MASON PARK FAMILY DENTAL

Please fill out form completely as it is of great value in treating your child. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.

DATE: _____

PATIENT INFORMATION

Name of Minor/Child _____
Last Name First Name Initial

Sex ☐ M ☐ F Age _____ Birthdate _____ Nickname _____

Home Address _____
Street City State Zip

Mailing Address _____
Street City State Zip

Person Financially Responsible _____ Home Phone _____ Work Phone _____

Whom may we thank for referring you? _____

MOTHER/GUARDIAN INFORMATION

Name _____
Last Name First Name Initial

Relationship to Patient _____

Address (if different) _____
Street City State Zip

Home # _____ Work # _____ Cell# _____ Other # _____

Soc Sec # _____ Birthday _____

Do you have insurance coverage for the child? *Y or N*

Employer _____ Occupation _____ # Yrs There____ Work # _____

Plan Name _____ Plan Number _____

Address _____
Street City State Zip

Group # _____ Policy # _____

FATHER/ GUARDIAN INFORMATION

Name _____
Last Name First Name Initial

Relationship to Patient _____

Address (if different) _____
Street City State Zip

Home # _____ Work # _____ Cell# _____ Other # _____

Soc. Sec. # _____ Birthday _____

Do you have insurance coverage for the child? Y or N

Employer _____ Occupation _____ # Yrs There____ Work # _____

Plan Name _____ Plan Number _____

Address _____
Street City State Zip

Group # _____ Policy # _____

Email address: _____

MEDICAL HISTORY

Minor/Child's Physician _____ City/State _____ Phone _____

Date of last physical exam _____ Results _____

Is child under care of physician now? Y or N Medications _____

Receiving any medications or drugs? Y or N _____

Ever been hospitalized? Y or N _____

Ever had surgery? Y or N Allergy _____

Is there excessive bleeding when cut? Y or N _____

HAS MINOR/CHILD HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING?

☐ AIDS/HIV	☐ Cerebral Palsy	☐ Epilepsy	☐ Kidney Disease	☐ Surgery
☐ Anemia	☐ Chicken Pox	☐ Fainting	☐ Liver Disease	
☐ Asthma	☐ Convulsions	☐ Hearing Problems	☐ Measles	
☐ Bladder Problems	☐ Diabetes	☐ Heart Problems	☐ Mononucleosis	
☐ Cancer	☐ Drug/Alcohol	☐ Hepatitis	☐ Mumps	
☐ Rheumatic Fever	☐ Sinus Problems	☐ Thyroid Disease	☐ Other	

Explain any above _____

Special needs or problems _____

Parent/Guardian Signature _____

DENTAL HISTORY

Reason for today's dental visit _____

Has your child previously been to a dentist? _____ Date of last visit _____

Date of last: Cleaning _____ Xrays _____

Has your child previously been to an orthodontist? Y or N Orthodontist's Name _____

Does your child currently use a: Pacifier? Y or N Bottle? Y or N Suck Finger/Thumb Y or N

Does child brush teeth daily? Y or N Floss daily? Y or N

Does child eat between meals? Y or N Eat many sweets? Y or N

Does child eat balanced meals? Y or N Have food allergies? Y or N

Does child use any fluorides? Y or N Have a special diet? Y or N

Is there now or has there ever been any of the following: (Circle all that apply)

Dental or oral pain	Toothache	Oral Habits	Cavities
Teeth straightened	Gum infection	Injured teeth	Extracted teeth
Unfavorable dental experience			

Because your child is a minor it is necessary that signed permission is obtained from a parent or a guardian. The signature below authorizes examination, and treatment if necessary, from the office of Glen R. Ginter, DDS, Inc. and further the use of procedures that the doctor deems necessary during the performance of any dental service.

Furthermore, the undersigned accepts responsibility for any financial obligations incurred for dental treatment of this patient. It is understood that fees for dental services shall be paid at the time services are rendered unless other arrangements have been made in advance.

Signature _____ *Printed Name* _____ Date _____

Notice of Privacy Practices
(HIPAAA)
Mason Park Family Dental
Glen R Ginter, DDS, INC.

This policy outlines they way Patient Health Information (PHI) will be used in this office and the patients rights concerning those records. You must read and consent to this policy before receiving services. A complete copy of the Health Information Portability and Accountability Act (HIPAA) is available here at: http://www.cms.gov/HIPAA

1. The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment.
2. The patient has the right to examine and obtain a copy of their health records at any time and request corrections. The patient may request to know what disclosures have been made, and submit in writing any further restrictions on the use of their PHI. This office is not obligated to agree to those restrictions.
3. The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services.
4. This office is committed to protecting your PHI and meeting its HIPPA obligations: Staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures.
5. Patients have the right to file a formal complaint with our privacy official about any suspected violations.
6. This office has the right to refuse treatment if the patient does not accept the terms of this policy.

Consent to Professional Treatment

The patient certifies that all information provided to this office is true and correct to the best of their knowledge. The patient grants their consent to this office and its staff to render treatment as deemed necessary by the attending doctor. If the patient is a minor/child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein. The parent/patient may refuse treatment at any time. Each six month dental visit consist of: exam, cleaning, fluoride and x-rays. If the parent/patient does not wish to have any of these procedures preformed it is your responsibility to notify staff. The patient consents to the performance of x-rays as deemed necessary by the attending doctor of this office. The patient, hereby states that they have no known limitations that would forbid the taking of x-rays. The patient further agrees that this office may seek outside interpretation of patient x-rays and biopsies by a qualified professional not employed by this office. The patient agrees to any additional fees associated with this service and assigns benefits to be paid directly to that professional by your third-party payor.

Assignment of Benefits and Release of Records

The patient hereby assigns benefits to be paid directly to this provider by all of their third party payors. This assignment is irrevocable. Failure to fulfill this obligation will be considered a breach of contract between the patient and this office. The patient authorizes this office to release any information required by a third party payor necessary for reimbursement of charges incurred.

Financial Obligation, Appointment Policy and Electronic Signature

The patient accepts full financial responsibility for services rendered by this practice. The parent/patient is responsible for providing the correct dental insurance prior to each dental visit; if not provided it will be the responsibility of the parent/patient to pay Mason Park Family Dental for dental services provided for that visit in full. This office reserves the right to change fair market value for missed appointments or appointments canceled without the advanced notification required by this office. The patient hereby acknowledges and attests that this is the patients official "electronic signature," equal in every way and use as the patients hand-written signature, and is fully enforceable under the law. Electronic signatures are required in order for us to file insurance claims.

Parent or Responsible party

Office Policies and Information

Patients: Established patients will be required to fill out forms every year or as requested.

Return checks: There is a $50.00 charge for all returned or canceled checks.

Late or Missed If you are unable to keep your appointment, please reschedule at least two days prior to your visit. A minimum of **24 hours** notice is required.

Appointments: We may allow someone else to take your place, if you arrive too late to be accommodated you may be rescheduled or worked in depending upon our schedule. **If you do not show or are too late to be seen for your appointment, we will bill you an appointment fee.**

Financial: You acknowledge full responsibility for the payment of such services and agree to pay at the time of service. You also, understand that insurance coverage is an arrangement between the insurance carriers and the patient. We may bill your insurance company as a courtesy, but you are ultimately responsible for payment should your insurance fail to pay within 90 days. It will be your responsibility to inform us of any changes in your insurance, telephone numbers, and address. Insurance company gives us 90 days to file a claim. Please have your **dental** insurance card or an online insurance print out available at all office visits. If you fail to provide us with a copy of your insurance card prior to services then **you will be accepted as a private pay patient at the time services are provided.** You also understand that you are responsible for payment for all services or items you receive. Our charges are an estimate of each insurance company's fee schedule. You may be asked to pay this estimated amount. After your insurance processes the claim and if you have a balance payment is due net 30. Therefore, if we bill the wrong insurance carrier because you failed to provide correct information the visit will be your responsibility. **Accounts turned over to a collections agency will be assessed a $25.00 fee.** You may also be given notice legally dismissing you from our practice and be asked to find another dentist. We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate such problems to us so that your account can be properly managed. There will be a **$25.00 charge for medical records released** to legal or other professional organizations.

We will not file a secondary insurance for payment.

Co-pays for office visits are usually higher for specialists versus primary-care dentist. So you can check with your insurance carrier to determine if you have a higher co pay for specialists. Again, check with your insurance carrier to determine how your benefits apply. Authorization for POS and DHMO insurance plans require that you obtain an authorization for treatment. Without a referral form DHMO's you have the option to receive services at a fee for service basis. Cigna DHMO will not cover services after patient is seven years old.

To ensure your appointment a **deposit** is required for certain procedures. You will forfeit this amount, if you no show for your scheduled appointment or give less than 24hrs notice.

Management: We feel it is important for parents to understand our philosophy of management of children in order to accomplish dental treatment. Our experience has shown that we receive a much better response from the majority of children if parents are not present during treatment. If parents are present we find that our control is greatly reduced as the parent is the predominate authority figure to the child. If a child tends to "cry and fuss" it is usually greatly heightened in the present of the parent.

Policy: We reserve the right to immediately cancel your care for conduct, non-cooperation or non-payment.

My signature below indicates that I have read and am in agreement with all statements.

*Parent or Responsible Party*_____

I am the parent/guardian of

_____

_____child/children.
I have the legal right to consent to treatment for this patient/patients. I hereby voluntarily authorize (when I am unavailable to give consent) the following individual(s),

_____

_____
to consent to any and all medical/dental care and attention. This delegation shall be modified or withdraw at anytime. Just notify office staff.

*Signature of Parent/Guardian*_____

HIPAA PATIENT CONSENT

Our Notice of Privacy Practice Notice is located at the front desk, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt. Copies are available upon request.
Signature of Parent/Guardian_____

THE IMPORTANCE OF REGULAR DENTAL CARE

Our primary goal for the children we treat is to help them maintain a state of optimum oral health, and reach maturity with sound permanent teeth. Experience has shown us that in order to attain this goal, it is important that we see children on a regular basis. There are several reasons for this:

To attain and maintain an acceptable level of oral hygiene, children often need reinforcement and encouragement from someone other than parent. We may be more effective in providing motivation

In general, children have more rapid rate of decay than do adults. In a relatively short period of time a small cavity can become large and endanger the life of the tooth.

A child's mouth is constantly changing, as the child grows and matures. It is important that these changes be observed to ensure that they occur as they should. For example, primary teeth frequently are not lost as they should be. This may prevent the permanent teeth from erupting in the correct position. If left untreated, correction can become difficult and costly. Orthodontic and related needs should be evaluated early. Many developing problems can be much more easily corrected at young ages.

We recommend that children be seen for a dental screening exam at their first birthday. This is a good time to educate parents in proper home habits for a healthy mouth. We recommend starting a child on a program of regular professional care at about three years of age and seeing them at six month intervals after the initial visit or after any necessary treatment is complete. Occasionally we will recommend that a child be seen on a more frequent basis for a particular need. If you prefer not to have your child seen as often as every six months, we can arrange to see them at either nine months or one year intervals. A usual visit will consist of a thorough examination of the teeth and related structures, necessary X-rays, a cleaning by the hygienist or doctor and a topical fluoride treatment. The child and parent may also be instructed as to what to do at home to improve oral health.