organs & Systems: Has your child ever had any treatment for any of the following? Please check yes or no:

YES	NO	YES	NO	YES	NO
☐	☐ Blood/Circulatory Transfusions	☐	☐ Gastrointestinal (stomach)	☐	☐ Muscles
☐	☐ Bones_____	☐	☐ Kidney/bladder	☐	☐ Nervous System
☐	☐ Endocrine Glands_____	☐	☐ Heart	☐	☐ Skin
☐	☐ Eyes,Ears,Nose,Throat (circle one)	☐	☐ Liver	☐	☐ Tonsils/Adenoids

Illness: has your child ever been diagnosed as having any of the following conditions? Please check yes or no:

YES	NO	YES	NO	YES	NO
☐	☐ AIDS,AIDS related complex, HIV	☐	☐ Epilepsy, convulsions, seizures	☐	☐ Orthopedic problems
☐	☐ ADD or ADHD	☐	☐ Eye or sight problems	☐	☐ Pneumonia
☐	☐ Allergy, seasonal	☐	☐ Excessive bleeding problems	☐	☐ Rheumatic heart disease or fever
☐	☐ Anemia	☐	☐ Gastroesophageal reflux	☐	☐ Respiratory disease
☐	☐ Arthritis_____	☐	☐ Gastrointestinal disease	☐	☐ Scoliosis
☐	☐ Asthma	☐	☐ Hearing or speech disorder	☐	☐ Sexually transmitted disease
☐	☐ Autism	☐	☐ Heart murmur	☐	☐ Sickle cell disease or trait
☐	☐ Brain injury	☐	☐ Hemophilia/other blood disorder	☐	☐ Spina Bifida
☐	☐ Cancer_____	☐	☐ Hepatitis, jaundice, liver disorder	☐	☐ Stroke
☐	☐ Cleft lip/palate	☐	☐ Kidney or bladder disease	☐	☐ Tuberculosis
☐	☐ Cystic fibrosis	☐	☐ Leukemia	☐	☐ Other
☐	☐ Diabetes	☐	☐ Mental or Developmental		
☐	☐ Emotional disturbance	☐	☐ Nutritional Deficiency		

Home Setting:

1. Parents' marital status: ☐ Single ☐ Married ☐ Partner ☐ Other ☐ Divorced ☐ Widowed

2. Family members in the home (check all that apply): ☐ Mother ☐ Father ☐ Brother(s) #___ ☐ Sister(s)#___
☐ Grandmother ☐ Grandfather ☐ Other relative(s)

3. Who is the primary caregiver for your child? ☐ Mother ☐ Father ☐ Other relative ☐ Caregiver outside the home

4. What is the level of your child's pain tolerance? (circle a number) 0 1 2 3 4 5 6 7 8 9 10
Least pain *most pain*

5. Have you or any of your child's caregivers had a negative dental experience? ☐ Yes ☐ No

6. Do you have any financial concerns regarding your child's dental appointment or potential treatment? ☐ Yes ☐ No

Is there anything else you think we should know about your child?_____
_____
_____

_____ _____ _____
Signature of person completing form Relationship to patient Date

DO NOT WRITE BELOW THIS LINE

Height_____ Weight_____ Heart rate_____ Respiratory rate_____ BP_____

Medical History Summary: (Summarize from parent interviews or medical record; include precautionary measures to dental care.)
_____
_____
_____
_____

SBE Recommendations:_____

Dental History Summary (Summarize briefly patient's past history and dental experience):_____
_____
_____
_____
_____

Reviewer:_____ Date: _____

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FINANCIAL POLICY

Your understanding of our financial policies is an essential element of your child's care and treatment. Please read our financial policy below and if you have any questions please discuss them with a Patient Services Coordinator at your child's appointment.

PAYMENT

- We accept the following forms of payment: cash, personal check, money order, Visa, MasterCard, Discover Cards and American Express. We also offer financing through Care Credit (please ask one of our Patient Services Coordinators for more information and an application).
- Please note: A $35.00 returned check fee will be assessed to your account if we are notified of Non-Sufficient Funds (NSF).
- The parent, guardian, or other adult who accompanies the child to his/her appointment is responsible for all payments due at time of service.

INSURANCE PATIENTS

- Insurance information will be checked and updated at every visit. As a courtesy to you, we will submit your charges to your insurance for payment. For us to do this accurately and timely, we will need to always have your correct information. Please have both primary and secondary insurance cards ready for review at each visit and inform the receptionist of any new information.
- Co-pays, coinsurance, and deductibles are due at the time services are rendered. As a courtesy we will estimate your insurance benefits based on the most recent information we can obtain from your insurance company but are not responsible for their accuracy. You are ultimately responsible to be familiar with your plan and benefits.
- If your dental plan does not assign benefits to our practice, you will be required to pay all charges in full at time of service.

SELF PAY PATIENTS

- If you are self pay, payment is expected in full at time of service.

DELINQUENT ACCOUNTS

- Past due accounts may be turned over to an outside collection agency. All fees, including but not limited to collection agency fees, legal fees, and interest charges which are incurred in our attempts to collect your account balance are your responsibility in addition to the balance for services rendered.

Your signature below indicates that you:

1. Have read and understand the Financial Policy of Lancaster Pediatric Dental Associates, PC.
2. Authorize and request payment under your dental insurance program to be made to Lancaster Pediatric Dental Associates, PC for covered services provided by Lancaster Pediatric Dental Associates, PC.
3. Accept responsibility for all fees incurred for services provided regardless of your insurance coverage.
4. Permit a copy of this authorization to be used in place of an original.

_____

Print Name- Parent or Responsible Party

_____ _____

Signature of Parent or Responsible Party **Date**

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APPOINTMENT POLICY

1. You must notify our office **24 hours** before your child's appointment if it is necessary to cancel. If your child is a new patient and a 24 hour notice is not given, your child will not be rescheduled.

2. Broken appointments and short notice cancellation of appointments will be subject to a $50 fee. Multiple broken appointments/short notice cancellations will lead to dismissal from our practice.

3. If you are more than 10 minutes late for your child's appointment we cannot guarantee all scheduled treatment will be completed and will complete what the remaining time allows. If you are more than 15 minutes late we may need to reschedule your child's appointment.

4. School excuses will be provided at your request for appointments scheduled during school hours.

5. As a courtesy, we will attempt to confirm your child's appointment 2 days in advance by phone, e-mail, or text.

NEW → 6. No food or drink permitted in treatment areas due to OSHA regulations.

NEW → 7. Your child may be accompanied by ***ONE*** person, over the age of 18 in the treatment areas. This includes both hygiene and operative treatment areas. For the safety of your family we request that you do not bring siblings and additional family members into the treatment areas who do not have a scheduled appointment.

Your signature below indicates understanding and acceptance of LPDA's appointment policy.

_____

Print Name - Parent or Responsible Party

_____ _____

Signature of Parent or Responsible Party **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.

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 Sept. 23, 2013, 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a 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 in formation 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 DISCLOSE 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, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. 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 programs, and licensing activities.

Individuals Involved in Your Care or Payment for 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 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. 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 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 for 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 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. 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 requested.

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 Examiners, 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 their 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 written authorization before using or disclosing your PHI for purposes other than those provided for in this 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 the 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 more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

Right to Request a Restriction. You have the 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) to 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.

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 means 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 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 Web site or by electronic mail (email).

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 also may 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 with the U.S. Department of Health and Human Services 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.

Our Privacy Official: **Dr. Peter J. Ross or his designee**

Telephone: **717-560-9002** Fax: **717-560-5102**

Address: **1875 Lititz Pike, Lancaster, PA 17601**

Email: **info@lpdakids.com**

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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.

Please Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement 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)**

(This Form is educational only, does not constitute legal advice, and covers only federal, not state, law in effect or proposed as of March 27, 2002. Subsequent law changes may require Form revision.)

Lancaster Pediatric Dental Associates PC

AUTHORIZATION TO RELEASE INFORMATION AND CONSENT TO DENTAL TREATMENT

Many of our patients have someone other than their parent, legal guardian, or legal custodian bring them to their appointments or call requesting account information. If you wish to have someone other than yourself bring your child(ren) to a dental appointment or call with questions about your account you must sign this form. Signing this form will only give the people listed authorization to approve dental care and to release medical/billing information to.

I, _____ (print name), verify I am the parent, legal guardian, or legal custodian of the child(ren) listed below.

_____	_____
Name of Child	Date of Birth
_____	_____
Name of Child	Date of Birth
_____	_____
Name of Child	Date of Birth
_____	_____
Name of Child	Date of Birth

I, _____ (print name), authorize the following individuals to bring my child(ren) to the LPDA for treatment, make treatment decisions for her/him and discuss treatment, medical and billing information in my absence :

_____	_____
Name of authorized individual	Relationship to child
_____	_____
Name of authorized individual	Relationship to child
_____	_____
Name of authorized individual	Relationship to child

I understand that information disclosed to any above recipient is no longer protected by federal or state law. I understand that I have the right to revoke this consent in writing.

_____	_____
Signature of parent/legal guardian	Date

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