Child Registration Form

Patient's Name _____ _____ ____ _____
Last First Initial Nickname

Sex: ☐ Male ☐ Female Date of Birth ___/___/_____ Age:___ Home Phone**: (___)____-_____**

Address_____City _____ State_____ Zip_____

Mother/Guardian's Name _____ Date of Birth ___/___/____

Social Security # _____-____-_____ E-mail address: _____
Home Address ☐ Same as child_____ City _____ State_____ Zip_____
Home Phone: (___)____-_____Work Phone: (___)____-_____Cell Phone: (___)____-_____
Employed By: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Father/Guardian's Name _____ _____ Date of Birth ___/___/___

Social Security # _____-____-_____ E-mail address: _____
Home Address_____ City _____ State_____ Zip_____
Home Phone: (___)____-_____Work Phone: (___)____-_____Cell Phone: (___)____-_____
Employed By: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Who is Responsible for this Account? _____

How would you prefer we contact you to confirm your appointments: ☐ Phone call ☐ Email ☐ Either

How did you hear about out office? ☐Yellow book ☐ Dex ☐ Hansen ☐ Location ☐ Website,
☐ Previous pt of Dr. Grimm ☐ Friend/Family_____ ☐ Other_____

Does the patient have dental insurance coverage? ☐Yes ☐ No Insurance Co._____
Who is the policy holder? ☐ Myself ☐ My spouse Insurance ID#_____
If insurance, how will you be paying your co-payment and non-covered benefits today?_____

Other Family Members in this Practice _____

Someone to notify in case of emergency not living with you:
_____ (__)_____
Name Phone number

RELEASE:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care including the possible use of diagnostic x-rays, local anesthetic and fluoride.
I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist or healthcare professional.
I hereby authorize payment of insurance benefits directly to the dentist or dental group otherwise payable to me.
I understand my (or my child's) dental care insurance carrier or payor of my (or my child's) dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my (or my child's) dental care payor.
I attest to the accuracy of the information on this page.

PATIENT SIGNATURE X_____ DATE ____/_____/____

over→

HIPPA Release Form

PRIVACY OF PROTECTION HEALTH INFORMATION
Federal and state law require us to maintain the privacy of your health information and to give you this notice about our privacy practices, our legal duties, and your rights concerning Protected Health Information (PHI). This notice took effect April 14, 2003. We reserve the right to change our privacy practices and the terms of this Notice at any time, law permitting. You may request a copy of our notice at any time.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION
We may use and disclose your protected health information in the following circumstances:
*To a dentist, physician or other healthcare provider in our health care team providing treatment to you.
*To obtain payment services we provide to you.
*In connection with our healthcare operations, including quality assessment and improvement activities, evaluating practitioner and provider competence, conducting training and educational programs, accreditation, certification, licensing or credentialing activities.
*When you give us written authorization to use your health information or to disclose it to anyone for any purpose other than treatment, payment and healthcare operations. You may revoke this authorization in writing at any time.
*Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect.
*We will disclose information to you, the patient. With your permission, we may disclose your health information to a family member, friend, or other person, to obtain help with your healthcare and payment for your care.
*To notify, or assist in notifying a family member, your personal representative or another person responsible for your care, of pertinent issues, such as your location, your general condition, illness, or death. If you are present, we will provide you an opportunity to object to such uses or disclosures.
*We will use or disclose your health information to provide you with appointment reminders such as voicemail messages, postcards or letters.
*Riverside Family Dental may use or disclose PHI for reasons other than those listed. Examples of such uses include: consultation with other professionals, patient recruitment, public health activities, health oversight activities and worker's compensation.

WE ARE REQUIRED BY LAW TO DISCLOSE YOUR PROTECTED HEALTH INFORMATION IN THE FOLLOWING CIRCUMSTANCES:
Abuse or Neglect
We are required by law to disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or other crimes, or to avert a threat to the health or safety of yourself or others.
Government Agencies
Under certain circumstances, we are required by law to disclose to military authorities the health information of Armed Forces personnel. We may disclose to authorized officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose protected health information to correctional institutions or law enforcement officials having custody of patients under certain circumstances.

WE WILL NOT DISCLOSE YOUR PROTECTED HEALTH INFORMATION IN THE FOLLOWING CIRCUMSTANCES:
Research
We will not use or disclose information about you for research purposes without your prior permission.
Marketing Health Related Services
We will not use your health information for marketing communications without your written authorization.

PATIENT RIGHTS REGARDING PROTECTED HEALTH INFORMATION
You have the right to:
*Expect that PHI will be treated confidentially within the dental care team.
*Receive copies of your PHI. To obtain access to your health information, you may use an authorization form or send a letter to the contact information at the end of this Notice. We will charge a reasonable, cost-based fee for expenses to make photocopies, radiograph copies, facsimiles or other formats of PHI.
*Receive a list describing how we or our business associates disclose your PHI for purposes, other than treatment, payment, and healthcare operations, since 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 the additional requests.
*Request that we place additional restrictions on our use or disclosure of PHI. Although we are not required to agree to these additional restrictions, if we do, we will abide by our agreement (except in an emergency).
*Request in writing that we amend your PHI. We may deny your request under certain circumstances.
*Request that we send PHI to you at an alternate address, if we can provide it in the format you requested. To make a request, you may contact our office at 319-648-3900.

QUESTIONS AND COMPLAINTS
You may contact us using the information at the end of this Notice if:
*You would like more information about our privacy practices.
*You wish to comment on a request you made to amend or restrict the use or disclosure of your health information.
*You disagree with a decision we have made about access to your health information.
*You feel that we may have violated your privacy rights.

You may also 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 the U.S. Department of Health and Human Service.

CONTACT INFORMATION Riverside Family Dental
380 East Hickory St.
Riverside, IA 52317
Telephone: 319-648-3900

Signature (Parent/Legal Guardian)_____ Date_____

Child Health History

Patient's Name _____ _____ _____ _____ _____
Last First Initial Nickname Age

Height: _____ Weight: _____

Date of last health care exam: _____ What was this exam for? _____

Physician's name and phone number: _____

Is your child is currently taking any medications? If so, please list name and dosage:

1. _____ 2._____ 3._____

Is your child allergic to or had any reactions to:

Local Anesthetics ..... No Yes
Penicillin or other antibiotics ..... No Yes
Aspirin ..... No Yes
Codeine ..... No Yes

Latex…… No Yes
Metals…….. No Yes
Dyes……. No Yes
Other_____

Has your child ever been hospitalized or had surgery? Yes / No If yes, please explain: _____

Does your child have behavioral/learning problems? Yes / No If yes, please explain: _____

Has your child had a history of: (Please check the appropriate response)

Diabetes	No	Yes	Heart Problems	No	Yes
Congenital Birth Defects	No	Yes	Asthma	No	Yes
Rheumatic Fever	No	Yes	Epilepsy or Seizures	No	Yes
Cerebral Palsy	No	Yes	Liver Problems	No	Yes
Cancer	No	Yes	Hepatitis	No	Yes
AIDS/HIV+	No	Yes	Infections	No	Yes
Thyroid Disease	No	Yes	Tuberculosis	No	Yes
Speech Impairments	No	Yes	Hearing Loss	No	Yes
Mental Retardation	No	Yes	Prolonged or Severe Bleeding	No	Yes
Eyesight Problems	No	Yes	Kidney Problems	No	Yes
Heart Murmur (Mitral Valve Prolapse)	No	Yes	Blood Disease	No	Yes

Is there anything else about your child's medical history or health you think the doctor should know about?

_____

I understand the above information is necessary to provide my child with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of changes in my child's health and medication.

_____ _____ _____
Parent or Guardian (Print Name) *Parent or Guardian Signature* *Date*

_____ _____ _____
Doctor (Print Name) *Doctor Signature* *Date*

Updated: Initials/Date

_____ / _____ _____ / _____ _____ / _____ _____ / _____ _____/_____

_____ / _____ _____ / _____ _____ / _____ _____ / _____ _____/_____

_____ / _____ _____ / _____ _____ / _____ _____ / _____ _____/_____

_____ / _____ _____ / _____ _____ / _____ _____ / _____ _____/_____

_____ / _____ _____ / _____ _____ / _____ _____ / _____ _____/_____

Financial Policy

Dental Insurance:

Please check with your insurance company to verify Dr. Grimm can provide dental care under your insurance plan. We will submit to any insurance company, but if Riverside Family Dental Practice is not currently a provider for your plan, you will be responsible for all outstanding charges after insurance payment.

You are responsible for being aware of what benefits are available with your insurance plan. We will assist you as much as possible, but if you have questions about your coverage you should consult your insurance manual or contact your insurance directly.

Riverside Family Dental Practice requires payment of your estimated co-payment the day you receive treatment. Your estimates are based on information your insurance company gives us which is often inadequate and may result in under or overpayment. You will be sent a statement if there is a balance due or a credit refund if there was overpayment.

We will send in any documentation or explanation of treatment to help process your claims. If, after 90 days, the claim is not paid or additional action on your part is necessary, you will be responsible for the balance in full.

Payments:

If you do not have dental insurance the total charges will be due the day of treatment.

We accept cash, personal checks, Master Card and Visa. If your payment is made with cash or check a 5% courtesy reduction will be given.

Financing options from outside companies, Care Credit and Citi Health Card are available to those who qualify. These plans allow monthly payments for your dentistry and may be interest free. Terms and conditions vary. Please visit carecredit.com or inquire at the practice for more information.

Cancellation Policy

Cancellations on short notice due to emergencies and last minute developments can and do happen to all of us. However, the lack of reasonable, advanced notice (less than 24 hours) results in lost opportunities to serve others. This unproductive time is frustrating, not only to us, but to those patients whose treatment requires more immediate attention than our busy schedule allows. Therefore, if a patient fails or cancels two (2) scheduled appointments with less than 24 hours advanced notice, a broken appointment fee of $50 will be assessed. This fee must be settled prior to scheduling any future appointments. If a patients fails or re-schedules three (3) appointments without adequate notice the doctor patient relationship may be terminated.

We greatly appreciate your efforts to honor your scheduled appointments and wish to continue to provide all our patients with the highest quality of care in a timely manner.

Signature (patient/parent/legal guardian)_____ Date_____

Parental Guidelines

You may choose whether or not you accompany your child into the treatment room for his/her appointment. Although we sense that some children do better without parents present. If you choose to be present, we ask that you follow these guidelines to improve chances of a positive outcome:

1. Allow us to prepare your child
2. Be supportive of our practice terminology. We try to avoid words that scare the child. Please support us by NOT USING negative words that are often used for dental care.

Don't Use	Instead Use
Needle/shot	Sleepy water
Drill	Mr. Whistle, Mr. Bumpy
Pull/Yank tooth	Wiggle out
Decay/Cavity	Sugar bug
Explorer/Exam	Tooth counter/count teeth
Gas	Silly air

   Our intention is not to "fool" the child, it is to create an experience that is positive.

3. Please be a silent observer
   a. This allows us to maintain communication with your child
   b. Children will normally listen to their parents instead of us and may not hear our guidance.
   c. You may give incorrect or misleading information

4. If asked to leave, be ready to immediately walk away
   a. Many children will try to control the situation
   b. This is intended to "short circuit" the control attempt.
   c. "Acting out" is normal, but unacceptable during treatment
   d. We will continue to support your child at all times. You may check on them silently from the hallway where they cannot see you.

5. Siblings are not allowed in the treatment room due to safety purposes. Siblings will need to wait in the waiting room while the child patient is receiving treatment. Please keep this in mind when scheduling appointments if you are uncomfortable with a sibling waiting unattended in the waiting room.

These are very important ways that you can actively help in the success of yours child's visit. We are confident that all will go well and hope that these guideline will help prepare you for the upcoming appointment.

Signature_____ Date_____