Sharon L. Holley, D.M.D., PA **Dentistry For Kids**
10115 Hickorywood Hill Avenue • Huntersville, NC 28078 • Telephone: 704.948.8494 • FAX: 704.948.8482

Patient Registration

Child's Name_____ Nickname_____ Date_____
☐ Male ☐ Female Age_____ Birthdate_____ Home Phone_____
Home Address_____
Street *city* *zip code*
School_____ Grade_____ Hobbies/Pets_____
Names *and ages* of other children in family_____
Do both parents live together? Yes ☐ No ☐ (If not, with whom does the child live?)_____
Person responsible for payment of account_____ SS#_____ DOB_____
Respon. Party Address_____ Home #_____ Work #_____
Email: _____
Relationship to child_____ How did you hear about us? _____

Parent/Guardian Information

Mother/Guardian_____ Father/Guardian_____
Mother's Employer_____ Father's Employer_____
Home #_____ Work #_____ Home #_____ Work #_____
Mobile #_____ Pager_____ Mobile #_____ Pager_____
SS#_____ Birthdate_____ SS#_____ Birthdate_____
Dental Insurance: ☐Yes ☐No Dental Insurance: ☐Yes ☐No
Plan Name_____ Plan Name_____
Group #_____Policy #_____ Group #_____Policy #_____
Dental Insurance Address_____ Dental Insurance Address_____
_____ _____
Dental Insurance Phone #_____ Dental Insurance Phone #_____

In the event of an emergency, whom should we contact?
Name_____ Relationship to Patient_____ Phone #_____

What is the reason for your child's dental visit?_____

Release and Assignment

I certify that my minor child is covered by insurance with _____, and I assign directly to Dentistry For Kids all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my child's insurance. I hereby authorize Dr. Holley to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____
Signature of Parent or Legal Guardian Date

Child's Name_____ DOB_____ Physician's Name_____

Physician's Address_____ Date of last physical exam _____

Patient Medical History

☐Yes ☐No Is your child in good health?
☐Yes ☐No Has your child ever had a health problems or been hospitalized?
Date _____ Reason? _____
☐Yes ☐No Is your child taking any medicines now?
If yes, what? _____ Reason_____
☐Yes ☐No Is your child allergic to medicine or food? If yes, what _____
☐Yes ☐No Were there any problems at birth? If so, what? _____
☐Yes ☐No Has your child received emergency medical treatment?
When/Why? _____
☐Yes ☐No Has your child ever received general anesthesia (been put to sleep)?
Any complications? _____
☐Yes ☐No Was your child ☐Breast fed ☐ Bottle fed Until what age? _____
☐Yes ☐No Are your child's immunizations up to date?

Please indicate Yes or No if your child presently has or previously had any of the following:

Y N	Y N	Y N	Y N
☐☐AIDS/HIV	☐☐Down Syndrome	☐☐Kidney/Liver disease	☐☐Strep Throat
☐☐Anemia	☐☐Ear disorders/Hearing loss	☐☐Lung disease	☐☐Stomach problem
☐☐Asthma/Breathing Problems	☐☐Epilepsy/Seizures	☐☐Measles/Mumps	☐☐Tuberculosis
☐☐Autism/ASD	☐☐Eye disorders/Blindness	☐☐Muscle disorder	☐☐Other _____
☐☐Bleeding tendency	☐☐Fainting/Dizziness/Headaches	☐☐Nose/Throat disorder	
☐☐Blood disease/Transfusion	☐☐Hayfever/Seasonal Allergies	☐☐Nutritional disorder	
☐☐Bone disorder	☐☐Heart Condition/Heart Murmur	☐☐Prolonged Illness	
☐☐Cancer/ Tumors	☐☐Hepatitis	☐☐Rheumatic Fever	
☐☐Cerebral Palsy	☐☐Hormone Disorder	☐☐Sickle Cell Anemia/Trait	
☐☐Chicken Pox	☐☐Hyperactivity/ADD/ADHD	☐☐Skin disease	
☐☐Diabetes/Endocrine problems	☐☐Jaundice	☐☐Speech problem	

Patient Dental History

☐Yes ☐No Has you child ever been to the dentist? Name of dentist & date_____
☐Yes ☐No Has your child experienced any unfavorable reaction from previous dental care?
Explain _____
☐Yes ☐No Does your child's jaw make noise or have pain with chewing, yawning, or wide opening?
☐Yes ☐No Does your child have any untreated injuries or inflamed areas in or around his/her mouth?
☐Yes ☐No Do your child's gums bleed?
☐Yes ☐No Has your child ever received a local anesthetic? Any complications? _____
☐Yes ☐No Has your child ever has nitrous oxide ("laughing gas")? Any complications? _____
☐Yes ☐No Does your family drink well water or city water? Does the water contain fluoride? _____ Yes _____ No
☐Yes ☐No Does your child take any vitamins or fluorides (drops or tablets)?
☐Yes ☐No Does your child use a fluoride toothpaste? When are your child's teeth brushed? By whom? _____
☐Upon rising ☐Before bed ☐Right after eating meals or any food
☐Yes ☐No Does your child have or has he/she had any of the following:
☐Cavities/Toothache ☐Lips/Finger biting ☐Sippy Cup ☐ Thumb/Finger/Pacifier habit
☐Cheek/Tongue chewing ☐ Mouth breathing ☐Sleeping with bottle ☐Other _____
☐ Gum Infections ☐Trauma
☐Yes ☐No Does your child have a dental condition about which you are especially concerned? If yes, explain _____
☐Yes ☐No Is there anything else about your child that you would like for us to know in order to better his/her oral care maintenance? _____

Authorizations/Consent for Dental Treatment

I, being the parent/legal guardian of _____ acknowledge that the information given is complete and correct to the best of my knowledge. I request and authorize Dr. Holley to examine, clean, and provide dental treatment for my child, including any necessary radiographs, diagnostic or procedures to accomplish these services. I understand that dental treatment for children includes efforts to guide their behavior by helping them understand the treatment in terms appropriate for their age. Dr. Holley will provide an environment likely to help my child learn to cooperate during treatment by using praise, explanation, and demonstration of procedures and instruments, and by using variable voice tone. I understand that I will be informed of all services before any treatment is rendered to my child. I understand that regardless of insurance status, I am fully responsible for my child's account for any professional services rendered.

_____ _____ _____

Signature of Parent or Legal Guardian Date Reviewer

FINANCIAL POLICY

Thank you for choosing our office for your child's dental treatment. We are committed to their successful treatment! Please understand that *payment of your bill is considered part of your child's treatment*. The following is a statement of our financial policy, which we ask that you read, understand, and sign prior to any treatment.

We are committed to providing your child with the best possible dental care, and we are happy to discuss our professional fees with you at any time during our normal office hours. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, our financial policy, or your responsibility.

- Please be aware that the parent bringing the child to Dr. Holley's office is *legally responsible for payment of all charges.* **We cannot send statements to other persons**.

- **Payment in full is requested for each appointment as services are rendered for patients with no dental insurance. Patients with insurance will be requested to pay their patient portion at the time services are rendered.** For the convenience of our patients, we accept cash, personal checks (which CANNOT be postdated), MasterCard, Visa, American Express, or Discover.

- **Dental Insurance –** 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. **Therefore, *we will accept assignment of benefits as a courtesy to you. However, you are responsible for the payment of your account.*** Reimbursement for claims filed by Dentistry for Kids should be made to Dr. Holley. Any payments not received from your insurance company within 45 days of filing will be billed to you. If there is an overpayment on your account by the insurance company, you may call our office upon receiving your explanation of benefits and we will reimburse you within 45 days of your call.

- **Emergency/Consultation Treatment –** All emergency and consultation treatment must be paid in full at the time the service is rendered.

We recognize that under unusual circumstances an account balance may be incurred. Dr. Holley's office requires that all outstanding balance *be paid in full within forty-five (45) days* unless other arrangements have been made. We reserve the right to apply an interest rate of 1.5% monthly from the date of service. Thank you in advance for your understanding of our financial policy.

_____ _____

Parent/Legal Guardian Date

_____ _____

Witness Date

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APPOINTMENT GUIDELINES

The scheduled appointment is reserved specifically for your child. Any change in this appointment affects many patients. If a cancellation is unavoidable, please call our office **at least 24 hours** in advance so that we may give that time to another patient. **Please initial each line.**

—— *Please plan to arrive 10 minutes or more before your scheduled appointment.* This will allow time to complete any additional paperwork and see your child on time.

—— *If you arrive **10 minutes** late for your appointment, you may be asked to reschedule for the next available appointment time.*

—— *Many restorative (fillings, extractions, etc.) procedures are scheduled in the morning,* specifically for those children ages 0-5 years old. Children, as well as adults, are more prepared and do better in the morning for these types of procedures.

—— *We strive to see all patients on time* for their scheduled appointment. There are times when our schedule is delayed in order to accommodate an injured child or one with an emergency. Please accept our apology in advance should this occur during your appointment. We will do the exact same if your child is in need of emergency treatment.

—— *Please call at least 24 hours in advance if a cancellation is unavoidable* so that we may service another patient.

—— *Broken or missed appointments affect many people.* If two (2) broken/missed appointments or two (2) cancellations occur without 24-hour notice, our office reserves the right to NOT schedule any subsequent appointments.

—— *If your child must be accompanied by someone other than the parents*, we require the name of the individual bringing your child on the Authorization For Release form. Please provide us with proper notification so we may FAX/e-mail an authorization for your signature.

If at any time you have questions, please feel free to ask our team or call our office. We are here to help you in any way we can. We appreciate you entrusting your child's dental health to us.

I certify that I have read and understand the above appointment guidelines

Signature of Parent/Legal Guardian_____

Relationship to child_____ Date_____

Dentistry For Kids
Authorization For Release of Information – Compound Release

Name of Patient (s) _____ Date (s) of Birth _____

Dentistry For Kids is authorized to release protected health information about the above named patient in the following manner and to the identified persons.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Appointment Reminders ☐ Other_____
☐ Other person (s) (provide name and phone number)(i.e. Nanny, Step-Parent, Grandparent, Aunt, Uncle etc) _____ _____	☐ Financial ☐ Treatment/Treatment Plans
☐ Email communication-Provide email address* _____ *For email communication to occur, please accept the disclosure below:	☐ Financial ☐ Treatment/Treatment Plans ☐ Appointment reminders ☐ Breach notification
☐ Text communication – Provide number * _____ *For text communication to occur, accept the disclosure below:	☐ Appointment reminder ☐ Other: _____
☐ For **email and/or text communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.	
☐ Photo of patient received by patient or legal guardian ☐ Photo taken by team member (Example: pre/post procedure) ☐ Other	☐ May be posted in office ☐ May be posted on website ☐ May be posted on social media

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my child's treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

_____Date _____

Signature of Parent or Legal Guardian

*Description of Personal Representative's Authority (attach necessary documentation)

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CHILDREN, PEDIATRIC DENTISTRY AND YOU

Parents are welcome to accompany their child into the treatment area during the initial examination. This gives you the opportunity to see our staff in action and allows Dr. Holley to discuss dental findings and treatment needs directly with you. We do ask that if you accompany your child you assume the role of a silent observer. **Your presence is greatly enhanced if you play a passive role.** If more than one person is speaking to the child they may become confused. Cooperation and trust must be established directly between Dr. Holley and your child, not through you. We also ask that siblings remain in the reception room or play area. There may be times when a child's experience is enhanced by a parent's absence. **We encourage children to come back to the treatment area by themselves as this builds autonomy and trust. Children typically do better without a parent present during an operative (filling) appointment**. Also, children who are very apprehensive may look for an "escape" by going to their parents. **Therefore parents are asked to remain in the reception area during operative appointments in order to facilitate a more direct line of communication between your child and Dr. Holley**. The following is a brief explanation of some of the methods we use to guide your child's behavior and provide a positive dental experience. Since each child is unique, no list can be complete and other methods may be explained as needed.

TELL, SHOW, DO

This is the most important tool for teaching your child. The child is told in simple terms what is going to be done. Then they are shown what is going to be done and then the procedure is performed.

IMAGERY

We tell children in simple terms what is going to be done. For example, a dental exam becomes "looking and counting your teeth". A dental prophylaxis and cleaning becomes "brush and tickle your teeth". We encourage you to use these terms when talking to your child about their dental experiences.

DISTRACTION

Sometimes it is necessary to distract your child from an unpleasant sensation by focusing his/her thoughts on something other than what is being done.

POSITIVE REINFORCEMENT

This is a technique used to reinforce good behavior by praising your child or providing a reward following a desired response in hopes of promoting continued good behavior.

VOICE CONTROL

Voice control is a controlled change of voice volume, tone or pace to influence and direct the child's behavior. This technique is used to establish a line of communication between the doctor and child.

RESTORATIVE RELATED PROCEDURES

Almost all procedures to repair teeth involve the use of the **dental handpiece,** which many people think of as the "drill". We refer to it as "Mr. Whistle" and the slow speed handpiece as "Mr. Bumpy". The sensations these instruments produce will be introduced to your child in a non-threatening manner. A **rubber dam** or "rain coat" is used to isolate the teeth being repaired. This helps keep saliva away from the tooth, protects the soft tissues of the mouth and keeps unfamiliar tastes out of your child's mouth. A **mouth prop** or "tooth pillow" is used occasionally so the child's jaw muscles don't become overtired during the procedure to prevent the child from biting the handpiece.

LOCAL ANESTHESIA

Most restorative procedures require the use of local anesthetic. We grew up calling it "novocaine". Please avoid using words such as "shot, needle or injection". We never use these words around children. A topical anesthetic is used to help numb the soft tissue at the injection site. The child is told we are going to "wiggle and pinch and put their tooth to sleep". The dental assistant places their arm lightly across the child's chest or holds their hands during the injection to protect the child from reaching up and grabbing the syringe and hurting themselves.

Photography Release

I, _____,

hereby authorize Dr. Holley or her assistants to take photographs, slides, and/or videos of my child's face, jaws, mouth, and teeth.

I understand that the photographs, slides, and/or videos will be used as a record of care, and may be used for educational purposes in study club meetings, lectures, seminars, demonstrations, and professional publications (journals, magazines, web).

I further understand that if the photographs, slides, and/or videos are used in any publication or as a part of a demonstration, my child's name or other identifying information will be kept confidential.

I do not expect compensation, financial or otherwise, for the use of these photographs.

Patient name: _____

Signature: _____

Date: _____

Dentistry for Kids

Sharon L. Holley, DMD, PA

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 receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

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 April 14, 2003 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 the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change 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 end 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.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

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, counter intelligence 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 (such as voicemail messages, postcards, or letters).

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 using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.50 for each page, $ 15.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)*

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 6 years, but not before April 14, 2003. 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 these additional requests.

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).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request 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.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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 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.

Contact Officer: SHARON L. HOLLEY, DMD, PA

Telephone: 704-948-8494 Fax: 704-948-8482

E-mail: info@dentistryforkidsnc.com

Address: 10115 HICKORYWOOD HILL AVENUE HUNTERSVILLE, NORTH CAROLINA 28078