Concord Pediatric Dentistry

16 Foundry Street, Concord
New Hampshire, 03301
(603)-224-3339 - Fax- (603)-224-3330

Come See Our Exciting Home!

Immediately off I-93 at Exit 16 (see directions below)
Please call our office for details.

Directions

From North: **I-93 South to Exit 16. Straight on to Foundry St. 1st left in parking lot. Building 16 1st floor**

From South: **I-93 North to Exit 16. Left at end of ramp, 1st Left onto Foundry St (after crossing over I-93). 1st left in parking lot. Building 16 1st floor**

From West: **I-89 South. I-93 North to Exit 16. (see directions 'from south')**

From East: **I-393 West. I-93 North to Exit 16. (see directions 'from south')**

CONCORD PEDIATRIC DENTISTRY

PLEASE COMPLETE THE FIRST TWO SHEETS AND MAIL BACK. THANK YOU!

Child's Registration and History

DATE_____

CHILD'S NAME_____ AGE_____ DATE OF BIRTH_____

NICKNAME _____ IDENTIFY AS_____

SCHOOL_____ GRADE_____

LEGAL GUARDIAN_____ LEGAL GUARDIAN_____

ADDRESS_____ ADDRESS_____

_____ _____

HOME PHONE_____ HOME PHONE_____

CELL PHONE_____ CELL PHONE_____

WORK PHONE_____ WORK PHONE_____

EMAIL_____ EMAIL_____

EMPLOYER_____ EMPLOYER_____

OCCUPATION _____ OCCUPATION_____

PERSON WHO CAN GIVE LEGAL CONSENT FOR TREATMENT_____ RELATIONSHIP TO CHILD_____

ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE _____

DENTAL INSURANCE _____

SUBSCRIBER NAME_____ DOB___/___/___ SS#_____

WHOM MAY WE THANK FOR REFERRING YOU _____

CHILD'S FAVORITE : ACTIVITY _____ TOY _____

HOBBY _____ PERSON _____FICTION CHARACTER _____

DENTAL HISTORY

Date of last dental visit _____

For what Service _____

_____

Child's attitude toward dentist_____

_____ YES NO

Any unhappy dental experiences _____ ☐ ☐

_____

Has child complained about dental problems _____ ☐ ☐

_____

Any injury to mouth – teeth – head _____ ☐ ☐

_____

Any mouth habits – mouth breathing, thumb sucking, nail biting, nursing, bottle habits, pacifier, etc. _____ ☐ ☐

_____

YES NO

Any unusual speech habits _____ ☐ ☐

_____

Any lost teeth_____ ☐ ☐

Orthodontic appliance worn now or ever_____ ☐ ☐

_____

Does your child brush teeth daily _____ ☐ ☐

Do you assist child with tooth brushing_____ ☐ ☐

How often _____

Is dental floss used _____ ☐ ☐

How often _____

Is fluoride taken in any form_____ ☐ ☐

Do you desire complete dental service for the child ☐ ☐
If no, please explain your expectations: _____

_____

HEALTH HISTORY

Child's Physician _____ Address _____ Phone _____

Date of last physical examination _____ Results _____

	YES	NO		YES	NO
Is child under care of physician now_____	☐	☐	Is there an allergy to penicillin or other drugs _____	☐	☐
Is child receiving any medication or drugs _____	☐	☐	Are there other allergies: food, pollen, animals, dust, other _____	☐	☐
Is there any excessive bleeding when cut _____	☐	☐	Does child have good physical coordination _____	☐	☐
			Are there any behavioral or emotional issues - please explain _____	☐	☐
Has child ever been hospitalized _____	☐	☐			
Has child ever had surgery _____	☐	☐	Females of reproductive age: Are you pregnant or using oral contraceptives_____	☐	☐

DOES THE CHILD HAVE DIFFICULTY WITH OR A HISTORY OF ANY OF THE FOLLOWING:

___ Anemia	___ Cerebral Palsy	___ Fainting	___ Kidney	___ Rheumatic Fever
___ Asthma	___ Chicken Pox	___ Hearing	___ Liver	___ Seizures/Epilepsy
___ Autism	___ Chronic Sinus	___ Heart	___ Malignancies	___ Thyroid
___ Bladder	___ Developmental Delays	___ Hepatitis	___ Measles or Mumps	___ Tuberculosis
___ Bleeding Issues	___ Diabetes	___ HIV+/AIDS	___ Mononucleosis	___ Other

SUMMARY: (for doctor's use)

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information we should be aware of that we have not discussed.

_____

_____

_____

_____

_____

Legal Guardian Signature _____ **Date** _____

Print Name _____ **Relation to Child** _____

ROGER A. ACHONG, DMD
PATRICK F. CAPOZZI, DDS
DANIELLE C. HINTON, DMD
ELLIOT C. CHIU, DMD

CONCORD PEDIATRIC DENTISTRY, P.A.
16 Foundry St. Suite 101
Concord, New Hampshire 03301-2551
TEL. (603) 224-3339 * FAX (603) 224-3330

SPECIALIZING IN
PEDIATRIC DENTISTRY

FINANCIAL UNDERSTANDING

Payment Policy: Since we request payment at the time dental care is delivered, we have provided the following information to help avoid confusion.

If You Have Dental Insurance: We can submit your dental claims to **most** insurance companies. A copy of your insurance card and a completed dental claim form are required. If a prior approval is required by your insurance company then **you** are responsible for informing us before we start services. We will gladly discuss your proposed treatment and answer any questions that you might have to the best of our ability. You must realize, however, that:

1. Your insurance contract is between you, your employer and the insurance company. We are not a party to that contract. As dental care providers, our relationship is with you, not your insurance company. Neither we nor you had a part in those negotiations and the benefits you may receive from your insurance have nothing at all to do with you receiving a high quality result. We have found the interests of insurance companies to be sometimes incompatible with our stated goal of delivering excellence in pediatric dental care.
   While filing the insurance claims is a courtesy we extend to our patients, should a dispute arise over coverage or benefits, we ask that you pay us the disputed amount and request direct reimbursement from your insurance company or employer.

2. **When you entrust your pediatric dental care to us, we are working for you and you alone. We do not work for any insurance companies and we do not allow insurance companies to determine what is the best possible treatment for your pediatric dental needs.**

3. Insurance deductibles and co-payments are the parent/legal guardian's responsibility at time of service.

4. This office allows six weeks for payment from the insurance company; if not received, then parent/legal guardian is responsible for payment. A rebilling charge of $10.00 per month will be assessed after the 1st statement. This charge is to help cover the administrative expense of producing the invoice, mailing the invoices and the staff time in responding to patient inquiries that invariably accompany any invoices for over due accounts.

If You Do Not Have Dental Insurance:
Full (100%) payment at the time of service. You may make payment with a personal check, cash, MC/VISA/DISCOVER or debit card.

Missed Appointments:

We feel it is your responsibility to remember scheduled appointment times. If contact cannot be established and an appointment is missed, or less than 24 business hours notice given for a cancellation, a charge of $50.00 per child/appointment will be assessed. No further (non emergency) appointments will be made until this is paid. This fee is partly to recover the fixed cost incurred for the unused time, but more importantly, to act as a deterrent to missed appointments that often result in compromised treatment outcomes.

Again, we thank you for selecting our Pediatric Dental Specialty Office. Please do not hesitate to ask questions regarding treatment, fees, or services. We will make every effort to avoid any misunderstanding and to preserve our good relations. It is our goal to deliver quality pediatric dental care, and we want you to feel comfortable with the investment you are making in your child's oral health.

I, the undersigned, have read, understand and agree to the above policies.

_____ _____
Parent/Legal Guardian (Print Name) Date

_____
Signed

CONCORD PEDIATRIC DENTISTRY, P.A.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Child's Name: _____ Child's Date of Birth: _____
Address: _____ Telephone: _____

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your child's protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your child's protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your child's protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting: Jamie C. Young, 16 Foundry St. Suite 101, Concord, NH 03301, (603) 224-3339.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat your child or to continue treating your child if you revoke this Consent.

SIGNATURE FOR CONSENT

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my child's protected health information to carry out treatment, payment activities and health care operations.

Parent or Legal Guardian Name: _____

Signature: _____ Date: _____

YOU ARE ENTITILED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my child's protected health information for treatment, payment activities, and healthcare operations.
I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat my child after I have revoked my Consent.

Parent or Legal Guardian Name:
_____
Signature: _____ Date: _____

CONCORD PEDIATRIC DENTISTRY, P.A.

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 child's health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your child's health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/14/03, 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 your child for treatment, payment, and healthcare operations. For example:
Treatment: We may use or disclose your child's health information to a physician or other healthcare provider providing treatment to your child.
Payment: We may use and disclose your child's health information to obtain payment for services we provide to your child.
Healthcare Operations: We may use and disclose your child's 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 child's health information for treatment, payment or healthcare operations, you may give us written authorization to use your child's 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 child's health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your child's health information to you, as described in the Patient Rights section of this Notice. We may disclose your child's health information to a family member, friend or other person to the extent necessary to help with your child's healthcare or with payment for your child's 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 child's care, of your child's location, your child's general condition, or death. If you are present, then prior to use or disclosure of your child's health information, we will provide you with an opportunity to object to such uses or disclosure. 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 child's healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your child's 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 Service: We will not use your child's health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your child's health information when we are required to do so by law.

Abuse or Neglect: We may disclose your child's health information to appropriate authorities if we reasonably believe that your child is a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your child's health information to the extent necessary to avert a serious threat to your child's 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, Counterintelligence, 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 child's 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 our copies of your child's 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 child's 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 child's 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.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your child's 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 Communications: You have the right to request that we communicate with you about your child's 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 child's 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 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 disagree with a decision we made about access to your child's health information or in response to a request you made to amend or restrict the use or disclosure of your child's 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 child's 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: Jamie C. Young, 16 Foundry St. Suite 101, Concord, NH, 03301, (603) 224-3339