ALFORD PEDIATRIC & GENERAL DENTISTRY

Child's Name _____ Date of Birth_____ Sex M F

DENTAL

Y N Is this your child's first dental visit? If no, when was the last visit and by whom?_____

Y N When does your child brush his/her teeth? ☐ Morning ☐ Between Meals ☐ Bedtime

Y N Do you or someone supervise the brushing?_____

Y N Does your child floss? _____

What type of water do you use? ☐ City ☐ Well ☐ Bottled

Y N Does your child currently use a bottle or breast feed? If no, at what age did they stop? _____months

Y N Does your child usually have a sippy cup between meals?

Does your child consume any of the following on a daily basis? (check all that apply)

☐ Soda ☐ Juice ☐ Chips ☐ Crackers/Dry Cereal ☐ Candy/Gum

Y N Does your child suck a thumb or finger, use a pacifer, chew on fingernails or other materials?

Are there any specific dental concerns you would like us to address?_____

MEDICAL

Please answer every question

Y N Does your child have a Doctor (Pediatrician)? Name: _____

Phone:_____

Y N Are your child's vaccinations current?

Y N **Does your child take a medication?**

Y N **Does your child have any allergies to medication, food, latex or other materials?**

Y N Has your child ever been admitted to a hospital, had surgery or a serious illness or injury?

Does your child have a history of any of the following (circle all that apply):

Y	N	Heart Murmur	Y	N	Bleeding Disorders
Y	N	Heart Disease	Y	N	Anemia
Y	N	Asthma	Y	N	Transfusions
Y	N	Reactive Airway Disease	Y	N	HIV
Y	N	Tuberculosis	Y	N	Immuno-compromised Conditions
Y	N	Epilepsy	Y	N	Diabetes
Y	N	Seizures	Y	N	Lupus
Y	N	Cerebral Palsy	Y	N	Arthritis
Y	N	Convulsions	Y	N	Autoimmune Diseases
Y	N	Shunts	Y	N	Premature Birth
Y	N	Sight Concerns	Y	N	Liver Disease (hepititis, jaundice, etc)
Y	N	Hearing Concerns	Y	N	Kidney Concerns (Stones)
Y	N	Speech Concerns	Y	N	Stomach/GI Concerns
Y	N	Cancer (Leukemia, Tumors)	Y	N	Skin/Bone/Muscle Disorders
Y	N	Attention Disorders (ADD, ADHD, etc)	Y	N	Snoring
Y	N	Sensory Disorders (Autisum Spectrum)			

Y N Any other conditions we should be made aware of: _____

If you anwered Yes to any of the above questions, please explain: _____

_____

_____

_____

_____ _____ _____

Guardian Signature Date Relationship to Child

ALFORD PEDIATRIC & GENERAL DENTISTRY

Patient Information Form

Patient's Full Name_____*Called*_____

Birth Date _____Sex: ☐ M ☐ F School the child attends_____

How did you hear about us? _____

Orthodontist _____Siblings Treated Here (if any) _____

Parent/Legal Guardian Information

Mother's Full Name (*if different from patient*)_____D.O.B._____

Street Address _____

City_____ State_____ Zip_____ Home #_____

Employer_____ Work #_____**Cell#**_____

Father's Full Name_____ D.O.B._____

Street Address (*if different from patient*)_____

City_____ State_____ Zip_____ Home #_____

Employer_____ Work #_____Cell#_____

Email Addresses: _____

We are delighted you have chosen our office for your child's dental care. We have implemented the following office and financial policies to better serve you and your child. Please read them carefully, and let us know if you have any questions or concerns.

OFFICE POLICIES

We allow only one parent in the examination room with your child. Siblings or other family members will be asked to remain in the reception room. This will help us provide the safest and most effective dental care for your child.

Any patient that has not been seen in our office within a Three-year span will become inactive and if seen again, will be considered a new patient. Our established recall patients will be seen until the ages of 19, with some exceptions for special needs patients.

If you have to cancel or reschedule an appointment, we request that you call our office **at least 48 hours prior** to the scheduled appointment time. This will enable us to contact other patients on our waiting list, some of whom are **in pain** and could take advantage of your appointment time if proper notification is given by you. A broken appointment charge of $25.00 will be made for failure to keep an appointment unless we are contacted **at least 24 hours in advance.**

If an emergency arises and you cannot keep your scheduled appointment, we ask your courtesy in notifying us **immediately**.

We continually strive to stay on schedule and see your child at his/her appointed time. In order to do this, we ask patients arriving **more than 15 minutes** late to reschedule their appointment unless the next appointment time slot is available.
Any child that has missed 3 consecutive appointments without proper notification will be dismissed from the practice.

I hereby authorize payment directly to the attending dentist for the group insurance benefits otherwise payable to me. I authorize the dentist to release any information acquired in the course of treatment or examination. I understand that responsibility for payment for dental services provided in the office for my dependents is mine, due and payable at the time services are rendered. I further understand that a 1.5% finance charge or a $5.00 billing fee (whichever is greater) will be added to any balance over 60 days. In the event of default, I understand there will be a 30% collection cost and reasonable attorney fees required to effect collection of the note. Please check with the front business office regarding which insurances Alford Pediatric and General Dentistry is in network with as well as what forms of payment are accepted or if this policy has changed.

Signature of Parent or Legal Guardian_____

Please Print Name _____ **Date** _____

ALFORD PEDIATRIC & GENERAL DENTISTRY

Insurance Information

PATIENT INFORMATION

Name (Last, First, MI):_____ DOB: _____

Gender: ☐ Male ☐ Female Social Security #:_____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Home Phone #:_____ Work #:_____ Cell #:_____ Other #:_____

Email Address:_____ Is it OK to Text and/or email you? ☐ YES ☐ NO Initials_____

Address: _____ City:_____ State:_____ Zip:_____

Employer: _____ Occupation:_____ Work #:_____

Have you or any member of your family been a patient at this office before? ☐ YES ☐ NO

If yes, please give us their name(s): _____

Who may we thank for recommending our office to you?_____

Otherwise, how did you learn about our practice? ☐ Google ☐ Radio ☐ Facebook ☐ Other _____

ACCOUNT RESPONSIBLE PARTY

Person responsible for Account:_____ Currently a patient in our office? ☐ Yes ☐ No

Social Security #:_____ DOB:_____ Drivers License:_____ State:_____

Home Phone #:_____ Cell #:_____ Other #:_____ Email:_____

Address: _____ City:_____ State:_____ Zip:_____

PRIMARY DENTAL INSURANCE

Insured's Name:_____ DOB:_____ Relation to Patient:_____

Social Security #:_____ Member ID:_____ Effective Date:_____

Insurance Carrier:_____ Phone #:_____ Employer:_____

Group/Policy #: _____ Union/Group Name:_____ Local #:_____

SECONDARY DENTAL INSURANCE

Insured's Name:_____ DOB:_____ Relation to Patient:_____

Social Security #:_____ Member ID:_____ Effective Date:_____

Insurance Carrier:_____ Phone #:_____ Employer:_____

Group/Policy #: _____ Union/Group Name:_____ Local #:_____

ALFORD PEDIATRIC & GENERAL DENTISTRY

6255 Sharlands Ave, Ste 3
Reno, NV 89523
(775) 339-3015
alfordsmiles.com

FINANCIAL POLICY

Payment for dental services is due at the time treatment is provided. If you have insurance, this payment typically includes the deductible, applicable coinsurance, and services not covered by your plan. We accept cash, personal checks, debit cards, and most major credit cards.

As a service to our patients we accept most, but not all, dental insurance programs. If we have received all of your insurance information on the day of the appointment, we will be happy to file your claim for you. You will be responsible for paying in full all services rendered if we are unable to verify your insurance information before treatment. We file all insurance electronically, so your insurance company will receive each claim within days of the treatment. Insurance payments are ordinarily received within 30 days from the time of filing a claim. You are responsible for any balance on your account after 30 days. If you have not paid your balance within 60 days, a re-billing fee of 1.5% will be added to your account each month until the outstanding balance is paid. We will be glad to send a refund to you if your insurance pays us. If for any reason the account is turned over to an attorney or collection agency for collection, an additional charge of 33-1/3% will be added to cover collection costs.

We strive to maximize your insurance benefits, but ultimately you are responsible for payment regardless of any insurance company's arbitrary determination. Please be aware that some or perhaps all of the services provided may or may not be covered by your insurance policy. The benefits paid by your insurance company are subject to eligibility, maximums, deductibles, limitations, and exclusions, which affect your patient portion.

You must be familiar with your insurance benefits. We will do our best to give you a rough estimate of patient co-payments and co-insurance balances, which will be collected at the time treatment is provided.

PLEASE UNDERSTAND that we file dental insurance as a courtesy to our patients. Your dental plan policy is a contract between you and your insurance company. We do not have a contract with your insurance company. Your plan and payment is your responsibility. We are not responsible for how your insurance company handles its claims, or for what benefits they pay on a claim. We do not guarantee what your insurance will or will not do with each claim. A plan is not a guarantee of payment; it often does not cover all the costs involved in treatment. We are not responsible for any errors in filing your insurance.

Our practice is dedicated to quality care and exceptional service. Our doctors and team spend extensive amounts of time preparing for your visit. Broken and missed appointments create scheduling problems for our team as well as other patients. If you find that you must change your appointment, we require a minimum of 48 hours notice so that we may make every effort to accommodate other patients. If proper notice is not received, we reserve the right to charge a fee of $50.00 for every hour of allotted time canceled. We may also require deposits for future appointments.

I understand that I (or my child) am electing to be seen by Dr. Jacqueline Alford or Dr. Jason Alford today. I have read, understand, and agree to the above terms and conditions. I understand that I am responsible for payment for dental services provided in this office and any remaining balances on my (or my child's) account after 30 days, and may be charged for a violation of the policies as set forth above.

_____ _____

Patient/Legal Guardian Signature Date

ALFORD PEDIATRIC & GENERAL DENTISTRY

TREATMENT OF MINOR CHILDREN
Parent/Legal Guardian Consent for Dental Treatment

6255 Sharlands Ave, Suite3
Reno, NV 89523
865-558-8857 (Phone)

_____ _____
Child's Name Date of Birth

I authorize the above child is legally under my care and I am able to make medical/dental decisions for him/her.

_____ _____ _____
Parent/Legal Guardian Contact (Print) Signature Date

Parental contact information for questions regarding treatment of the child:

Contact info: (Primary Phone) _____ (Secondary Phone) _____

(Email Address) _____

I give my authorization for all dental treatment, for the above named child, which may be required with or without my presence. I agree to pay for all services rendered to my child. This may include, but not limited to prophy (cleanings), fluoride treatments, diagnostic radiographs, examination, composite fillings, sealants and extractions. If additional treatment is needed, Alford Pediatric and General Dentistry has my permission to perform that treatment regardless of my presence in the office with consent from the guardian bringing in my child.

In the event of an emergency, Alford Pediatric and General Dentistry and staff have my permission to take any and all necessary steps to ensure the safety and well-being of my child.

I understand and agree to Alford Pediatric and General Dentistry's Treatment of Minor Consent Form and its terms. This authorization will remain in effect until I revoke this authorization in writing and submit it to Alford Pediatric and General Dentistry prior to this date.

Printed Name of Guardian: _____
Signature of Guardian: _____ Date _____
Relationship to Patient: _____

Alford Pediatric and General Dentistry understands that from time to time you may not be able to bring your child to their dental appointment. This consent gives us the permission to treat your child (children) while you are not present.

As legal guardian of the above child, I am allowing the following people to act as my child's guardian to make medical/dental decisions.

_____ _____
Person Acting as Guardian Relationship to Patient

_____ _____
Person Acting as Guardian Relationship to Patient

ALFORD PEDIATRIC & GENERAL DENTISTRY

AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient _____ Date of Birth _____

ALFORD PEDIATRIC AND GENERAL DENTISTRY is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions. Description of information to be released could be, but not limited to the following: Appointment times, Billing Information, Insurance Information, Treatment Plans, Medical Information, School Excuses, K-12 Release Information.

Mode to Receive Information (Approve each mode that you authorize to receive information)

Y / N CELL PHONE (and text)

Y /N VOICEMAIL

Y /N EMAIL

Y /N POSTAL MAIL

Entity to Receive Information (Approve each person/entity that you authorize to receive information)

Y / N CHILDS'S SCHOOL Name of School: _____

Y / N PARENT (MOTHER)

Y / N PARENT (FATHER)

Y / N LEGAL GUARDIAN OR OTHER (ex. Grandparent) Name:_____

Y / N PEDIATRICIAN Name of Doctor: _____

Rights of the Patient

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Alford Pediatric and General Dentistry.

I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY CHILD'S HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

I HAVE ACKNOWLEDGED THAT I HAVE RECEIVED A COPY OR WAS ABLE TO READ A COPY OF THE ALFORD PEDIATRIC AND GENERAL DENTISTRY'S NOTICE OF PRIVACY PRACTICES IF REQUESTED.

_____ Date: _____

Signature of Parent, Legal Guardian, or Personal Representative

Relationship to Patient _____ Printed Name _____

NOTICE OF PRIVACY PRACTICES

As required by the Privacy Regulations Promulgated Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) 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.

Please review this Notice carefully. The privacy of your health information is important to us. This Notice takes effect September 1, 2019, and will remain in effect until we replace it. We may update our privacy practices and the terms of this Notice at any time, subject to applicable law. You may request a copy of this Notice at any time.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to another dentist or other healthcare provider providing treatment to you, or to family and friends you approve. We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for services may require that your relevant protected health information be disclosed to your insurance company.

Healthcare Operations: We may use and disclose your 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 health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for <u>any purpose</u>. You also have the right to request restrictions on disclosure of PHI (Personal Health Information), or alternative means of communication to ensure privacy. Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object, unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or this organization has taken an action in reliance on the use or disclosure indicated in the authorization.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law or national security activities.

Abuse or Neglect: We may disclose your health information to appropriate authorities when we suspect abuse or neglect.

Contacting You: We may use or disclose your health information to contact you about appointments and other matters, and to send you billing statements. We may contact you by mail, email, and telephone, and may leave messages at the telephone number you give us.

PATIENT RIGHTS

Access: You have the right to inspect or copy your health information, with limited exceptions. If you request copies, we may charge you fees for expenses such as copies, staff time, and postage.

Amendment: You have the right to request that we amend your health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information, including uses or disclosures for treatment, payment, and health care operations, and to family members, friends, or others involved in your care or payment for your care. You must submit a written request that is signed and dated to the Privacy Officer at 6255 Sharlands Avenue, Suite 3, Reno, NV 89523. We are not required to agree to these additional restrictions, but if we do we will abide by our agreement (except in certain situations, such as to provide you with emergency treatment). You have a right to use another healthcare professional.

Means of Communication: You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, e.g., electronically.

Accounting: You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

Changes: We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us by contacting our Privacy Officer. You also may submit a written complaint to the U.S. Department of Health and Human Services. Upon request, we will provide you with the address to file your complaint.

We support your right to the privacy of your health information, and are required by law to maintain the privacy of protected health information. We will not retaliate in any way if you choose to file a complaint with us with the U.S. Department of Health and Human Services. A Privacy/Contact Officer has been designated for this office.

Privacy Officer Contact Information: 6255 Sharlands Avenue, Suite 3, Reno, NV 89523
(775) 339-3015

ALFORD PEDIATRIC &
GENERAL DENTISTRY

6255 Sharlands Avenue, Suite 3
Reno, NV 89523
(775) 339-3015

PATIENT ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

I, _____, acknowledge that I have received a written copy of Alford Pediatric & General Dentistry's ("Alford Dental") NOTICE OF PRIVACY PRACTICES.

I consent to the use and disclosure of my (and/or my child's) personal health information by Alford Dental for Treatment, Payment, Healthcare Operations, and pursuant to applicable law and/or further approval, as outlined in the NOTICE OF PRIVACY PRACTICES.

_____ _____

Signature of Patient/Parent/Legal Guardian Date

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ALFORD PEDIATRIC & GENERAL DENTISTRY

Consent to use photographs

6255 Sharlands Ave, Suite 3
Reno, NV 89523
775-339-3015 (Phone)

ALFORD PEDIATRIC AND GENERAL DENTISTRY PHOTO RELEASE FORM

I hereby grant Alford Dental, PLLC ("Alford Pediatric and General Dentistry") permission to use my child's (children's) likeness in a photograph, video, or other digital media ("photo") in any and all of its publications, including web-based publications and educational materials, without payment or other consideration.

I understand and agree that all photos will become the property of Alford Pediatric and General Dentistry and will not be returned.

I hereby irrevocably authorize Alford Pediatric and General Dentistry to edit, alter, copy, exhibit, publish, or distribute these photos for any lawful purpose. In addition, I waive any right to inspect or approve the finished product wherein likeness appears.

I hereby hold harmless, release, and forever discharge Alford Pediatric and General Dentistry from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

I HAVE READ AND UNDERSTAND THE ABOVE PHOTO RELEASE. I AFFIRM THAT I AM THE LEGAL GUARDIAN OF THE NAMED CHILD (CHILDREN). I ACCEPT:

Patient(s) name: _____

Printed Name of Guardian:_____

Signature of Guardian: _____ Date _____