dr. garrett
PEDIATRIC DENTISTRY

Parent/Guardian Information:

Parent/Guardian #1	Parent/Guardian #2
Name:	Name:
Date of Birth: SSN#:	Date of Birth: SSN#:
Address:	Address:
City, State, Zip:	City, State, Zip:
Home Phone:	Home Phone:
Cell Phone:	Cell Phone:
E-mail:	E-mail:
Occupation:	Occupation:
How did you hear about our office?	

Insurance Information:

Person #1	Person #2
Insurance Company Name:	Insurance Company Name:
Employer:	Employer:
Subscriber ID# or SSN:	Subscriber ID# or SSN:
Group Name:	Group Name:
Group Number:	Group Number:

Additional Questionnaire (For Insurance Purposes):

Parents Marital Status: Single Married Widowed

Divorced With Whom Does Child Reside? _____

Who Has Custody? _____

Do parents and child/children all live together? Yes No

Patient Information:

Child Name	DOB	Male/Female/ Other	Hobbies	Dental Concerns	Last Dental Visit
		M F O			
		M F O			
		M F O			
		M F O			
		M F O			
		M F O			

I authorize routine dental diagnostic procedures for my child. If I accept the proposed treatment plan for my child after examination, I also agree to the use of medications considered necessary or advisable by the dentist for the comfort and well-being of my child.

I understand that the office will bill my insurance as a courtesy to me. The office will do its best to collect from my carrier. I authorize insurance payments be issued to Dr. Garrett Pediatric Dentistry. I also understand that I am ultimately responsible for knowing my benefit information and for any and all account balances. All past due balances are subject to a finance charge of 1.5% per month, which is an annual rate of 18%. Account is also subject to all legal/collection expenses. Cancellation fees may apply without 48 hours of notice. There is a $50 fee for returned checks.

Parent/Guardian Signature: _____ Date: _____

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Medical History

Child's Full Name: _____ Nickname: _____
Gender: ❑M ❑F Race/Ethnicity: _____ Weight: _____
Name/address/phone of primary physician: _____

- Is your child being treated by a physician at this time? ❑ YES ❑ NO
  Reason _____
- Is your child taking any medication (prescription or over the counter), vitamins, or dietary supplements? ❑YES ❑NO
  List name, dose, frequency & date started:_____
- Has your child ever been hospitalized, had surgery or a significant injury, or been treated in an emergency department? ..... ❑ YES ❑ NO
  List date & describe: _____
- Has your child ever had a reaction to or problem with an anesthetic? ..... ❑ YES ❑ NO
  Describe _____
- Has your child ever had a reaction or allergy to an antibiotic, sedative, or other medication? ..... ❑ YES ❑ NO
  Describe _____
- Is your child allergic to latex or anything else such as metals, acrylic, or dye? ..... ❑ YES ❑ NO
  List _____
- Is your child up to date on immunizations against childhood diseases? ..... ❑ YES ❑ NO

Is there any other significant medical history pertaining to this child or his/her family that the dentist should be told? ..... ❑ YES ❑ NO
If YES, describe _____

Dental History

Has your child ever had a difficult dental appointment? ❑ YES ❑ NO

- If yes, please describe: _____

How do you expect your child will respond to dental treatment?

❑ Very well ❑ Fairly Well ❑ Somewhat poorly ❑ Very poorly

Is there anything else we should know before treating your child? _____

_____

_____ _____ _____ _____
Signature of parent/guardian Relationship to child Date Dr. Garrett Lee signature

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Office Policies

1. I understand that Dr. Garrett Pediatric Dentistry will bill my dental insurance as a courtesy but ultimately I am responsible for all charges should my insurance company not pay for any reason. I also understand that my portion is due at the time treatment is rendered. I hereby authorize payment of dental benefits to Garrett Lee, DDS. _____ initials

2. We strive to respect your time, being so, we respectfully require 48 hours notice to cancel or reschedule appointments. Families with three broken appointments within a twelve month period will be eligible for emergency care only for a period of one month after the third broken appointment. An appointment is considered broken if the patient (1) does not show up for the appointment, (2) arrives more than 15 minutes late, or (3) cancels the appointment with less than 48 hours notice. _____ initials

3. I have received, read and agree to support the practice terminology. In the event of a scheduled treatment appointment, I also agree to uphold the parent guidelines provided. _____ initials

Name _____

Signature _____

Date _____

Notice of Privacy Practices

This Notice describes how your health information 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

Federal and state laws require us to maintain the privacy of your health information. We are also required to provide this Notice about our office's privacy practices, our legal duties, and your rights regarding your health information. We are required to follow the practices that are outlined in this Notice while it is in effect. This Notice takes effect December 1, 2015, 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 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. For more information about our privacy practices or additional copies of this Notice, please contact us (contact information below).

Uses and Disclosures of Health Information

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

For example:

Treatment:
We disclose medical information to our employees and others who are involved in providing the care you need. We may use or disclose your health information to another dentist or other healthcare providers providing treatment that we do not provide. We may also share your health information with a pharmacist in order to provide you with a prescription, or with a laboratory that performs tests or fabricates dental prostheses or orthodontic appliances.

Payment:
We may use and disclose your health information to obtain payment for services we provide you, unless you request that we restrict such disclosure to your health plan when you have paid out-of-pocket and in full for services rendered.

Healthcare Operations:
We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include, but are not limited to, 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 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 is in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends:
We must disclose your health information to you, as described in the Patient Rights section of this Notice. You have the right to request restrictions on disclosure to family members, other relatives, close personal friends, or any other person identified by you.

Unsecured Email:
We will not send you unsecured emails pertaining to your health information without your prior authorization. If you do authorize communications via unsecured email, you have the right to revoke the authorization at any time.

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 care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. 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 healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your 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 Services:
We may contact you about products or services related to your treatment, case management or care coordination, or to propose other treatments or health-related benefits and services in which you may be interested. We may also encourage you to purchase a product or service when you visit our office. If you are currently an enrollee of a dental plan, we may receive payment for communications to you in relation to our provision, coordination, or management of your dental care, including our coordination or management of your health care with a third party, our consultation with other health care providers relating to your care, or if we refer you for health care. We will not otherwise use or disclose your health information for marketing purposes without you written authorization. We will disclose whether we receive payments for marketing activity you have authorized.

Change of Ownership:
If this dental practice is sold or merged with another practice or organization, your health records will become the property of the new owner. However, you may request that copies of your health information be transferred to another dental practice.

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

Public Health:
We may, and are sometimes legally obligated, to disclose your health information to public health agencies for purposes related to preventing or controlling disease, injury or disability; reporting abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. Upon reporting suspected elder or dependent adult abuse or domestic violence, we will promptly inform you or your personal representative unless we believe the notification would place you at risk of harm or would require informing a personal representative we believe is responsible for the abuse or harm.

Abuse or Neglect:
We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your 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 institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Appointment Reminders:
We may contact you to provide you with appointment reminders via voicemail, postcards, or letters. We may also leave a message with the person answering the phone if you are not available.

Sign In Sheet and Announcement:
Upon arriving at our office, we may use and disclose medical information about you by asking that you sign an intake sheet at our front desk. We may also announce your name when we are ready to see you.

Patient Rights

Access:
You have the right to look at or get copies of your 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 health information. You may obtain a form to request access by contacting our office. 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. If you request copies, there may be a charge for time spent. If you request an alternate 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 for a full explanation of our fee structure.

Disclosure Accounting:
You have a right to receive a list of instances in which we disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities for the last six years. 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.

Restriction:
You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in emergency). In the event you pay out-of-pocket and in full for services rendered, you may request that we not share your health information with your health plan. We must agree to this request.

Alternative Communication:
You have the right to request that we communicate with you about your 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 of how payments will be handled under the alternative means or location you request.

Breach Notification:
In the event your unsecured protected health information is breached, we will notify you as required by law. In some situations, you may be notified by our business associates.

Amendment:
You have the right to request that we amend your 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.

Questions and Complaints:
If you want more information about our privacy practices or have questions or concerns, please contact us at:

Contact: Garrett Lee, DDS

Telephone: (916) 905-6120 Fax: (916) 896-1671

E-mail: office@drgarrett.com

Address: 8241 Bruceville Road Suite #180, Sacramento, CA 95823

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 send a written complaint to our office or to the U.S. Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Acknowledgement of Receipt of Notice of Privacy Practices

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of the Dr. Garrett Pediatric Dentistry Notice of Privacy Practices.

[Please Print Name] _____

[Signature] _____

[Date] _____

If this Acknowledgement is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's name _____

Relationship to Patient _____

For Program Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

D Individual refused to sign

D Communications barriers prohibited obtaining the acknowledgement

D An emergency situation prevented us from obtaining acknowledgement

D Other (Please Specify) _____