Southern Village
PEDIATRIC DENTISTRY
Growing Healthy Smiles
919-967-2773
410 Market Street, Suite 430
Chapel Hill, NC 27516

PATIENT INFORMATION AND HEALTH HISTORY FORM

Child's Name: _____Preferred Name: _____ Date of Birth___/___/____
Street Address: _____City: _____State:____ Zip:_____
Home Phone:_____ Age: _____ Preferred Pronoun: □ He/Him □ She/Her □ They/Them
School Currently Attending: _____Grade Level: _____

PARENT INFORMATION

Parent/Legal Guardian: _____ Relation to patient:_____
Employer:_____ Work #:_____ Mobile #:_____Date of Birth ___/___/____
Parent/Legal Guardian: _____ Relation to patient:_____
Employer:_____ Work #:_____ Mobile #:_____Date of Birth ___/___/____
Guardian's Email: _____
Who has legal custody? _____ Dental Insurance □ Yes □ No
Person responsible for payment of account _____ SSN#: _____

WHOM MAY WE THANK FOR REFERRING YOU?

□Our Website □Building Sign □ Facebook □Pediatrician □Carolina Parent □Community Event
□Dental Office □School/Daycare □Friend □Other
Please Specify:_____

EMERGENCY CONTACT

Name: _____ Relationship: _____
Home Phone: _____Work Phone: _____ Mobile: _____

HEALTH PROVIDER

Child's Physician/Pediatrician: _____ Phone#: _____
Mailing Address: _____ City: _____ State:_____ Zip: _____
Preferred Pharmacy:_____

DENTAL HISTORY

What is the reason for your child's dental visit?_____

□ Yes □ No Has your child ever been to the dentist? Date of last cleaning & x-rays (if taken)_____
Name of previous dentist: _____Phone: _____

□ Yes □ No Has your child experienced any unfavorable reaction from previous dental care?
Explain _____

□ Yes □ No Does your child suck a finger, thumb, or pacifier?
□ Yes □ No Does your child have pain with chewing, yawning, or wide opening
□ Yes □ No Does your child go to bed with a bottle or sippy cup?
□ Yes □ No Does your child snack frequently? What are their favorite snack foods? _____
□ Yes □ No Has your child had local anesthetic? Were there any problems? _____
□ Yes □ No Has your child been sedated for dental treatment? Were there any problems? _____
□ Yes □ No Has your child's teeth ever been injured? Which teeth: _____
Dental treatment for trauma: _____

Please check if your child is having problems with any of the following:

□ Cavities	□ Toothache	□ Sensitive Teeth	□ Mouth Breathing
□ Trauma	□ Gum Infections	□ Color of Teeth	□ Other
□ Orthodontics	□ Jaw Sounds	□ Grinding of Teeth	

Comments: _____

FLUORIDE HISTORY

What is your home water source: □ City □ Well

□ Yes □ No Does your child use a fluoride toothpaste?

□ Yes □ No Do you give your child any other forms of fluoride? What? _____

MEDICAL HISTORY

□ Yes □ No Is your child in good health? Date of last physical exam _____

□ Yes □ No Has your child ever had a health problem? _____

□ Yes □ No Is your child allergic to anything? _____

□ Yes □ No Is your child currently taking any medications? Please give medication, dose, and reason: _____

_____

□ Yes □ No Are your child's immunizations current?

□ Yes □ No Has anyone in your immediate family travelled to: Liberia, Sierra Leone or Guinea in the last 21 days? If yes, please let us know when you arrived into the U.S.? Month _____ Day_____

□ Yes □ No Is your child feeling feverish today?

□ Yes □ No Have you ever been told that your child needs to take *antibiotics before dental treatment*?

□ Yes □ No Has your child ever been hospitalized, had general anesthesia, or emergency room visits? Please explain:

_____

□ Yes □ No Were there any difficulties at birth? _____

Do you consider your child to be:
□ advanced in the learning process
□ progressing normally
□ slow in the learning process

Please check if your child has been treated for any of the following:

□ Abuse	□ Cancer/tumors	□ Heart murmur	□ Rheumatic fever
□ ADD/ADHD	□ Cerebral palsy	□ Hepatitis	□ Seizures
□ AIDS	□ Cleft lip/palate	□ Kidney disease	□ Sickle cell disease/trait
□ Anemia	□ Congenital birth defects	□ Liver/GI disease	□ Significant injuries
□ Anxiety disorder	□ Diabetes	□ Mental delays	□ Snoring
□ Arthritis	□ Endocrine/growth	□ Personality/social disorder	□ Speech/hearing
□ Asthma/breathing	□ Eyesight	□ Physical delays	□ Spina bifida
□ Autism	□ Frequent infections	□ Recurrent headaches	□ Tonsil/adenoid problems
□ Bleeding/transfusions	□ Heart Disease	□ Recurrent herpes/fever blisters**	□ Tuberculosis
□ Blood dyscrasias			

Please note that if your child has an **active herpes lip lesion on the day of your scheduled appointment, we will ask you to reschedule.

Other: _____

If any boxes checked, please describe further:_____

_____

CONSENT FOR DENTAL TREATMENT

As the parent and/or legal guardian of the patient, I do hereby request and authorize Dr. Annelise Hardin and her staff to examine, clean, and provide dental treatment on my child. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Hardin to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or child's teeth for diagnostic or educational purposes. 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. Hardin will provide an environment that will help your child learn to cooperate during treatment including praise, explanations, and demonstrations of procedures and instruments, and using variable voice tones. The usual and most frequent risks or complications occurring from dental operative treatment include but are not limited to, the possibility of pain or discomfort during the treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of a temporomandibular joint disorder, temporary or permanent numbness, and allergic reactions.

I understand I will be responsible for any charges incurred for my child for dental treatment. I affirm that the information above is correct to the best of my knowledge. I understand it is my responsibility to inform Southern Village Pediatric Dentistry of any changes in my child's medical status.

Legal Guardian's Signature: _____ Date:_____

Doctor Signature: _____ Date:_____

Southern Village
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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient(s) Name: _____ Date of Birth: _____

I request and authorize _____
Name & Phone Number of Previous Dentist

to release healthcare information of the patient named above to:

PLEASE FAX/MAIL/EMAIL TO:
Southern Village Pediatric Dentistry
410 Market Street, Suite 430
Chapel Hill, NC 27516
P: 919-967-2773 F: 919-967-2774
frontdesk@southernvillagepedo.com

Reason for Release: _____

This request and authorization applies to:

☐ All Dental Records

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

Legal Guardian's Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- Treatment means providing, coordinating, or managing healthcare and related services by one or more health care providers. An example of this would include teeth cleaning services.
- Payment includes, but is not limited to, activities such as: obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Healthcare operations are the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all reference to an individual or any individuals.
We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.
All other uses and discloses will be made only with your written authorization. You may revoke the authorization in writing and we are required to honor and abide by that written request, except in relation to disclosures made prior to that date.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses, and disclosures, of protected health information, including information disclosed to family members, other relatives, close personal friends, or any other person you identify. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communication of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of November 28, 2006 and we are required to abide by the terms of the *Notice of Privacy Practices* currently in effect. We reserve the right to change the terms of our *Notice of Privacy Practices* and to make the new provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised *Notice of Privacy Practices* from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint to our Privacy Officer, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:
Southern Village Pediatric Dentistry
Attn: Angie Bosch
919-967-2773

For more information about HIPAA or to file a complaint:
The US Department of Health and Human Services
Office of Civil Rights
202-619-0257
Toll Free: 1-877-696-6775

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

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

Notice of Privacy Practices: You have the right to read our Notice of 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 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, which will contain the changes. Those changes may apply to any of your 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 requesting it from us or print the online version.

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation. 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 will decline to treat you or to continue treating you if you revoke this consent.

SIGNATURE

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 protected health information as described in the "Notice of Privacy Practices."

Legal Guardian's Signature _____ Date_____

SOUTHERN VILLAGE PEDIATRIC DENTISTRY FINANCIAL POLICY

Thank you for choosing our office to provide dental care for your child. Because we value our relationship with you and believe that the best relationships are based on understanding, we offer these explanations of payment for services:

1. **Dental Insurance:**

As a courtesy to you we will file your Primary dental insurance claim for you, and we will also accept assignment of benefits. You will be expected to pay your estimated uncovered portion at the time of service. A copy of your card will be requested at each visit. You must be familiar with your insurance benefits. Once the insurance company reimburses our office, if there is a balance, you will be billed for the remaining portion. If there is a credit, you will be sent a refund check. Please be aware our office does not file secondary insurance.

We file insurance electronically. Your claim will be sent out on the day of service. If your insurance company does not pay on your claim, you will be expected to pay it in full within 30 days of the date of treatment. It will be the policy holder's responsibility to follow up on any unpaid claim. Please note that BCBS and Delta Dental will not reimburse our office directly. If you have **BCBS or Delta Dental**, you are responsible for the full cost of each visit at the time of service. We will have the paperwork ready for you to mail in and you will be reimbursed directly.

Please note that we file dental insurance as a courtesy to our patients. We do not have a direct relationship with any insurance companies. We are not responsible for how your insurance company handles its claims. We only assist in estimating your portion of the cost and we will verify benefits prior to treatment whenever possible.

Please be aware that the person bringing the child for dental care is legally responsible for payment of all charges (excluding Medicaid and Health Choice patients).

2. **Payment:**
   a. Payment is due in full for uncovered services by cash, personal check, or charge card at each appointment as services are rendered.
   b. We accept Master Card and Visa.
   c. We offer Healthcare Financing through Care Credit with any transaction of $500.00 or greater.
   d. A charge of $30.00 will be assessed on checks returned for any reason. After two incidents of returned checks, we will no longer accept checks.

3. **Pretreatment Authorization:**
   a. Some insurance companies request an estimate of the work to be done and the fees to be charged before determining their benefits to you (i.e., Impacted Canine Exposure).
   b. We will give you an estimate of necessary treatment and our fees and we will gladly send a predetermination claim to your insurance company.
   c. It will be up to you to determine if you wish to proceed with treatment before the insurance benefit is determined or after predetermination is returned.

4. **Fillings:**
   a. Our dental material of choice for "fillings" is a white filling, also known as composite resin.
   b. Please understand that some insurance companies do not pay for a white filling (composite resin) at the same level as a silver filling (amalgam). The co-payment is your responsibility.
   c. In some cases, when the cavity is too large to be restored with a composite resin, the tooth will need to be crowned
      i. We use silver stainless steel crowns or white zirconia crowns.
      ii. If the tooth requires nerve treatment (pulpotomy or pulpectomy), the tooth will need to be crowned with a silver stainless steel crown.

5. **Nitrous Oxide:**
   a. Nitrous oxide is an inhalational sedation technique often used by pediatric dentists.
      i. Nitrous oxide is a slightly sweet smelling inert gas that induces a sense of well- being and relaxation.
      ii. It is very safe, perhaps the safest sedative agent in dentistry.

iii. It is non-addictive. It is mild, easily taken, and then quickly eliminated by the body.
iv. Your child remains fully conscious and keeps all natural reflexes when breathing nitrous oxide/oxygen.
v. Nitrous oxide is not always covered by dental insurance.

6. **Oral Sedation:**
    a. Conscious sedation is a management technique that uses medications to assist the child to cope with fear and anxiety and cooperate with dental treatment
    b. Who should be sedated?
        i. Children who have a level of anxiety that prevents good coping skills or are very young and do not understand how to cope in a cooperative fashion for the delivery of dental care should be sedated.
        ii. Conscious sedation is often helpful for some children who have special needs.
    c. Oral sedation is not always covered by dental insurance. We thank you for the payment the day you schedule your child's oral sedation appointment.

7. **Appliances:**
    a. The cost of the appliance (space maintainer) is due the day the impression is taken. This is necessary because our office must pay for the lab fees when appliances are ordered, not when they are completed.
    b. Space maintainers are not always covered by dental insurance.

8. **Emergency Treatment:**
    a. All emergency treatment must be paid in full at the time the service is rendered.
    b. If an emergency occurs after normal business hours, an "After Hours Office Visit Fee" will be charged.

Please remember, even if you have insurance coverage, you are responsible for payment of your account. Please realize that insurance coverage is a relationship between you, the insured patient, and your insurance company. Your understanding and cooperation with this matter is greatly appreciated.

I have read and understand my financial obligation to Southern Village Pediatric Dentistry.

Legal Guardian's Signature_____Date:_____

SOUTHERN VILLAGE PEDIATRIC DENTISTRY APPOINTMENT POLICY

- A parent or legal guardian must accompany any child under the age of 18 and ***is required to be present in the office at all times*.**

- Parents are welcome back for the initial dental visit and for all preventative visits. *For all* ***restorative visits****, it is the philosophy of Southern Village Pediatric Dentistry that* ***parents wait for their children in the waiting room***. We find that children's independence is fostered in such an atmosphere.

- ***All restorative (fillings, extractions, etc.) procedures are scheduled in the morning.*** Children, as well as adults, are more prepared and do better in the morning for these types of procedures.

- Broken or missed appointments affect many people. If two broken or missed preventative appointments occur, *or two are cancelled with 24-hours or less notice*, our office reserves the right to dismiss the patient from our care or charge a **$40.00 broken appointment fee.**

    - *Due to the large amount of time reserved and amount of set up required,* ***Restorative appointments missed or cancelled with notice of 24 hours or less*** *are subject to an immediate* ***$40 broken appointment fee or dismissal of patient.***

- Please plan to arrive 10-15 minutes or more before your scheduled appointment. This will allow time for parking and to complete any additional paperwork required. ***If you arrive 10-15 minutes late for your appointment, you may be asked to reschedule for the next available appointment time.***

- We strive to see all patients on time for their scheduled appointment. There are times when our schedule is delayed in order to accommodate an injured child or an emergency. Please accept our apology in advance should this occur during your appointment. *We will do the exact same if your child is in need of emergency treatment.*

- The American Association of Pediatric Dentistry and Dr. Hardin recommend a preventative appointment for your child *every 6 months*. Preventative appointments allow Dr. Hardin to check your child's teeth, gums and help prevent dental decay.

- For your safety and the safety of our patients and staff we respectfully request that no food, drink, or cell phones be used in the office.

I have read and understand the appointment policy.

Legal Guardian's Name _____

Signature_____Date:_____

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INSURANCE INFORMATION

If you have dental insurance and would like help in completing a standard ADA claim form to submit for reimbursement from your insurance company, complete the information listed below.

Policy Holder Name_____
First Last Middle Initial Date of Birth

Home Address _____
Street City State Zip

Policy Holder SSN and/or Member ID #_____

Relationship to Patient_____

Employer Name _____

Insurance Company Name _____

Group # (if applicable) _____

Phone Number of Insurance Company _____

Address to Mail Dental Claims To:

_____
Street/P.O. Box

_____
City State Zip Code

410 Market Street, Suite 430 ● Chapel Hill, NC ● 27516
Office (919) 967-2773 ● Fax (919) 967-2774 ● www.southernvillagepedo.com