Kisha Steele Mitchell, DDS

Dentistry for Kids

10115 Hickorywood Hill Avenue • Huntersville, NC 28078 • Telephone: 704.948.8494 • FAX: 704.948.8482

Patient Information

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_____________________________

Mother's Employer___________________________

Home #______________ Work #_______________

Mobile #__________________ Pager____________

SS#_______________ Birthdate________________

Dental Insurance: ☐ Yes ☐ No

Plan Name___________________________________

Group #______________Policy #_______________

Dental Insurance Address_____________________

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Dental Insurance Phone #_____________________

Father/Guardian_____________________________

Father's Employer___________________________

Home #____________ Work #_______________

Mobile #_________________ Pager___________

SS#________________ Birthdate____________

Dental Insurance: ☐ Yes ☐ No

Plan Name__________________________________

Group #_______________Policy #___________

Dental Insurance Address___________________

____

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 Dr. Holley 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 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 Person Financially Responsible 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 you 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 maintainence? ____

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 on my child's teeth, including any necessary radiographs/diagnostic 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 children learn to cooperate during treatment by using praise, explanation, and demonstration of procedures and instruments, and 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 account for any professional services rendered.

____ ________________________ ______________________________

Signature of Legal Consent 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

Dentistry for Kids

Kisha Mitchell, DDS

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)

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Authorization for Release of Information to Family and/or Friends

Name of Patient(s):______________________________ Date(s) of Birth: ________________

Dr. Sharon L. Holley is authorized to release protected health information about the above named patients(s) to the listed names below.

Please circle who we are able to give information to: spouse, step-mother/father, grandparents, biological father/mother, nanny, other (indicate "other") ________________________

Please print name of the person you have authorized for us to release information to, as indicated above

__________________________, ____________________________, ________________________

Initial each that to this authorization

________ Leave information on the voice mail
________ If they call, we are able to discuss over the phone
________ Electronic mail

Description of information to be released

________ Financial information
________ Family billing information
________ Information results from test and x-rays
________ Medical information as follows: ____

Rights of the Patient

I understand that I have the rights to revoke this authorization at any time and that I have the right to inspect or copy the protect health information to be disclosed as described in this document by sending a written notification to Dr. Sharon L. Holley. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that 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 state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing this authorization.

This authorization shall be in force and in effect until revoked by the patient or representative signing the authorization.

____ ________________________
Signature of Parent, Legal Guardian, or Personal Representative Date

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

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 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: Kisha Mitchell, DDS

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

E-mail: info@dentistryforkidsnc.com

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