Patient Registration

General Information

First name – Patient _____

Middle name _____

Last name - Patient _____

Nickname/Preferred Name _____

Prefix/Honorific _____

Degree/Suffix _____

Gender _____

Patient date of birth _____

Preferred language _____

Email address _____

Marital status _____

Contact Information

Home # _____

Work # _____

Mobile #_____

Patient mailing address:

_____

_____

_____

Patient billing address:

_____

_____

_____

Has the main contact for the family changed since your last visit? _____

Has the main person responsible for payments for the family changed since your last visit? _____

Other Information

Occupation: _____

Employer: _____ Employer phone #:_____
Social Security number:_____ Driver's license number:_____
Previous provider:_____ Previous provider phone:_____

Non-verbal communication needed with patient: _____

Has your insurance information changed since your last visit? _____

Signature: _____ Date: _____

Medical History

General Information

First name – Patient _____

Middle name _____

Last name - Patient _____

Gender _____

Patient date of birth _____

Email address _____

Emergency Information

Emergency Contact

_____

Emergency Number

_____

Family Doctor

_____

Family Doctor #

_____

Dental Information

Have you had any problems associated with previous dental treatment? _____

Is this your child's first dental visit? _____

Do your gums bleed when you brush or floss? _____

Are you currently experiencing dental pain or discomfort? _____

Does your child have any habits such as pacifier or thumb? _____

Do you have any clicking, popping or discomfort in your jaw? _____

Does your child need antibiotic treatment prior to their dental appointment? (not for dental infection)

_____

Do you grind your teeth? _____

Have you ever had a serious injury to your head, neck or mouth? _____

Medical Information

Allergies

____Acetaminophen/Tylenol®	____Animals	____Artificial dyes	____ Aspirin
____Bactrim	____Codeine	____Erythromycin	____Food
____Ibuprofen/Motrin®/Advil®	____ Iodine	____ Latex	____Hay fever/seasonal
____Local anesthetic	_____Metals	_____Milk	____Morphine
____Penicillin	_____Sulfa	_____Tetracycline	____Other

Conditions

____Abnormal/excessive bleeding	_____ADHD	____AIDS or HIV infection
_____Anemia	____Anxiety	____Asthma
_____Autoimmune Disease	____Autism	____ Cancer/chemotherapy/ radiation treatment
_____Bronchitis	____Cardiovascular disease	_____Cerebral Palsy Cleft Lip/Palate
_____ Damaged heart valves	____Developmental Delay	_____Diabetes
_____Down Syndrome	____Epilepsy Fainting spells or seizures	____G.E. Reflux/persistent heartburn
_____Hearing difficulties	_____Heart murmur	_____Heart rhythm disorder
_____Hemophilia	_____Hepatitis, jaundice or liver disease	_____Kidney problems
_____Liver Disease	_____Other congenital heart defects	_____Psychological Disorders
_____Rheumatic fever	_____Sickle Cell Anemia	_____Speech Delay
_____ Spina Bifida	_____Systemic lupus	_____Erythematosus
_____Thyroid problems	_____TMJ Disorder	_____Tumors or growths Other

Details:

_____

Please indicate if you have or any of the following diseases or problems:

_____

Preferred pharmacy:

_____

Pharmacy #:

_____

Date of last physical exam:

_____

Have you had a serious illness, operation or been hospitalized in the past 5 years?

Are you taking any prescription or over-the-counter medicines?

_____

Do you have sleep apnea?

_____

Please list any surgical procedures you have undergone and when they occurred.

_____

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?

_____

Physician's phone number:

_____

Please read the above and understand that the information provided in this form is accurate. A truthful health history will help ensure the best possible dental treatment. The information provided here will be used by the doctor and patient to inform any further discussion of the patient's health prior to or during an appointment. By signing below, you also acknowledge that you will not hold the dentist, the dental practice or any other member of the practice staff responsible for any action or lack of action because of errors or omissions that may have been made during the completion of this form.

Signature: _____ Date: _____

Financial Responsibility

INSURANCE

Our office is committed to helping our patients maximize their benefits. Your estimated patient portion, deductibles, co-pay amounts, and non-covered services must be paid at the time of service. As a service to our patients, we will bill insurance companies for services and allow them 30 days to render payment in full. After 30 days you are responsible for the entire balance, and it will be due in full. Insurance policies

vary greatly therefore we can estimate your coverage in good faith but cannot guarantee coverage due to the complexities of insurance contracts. Any questions regarding your benefits should be directed to your insurance carrier directly.

MISSED APPOINTMENTS

Once an appointment has been made, please remember that this time has been reserved specifically for you. If you are unable to make it to your child's appointment, we ask that you give our office 24 business hours before rescheduling the appointment. A standard fee of $40.00 dollars will be charged to your account for any dental appointment cancelled or failed within 24 business hours of the scheduled appointment time, $60 dollars for the second appointment, $80 dollars for the third time and possible dismissal from our office the fourth time. If you have more than one child, each child is one appointment. Note: All cancellation fees must be paid prior to scheduling future appointments with our office. When we reserve time for you, we require all that time to provide you with the best quality work possible. When you are late it decreases our ability to accomplish this. If you arrive 15 or more minutes late the appointment is considered missed and the missed appointment fee will apply, we will then reserve the right to reschedule your appointment.

PAYMENT TYPES

We accept VISA, MC, AMEX, DISCOVER, ZELLE. We also offer care credit and spring stone as a third-party payment plan in our office. **WE DO NOT ACCEPT CHECKS.**

FINANCIAL CHARGES AND COLLECTION FEES

Monthly financial charges of 5% may be applied to all balances not paid within 30 days of the monthly billing date. If this account goes unpaid, and we are forced to use an outside collection agency and / or an attorney, it is understood and agreed that up to 40 % of the principal amount due will be added as collection fees. If we are forced to file a lawsuit, it is understood and agreed that you will be liable for all court costs whether judgment has been entered or not.

FINANCIAL CONSENT

The Responsible party agrees to be fully responsible for total payment of treatment performed in this office.

_____

ACKNOWLEDGEMENT OF RECEIPT: I acknowledge that I received a copy of the financial consent.

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

The Loose Tooth Pediatric Dentistry and Aligned Orthodontics

15041 S. Van Dyke Rd, #105

Plainfield, IL 60544

815.267.7299

Acknowledgement

I hereby acknowledge that I have received and reviewed a copy of The Loose Tooth and Aligned Orthodontics' HIPAA Notice of Privacy Practices.

I understand that The Loose Tooth and Aligned Orthodontics'' HIPAA Notice of Privacy Practices may change periodically and that I am entitled to receive a copy of The Loose Tooth and Aligned Orthodontics' revised HIPAA Notice of Privacy Practices upon request.

I understand that, if I have questions about HIPAA Notice of Privacy Practices, I may contact Rhiannon Holcombe, DDS.

I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that The Loose Tooth and Aligned Orthodontics will not refuse treatment to me if I refuse to sign this Acknowledgement.

I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding The Loose Tooth and Aligned Orthodontics' privacy policies and procedures. For information on how to contact the U.S. Department of Health and Human Services, please ask Rhiannon Holcombe, DDS, noted above, for assistance.

Signature:_____ Date:_____

FOR OFFICE USE ONLY

The Loose Tooth and Aligned Orthodontics made a good-faith effort to obtain Acknowledgement, from the patient noted above, of receipt of its HIPAA Notice of Privacy Practices. In spite of these efforts, Th Loose Tooth and Aligned Orthodontics was unable to obtain a signed Acknowledgement for the following reason(s):

o Refusal to sign Acknowledgement on _____, 20_____.

o Communications barriers prohibited us from obtaining a signed Acknowledgement.

o An emergency situation prohibited us from obtaining a signed Acknowledgement.

o Other (Describe):_____

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

The Loose Tooth Pediatric Dentistry and Aligned Orthodontics

15041 S Van Dyke Rd Suite 105

Plainfield, IL 60544

Patient Authorization

I hereby authorize The Loose Tooth Pediatric Dentistry and Aligned Orthodontics to release, use and/or disclose my protected health information as directed below.

Health Information

This Authorization pertains to the following types of protected health information about me:

o All dental records received or created by The Loose Tooth Pediatric Dentistry and Aligned Orthodontics

o Dental report(s) (please specify)

o Dental image(s) (please specify)

o All dental records relating to (specify injury or condition)

o Other (please describe)

I understand that, per my voluntary request, this Authorization permits The Loose Tooth Pediatric Dentistry and Aligned Orthodontics to release, use or disclose my protected health information and transfer dental x-rays only to authorized parties. I further understand that I may revoke this Authorization at any time by providing written notification to The Loose Tooth Pediatric Dentistry and Aligned Orthodontics. Revocation of this Authorization will be effective on the date notice is received and processed by The Loose Tooth Pediatric Dentistry and Aligned Orthodontics except to the extent that action has already been taken in reliance upon this Authorization.

Authorization Expiration

This Authorization will expire one (1) year from the date that I sign it, unless I indicate an alternative expiration date below:

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Know Your Rights

Your decision to sign this Authorization is voluntary. THE LOOSE TOOTH PEDIATRIC DENTISTRY AND ALIGNED ORTHODONTICS will not refuse treatment to you if you refuse to sign this Authorization.

When your protected health information is released as provided by this Authorization, please be aware that the named recipient (above) may not be legally obligated (under HIPAA) to obtain an authorization for subsequent re-disclosure of your protected health information.

Signature: _____ Date: _____

I have read the contents of this Authorization, and I confirm that the contents are consistent with my directions. I understand that by signing this Authorization, I am permitting THE LOOSE TOOTH PEDIATRIC DENTISTRY AND ALIGNED ORTHODONTICS to release, use or disclose my protected health information.

Patients Name: _____

I affirm that I am the personal representative of the patient noted above and that I have the authority to authorize the release, use or disclosure of the patient's protected health information on his/her behalf. I have read the contents of this Authorization, and I confirm that the contents are consistent with my directions. I understand that by signing this form, I am authorizing, on behalf of the patient, the release, use or disclosure the patient's protected health information.

Signature: _____ Date: _____

Pediatric Dentistry Informed Consent for Patient Management Techniques

Please read carefully and feel free to ask questions. We will be happy to explain it further. It is our intent that our dental. care delivery be the best available. We are highly experienced in helping children overcome anxiety and we ask that you allow your child to accompany us through the dental experience. Dental anxiety is not uncommon in children so please try not to be concerned if your child exhibits some negative behavior: this is normal and will soon lessen with time. Studies and experience have shown that most children react more positively when permitted to experience the dental visit in an environment designed for children. Every effort will be made to obtain your child's cooperation through warmth, charm, humor, and understanding. When these fail, there are several behavior management techniques our office uses to minimize disruptive behavior.

The techniques used are recommended by the American Academy of Pediatric Dentistry and are described below.

***Tell-Show-Do**: The dentist or assistant first explains to the child what is to be done, then demonstrates on a model or on the child's finger. Finally, the procedure is completed on the patient's tooth. Praise is used to reinforce cooperative behavior.

***Positive Reinforcement**: This technique rewards the child who displays any desirable behavior. The rewards include compliments, praise, or a prize.

***Voice Control**: The attention of a disruptive child is gained by changing the tone, increasing, or decreasing the volume of the practitioner's voice.

***Mouth Props**: A rubber device is gently placed in the child's mouth to prevent either intentional or unintentional closure on the dentist's fingers or drill.

***Touch and Go by Dentist/Assistant**: Our assistants ask the child to hold their hand to prevent from grabbing a moving drill or a sharp object. They are not able to grab the practitioner's hand while delicate work is being performed. This is for the safety of the child and to facilitate treatment.

The following will be used AFTER obtaining consent from the parent/guardian

• **Laughing gas**: Nitrous oxide (Laughing gas) is administered to calm and sooth the patient prior to a dental procedure. Nitrous oxide is a very safe medication that on a rare occasion may cause nausea. We ask that your child not eat four hours prior to the nitrous oxide procedure.

• **Protective Immobilization**: This is an immobilizing device (papoose) to limit the patient's disruptive movements and to prevent injury. It is used only as a last resort when treatment cannot be accomplished in any other way.

The above listed pediatric dentistry behavior management techniques have been explained to me. I understand their use, and the risks benefits/alternatives available. I have had all my questions answered and I realize I can always seek further information or revoke permission for any of these techniques.

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT: I acknowledge that I received a copy of the Patient management consent.

The Loose Tooth Pediatric Dentistry and Aligned Orthodontics

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Dental Practice Covered by this Notice

This Notice describes the privacy practices of The Loose Tooth Pediatric Dentistry and Aligned Orthodontics ("Dental Practice"). "We" and "our" means the Dental Practice. "You" and "your" means our patient.

II. How to Contact Us/Our Privacy Official

If you have any questions or would like further information about this Notice, you can contact Privacy Official at:

The Loose Tooth Pediatric Dentistry and Aligned Orthodontics

15041 S Van Dyke Rd Suite 105

Plainfield, IL

815-267-7299

815-267-7511

Theloosetooth2014@gmail.com

III. Our Promise to You and Our Legal Obligations

The privacy of your health information is important to us. We understand that your health information is personal and we are committed to protecting it. This Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required by law to:

- Maintain the privacy of your protected health information;

- Give you this Notice of our legal duties and privacy practices with respect to that information; and
- Abide by the terms of our Notice that is currently in effect.

V. How We May Use or Disclose Your Health Information

The following examples describe different ways we may use or disclose your health information. These examples are not meant to be exhaustive. We are permitted by law to use and disclose your health information for the following purposes:

A. Common Uses and Disclosures

1. Treatment. We may use your health information to provide you with dental treatment or services, such as cleaning or examining your teeth or performing dental procedures. We may disclose health information about you to dental specialists, physicians, or other health care professionals involved in your care.

2. Payment. We may use and disclose your health information to obtain payment from health plans and insurers for the care that we provide to you.

3. Health Care Operations. We may use and disclose health information about you in connection with health care operations necessary to run our practice, including review of our treatment and services, training, evaluating the performance of our staff and health care professionals, quality assurance, financial or billing audits, legal matters, and business planning and development.

4. Appointment Reminders. We may use or disclose your health information when contacting you to remind you of a dental appointment. We may contact you by using a postcard, letter, phone call, voice message, text or email.

5. Treatment Alternatives and Health-Related Benefits and Services. We may use and disclose your health information to tell you about treatment options or alternatives or health-related benefits and services that may be of interest to you.

6. Disclosure to Family Members and Friends. We may disclose your health information to a family member or friend who is involved with your care or payment for your care if you do not object or, if you are not present, we believe it is in your best interest to do so.

7. Disclosure to Business Associates. We may disclose your protected health information to our third-party service providers (called, "business associates") that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use a business associate to assist us in maintaining our practice management software. All of our business associates are obligated, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

B. Less Common Uses and Disclosures

1. Disclosures Required by Law. We may use or disclose patient health information to the extent we are required by law to do so. For example, we are required to disclose patient health information to the U.S.

Department of Health and Human Services so that it can investigate complaints or determine our compliance with HIPAA.

2. Public Health Activities. We may disclose patient health information for public health activities and purposes, which include: preventing or controlling disease, injury or disability; reporting births or deaths; reporting child abuse or neglect; reporting adverse reactions to medications or foods; reporting product defects; enabling product recalls; and notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

3. Victims of Abuse, Neglect or Domestic Violence. We may disclose health information to the appropriate government authority about a patient whom we believe is a victim of abuse, neglect or domestic violence.

4. Health Oversight Activities. We may disclose patient health information to a health oversight agency for activities necessary for the government to provide appropriate oversight of the health care system, certain government benefit programs, and compliance with certain civil rights laws.

5. Lawsuits and Legal Actions. We may disclose patient health information in response to (i) a court or administrative order or (ii) a subpoena, discovery request, or other lawful process that is not ordered by a court if efforts have been made to notify the patient or to obtain an order protecting the information requested.

6. Law Enforcement Purposes. We may disclose your health information to a law enforcement official for a law enforcement purposes, such as to identify or locate a suspect, material witness or missing person or to alert law enforcement of a crime.

7. Coroners, Medical Examiners and Funeral Directors. We may disclose your health information to a coroner, medical examiner or funeral director to allow them to carry out their duties.

8. Organ, Eye and Tissue Donation. We may use or disclose your health information to organ procurement organizations or others that obtain, bank or transplant cadaveric organs, eyes or tissue for donation and transplant.

9. Research Purposes. We may use or disclose your information for research purposes pursuant to patient authorization waiver approval by an Institutional Review Board or Privacy Board.

10. Serious Threat to Health or Safety. We may use or disclose your health information if we believe it is necessary to do so to prevent or lessen a serious threat to anyone's health or safety.

11. Specialized Government Functions. We may disclose your health information to the military (domestic or foreign) about its members or veterans, for national security and protective services for the President or other heads of state, to the government for security clearance reviews, and to a jail or prison about its inmates.

12. Workers' Compensation. We may disclose your health information to comply with workers' compensation laws or similar programs that provide benefits for work-related injuries or illness.

VI. Your Written Authorization for Any Other Use or Disclosure of Your Health Information

Uses and disclosures of your protected health information that involve the release of psychotherapy notes (if any), marketing, sale of your protected health information, or other uses or disclosures not described in this notice will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization at any time, in writing, except to the extent that this office has taken an action in reliance on the use of disclosure indicated in the authorization. If a use or disclosure of protected health information described

above in this notice is prohibited or materially limited by other laws that apply to use, we intend to meet the requirements of the more stringent law.

VII. Your Rights with Respect to Your Health Information

You have the following rights with respect to certain health information that we have about you (information in a Designated Record Set as defined by HIPAA). To exercise any of these rights, you must submit a written request to our Privacy Official listed on the first page of this Notice.

A. Right to Access and Review

You may request to access and review a copy of your health information. We may deny your request under certain circumstances. You will receive written notice of a denial and can appeal it. We will provide a copy of your health information in a format you request if it is readily producible. If not readily producible, we will provide it in a hard copy format or other format that is mutually agreeable. If your health information is included in an Electronic Health Record, you have the right to obtain a copy of it in an electronic format and to direct us to send it to the person or entity you designate in an electronic format. We may charge a reasonable fee to cover our cost to provide you with copies of your health information.

B. Right to Amend

If you believe that your health information is incorrect or incomplete, you may request that we amend it. We may deny your request under certain circumstances. You will receive written notice of a denial and can file a statement of disagreement that will be included with your health information that you believe is incorrect or incomplete.

C. Right to Restrict Use and Disclosure

You may request that we restrict uses of your health information to carry out treatment, payment, or health care operations or to your family member or friend involved in your care or the payment for your care. We may not (and are not required to) agree to your requested restrictions, with one exception: If you pay out of your pocket in full for a service you receive from us and you request that we not submit the claim for this service to your health insurer or health plan for reimbursement, we must honor that request.

D. Right to Confidential Communications, Alternative Means and Locations

You may request to receive communications of health information by alternative means or at an alternative location. We will accommodate a request if it is reasonable and you indicate that communication by regular means could endanger you. When you submit a written request to the Privacy

Official listed on the first page of this Notice, you need to provide an alternative method of contact or alternative address and indicate how payment for services will be handled.

E. Right to an Accounting of Disclosures

You have a right to receive an accounting of disclosures of your health information for the six (6) years prior to the date that the accounting is requested except for disclosures to carry out treatment, payment, health care operations (and certain other exceptions as provided by HIPAA). The first accounting we provide in any 12-month period will be without charge to you. We may

charge a reasonable fee to cover the cost for each subsequent request for an accounting within the same 12-month period. We will notify you in advance of this fee and you may choose to modify or withdraw your request at that time.

F. Right to a Paper Copy of this Notice

You have the right to a paper copy of this Notice. You may ask us to give you a paper copy of the Notice at any time (even if you have agreed to receive the Notice electronically). To obtain a paper copy, ask the Privacy Official.

G. Right to Receive Notification of a Security Breach

We are required by law to notify you if the privacy or security of your health information has been breached. The notification will occur by first class mail within sixty (60) days of the event. A breach occurs when there has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of your health information.

The breach notification will contain the following information: (1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach; (2) the steps you should take to protect yourself from potential harm resulting from the breach; and (3) a brief description of what we are doing to investigate the breach, mitigate losses, and to protect against further breaches.

VIII. Special Protections for HIV, Alcohol and Substance Abuse, Mental Health and Genetic Information

Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including HIV-related information, alcohol and substance abuse information, mental health information, and genetic information. For example, a health plan is not permitted to use or disclose genetic information for underwriting purposes. Some parts of this HIPAA Notice of Privacy Practices may not apply to these types of information. If your treatment involves this information, you may contact our office for more information about these protections.

IX. Our Right to Change Our Privacy Practices and This Notice

We reserve the right to change the terms of this Notice at any time. Any change will apply to the health information we have about you or create or receive in the future. We will promptly revise the Notice when there is a material change to the uses or disclosures, individual's rights, our legal duties, or other privacy practices discussed in this Notice. We will post the revised Notice on our website (if applicable) and in our office and will provide a copy of it to you on request. The effective date of this Notice is September 7, 2014

X. How to Make Privacy Complaints

If you have any complaints about your privacy rights or how your health information has been used or disclosed, you may file a complaint with us by contacting our Privacy Official listed on the first page of this Notice.

You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you in any way if you choose to file a complaint.

Signature: _____ Date:_____