DAYSPRING DENTAL

DATE: _____

CHILD|PATIENT INFORMATION

Patient's Name: _____ Preferred Name: _____

D.O.B: _____ Gender: _____ Social Security #: _____

Street Address: _____ City: _____

State: _____ Zip Code: _____

School Currently Attending: _____ Grade Level: _____

PARENT|LEGAL GUARDIAN INFORMATION

Parent/Legal Guardian (Full Name): _____ D.O.B: _____

Relationship: _____ Cell Phone #: _____

Email: _____

Employer: _____ Years Held: _____

Present Work Position: _____ Work Phone #: _____

Business Address: _____ City: _____

State: _____ Zip Code: _____

Parent/Legal Guardian (Full Name): _____ D.O.B: _____

Relationship: _____ Cell Phone #: _____

Email: _____

Employer: _____ Years Held: _____

Present Work Position: _____ Work Phone #: _____

Business Address: _____ City: _____

State: _____ Zip Code: _____

PREFERRED METHOD OF CONTACT (Please circle all that apply below)

Home Phone Cell Phone Text Email

DAYSPRING DENTAL

INSURANCE INFORMATION

Primary Company: _____ Policy/Group #: _____

Policy Holder: _____ D.O.B: _____

Policy Holder SS/ID #: _____

Address Of Company: _____ Phone #: _____

_____

Secondary Company: _____ Policy/Group #: _____

Policy Holder: _____ D.O.B: _____

Policy Holder SS/ID #: _____

Address Of Company: _____ Phone #: _____

_____

Who will pay this account? _____

HOW DID YOU HEAR ABOUT US? (Please circle all that apply below)

Website Drive By Facebook Health Provider Friend Other

- Please specify: _____

DAYSPRING DENTAL

CHILD|PATIENT INFORMATION

Patient's Name: _____ Current Age: _____

What are your child's hobbies or interests? _____

What are some of your child's favorite TV shows? _____

HEALTH PROVIDER

Child's Physician/Pediatrician: _____ Phone #: _____

Mailing Address: _____ City: _____

State: _____ Zip: _____

Preferred Pharmacy: _____

DENTAL INFORMATION

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

Are there any specific concerns you may have? _____

Is this your child's first dental visit? Y N

- If no, when was your child's last dental exam? _____

last dental cleaning? _____

last dental x-rays? (if taken) _____

Have you been informed of any missing or extra permanent teeth? Y N

Has your child ever had an orthodontic examination and/or treatment? Y N

Is your child nervous or frightened prior/during dental visits? Y N

- If yes, please circle: Least Nervous 0 1 2 3 4 5 Most Nervous

Has your child had any unfavorable medical or dental experience? Y N

- If yes, please explain: _____

What are you looking for most in choosing a dentist for your child? _____

Have there been any injuries to the face, mouth or teeth? Y N

- If yes, please describe: _____

Past/Present finger and/or thumb sucking, pacifier habit? Y N

- If yes, please specify and until what age? _____

Any other oral habits? _____

DAYSPRING DENTAL

DENTAL INFORMATION (CONT)

Does your child use a sippy cup? Y N

Does your child go to bed nursing, using a bottle or sippy cup? Y N

- If previously, until what age? _____

DOES YOUR CHILD OR HAS YOUR CHILD EXPERIENCED ANY OF THE FOLLOWING?

Daytime Mouth Breathing	Y	N	Nighttime Mouth Breathing	Y	N
Tooth Grinding	Y	N	Snoring	Y	N
Hearing Deficiency	Y	N	Bedwetting	Y	N
Frequent Middle Ear Infections	Y	N	Restless Sleep	Y	N
Speech Problems	Y	N	History of Sleep Apnea	Y	N
Environmental Allergies	Y	N			

FLUORIDE INFORMATION

For most drinking/cooking do you use (please circle): Town Water Well Water Bottled Water

- If well or bottled, has water been tested for fluoride? Y N

Does your child take fluoride supplements? Y N

- If yes, Dose _____ Frequency _____

MEDICAL INFORMATION

Is your child in good health? Y N Date of last physical exam: _____

Has your child had any serious illness or injury? Y N

- If yes, please specify: _____

Has your child ever been hospitalized or had surgery? Y N

- If yes, DATE: _____ REASON: _____

DATE: _____ REASON: _____

Have your child's tonsils and/or adenoids been removed? Y N

- If yes, please specify: _____

Has your child experienced abnormal bleeding with extractions, surgery or trauma? Y N

Is your child allergic to anything? Y N

- If yes, please specify: _____

DAYSPRING DENTAL

MEDICAL INFORMATION (CONT)

Is your child taking any medications? Y N

- If yes, please specify medication, dose and reason: _____

_____

Does your child take any vitamins, supplements? Y N

- If yes, please specify: _____

Does your child have any mental or physical disabilities? Y N

- If yes, please specify: _____

Have you ever been told that your child needs to take antibiotics before dental treatment? Y N

DOES YOUR CHILD HAVE OR HAS YOUR CHILD HAD ANY OF THE FOLLOWING?

Acid Reflux	Y	N	Jaundice	Y	N
ADD/ADHD	Y	N	Kidney Disease/Problems	Y	N
AIDS	Y	N	Learning Problems	Y	N
Asthma/Breathing Problems	Y	N	Liver/GI Disease/Problems	Y	N
Birth Defects	Y	N	Mental/Emotional Problems	Y	N
Bone Disorders	Y	N	Mononucleosis	Y	N
Behavior Problems	Y	N	Recurrent Headaches	Y	N
Congenital Heart Lesions	Y	N	Rheumatic Fever	Y	N
Diabetes	Y	N	Seizures	Y	N
Fainting Spells	Y	N	Stomach Ulcers	Y	N
Growth Problems	Y	N	Sickle Cell Disease/Trait	Y	N
Heart Disease	Y	N	Sinus Problems	Y	N
Heart Murmur	Y	N	Thyroid Problems	Y	N
Hepatitis	Y	N	Tuberculosis	Y	N

- If you answered YES to any of the medical conditions listed, please describe further: _____

_____

DAYSPRING DENTAL

FINANCIAL ARRANGEMENTS AND DENTAL INSURANCE

We are committed to providing you with the best possible care. If you have dental insurance, we are eager to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy.

Payment of services is due at the time services are rendered. If you have dental insurance, you must make the estimated co-payments at the time of treatment, and you are completely responsible for anything the insurance company does not want to pay within 45 days after billing. We accept cash, personal checks, Visa, Mastercard, Discover and American Express. We also offer Care Credit, interest free financing for your choice of 3, 6, 12, or 18 months upon qualifying. Please ask for an application if you are interested. Returned checks or balances older than 30 days may be subject to additional collection fees. Charges may also be made for missed appointments and appointments canceled without 24 hours advance notice.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize however, that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a Party to that contract.

2. Not all services are a covered benefit in all contracts. Some insurance companies select services they will not cover. You become financially responsible for these services.

3. Please be advised that this office does not place silver fillings in posterior (back) teeth. We only place white composite filling material, 99% of all insurance companies only allow for amalgam (silver) filling material, but will pay an alternate benefit for the silver. This means you, the patient then becomes responsible for any difference.

4. In cases of divorce or separation with children involved it is our office policy that the parent who has residential custody is responsible for paying any co-payment and/or deductible at the time of service. If insurance is involved and they pay less than expected, again the parent with residential custody is responsible for the balance. We will give the parent receipts to obtain reimbursement from other parties involved.

DAYSPRING DENTAL

FINANCIAL ARRANGEMENTS AND DENTAL INSURANCE (CONT)

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. The filing of insurance claims is a courtesy we extend to our patients; all charges are your responsibility from the date services are rendered. If financial problems do arise we encourage you to contact our office promptly so that we may help you with the management of your account.

Again, thank you for selecting Dayspring Dental for your dental needs. If at any time you have a question regarding your treatment, fees or services, please contact us promptly to discuss.

By signing this paper you agree to and fully understand our payment policy.

_____ _____

Signature Date

If you have dental insurance please sign and date below as "Signature on File" so that we may manually or electronically submit your dental claims on your behalf.

_____ _____

Signature Date

DAYSPRING DENTAL

PAYMENT OPTIONS

We feel that it is very important for us to provide you with the treatment that is wanted and needed, therefore, we have several payment options available for your convenience. Please indicate which option(s) will work best for you.

INSURANCE:

- ▢ I do not have insurance to cover your fees.
- ▢ I have insurance coverage and would like you to file my claim and charge me for my estimated portion at the time of service.
- ▢ I have insurance coverage and will pay you directly then file my own claims for reimbursement.

OTHER PAYMENT:

I recognize that I am responsible for all fees related to my treatment. For that portion not covered by my insurance I will pay by:

- ▢ Cash or Check
- ▢ Visa, MasterCard, American Express, Discover or Debit Card
- ▢ Care Credit
    - ▢ I have one, my account # is _____
    - ▢ I wish to apply
- ▢ Lending Club
    - ▢ I have one, my account is # is _____
    - ▢ I wish to apply

_____ _____ _____

Patient's Name (Please Print) Signature Date

DAYSPRING DENTAL

MAY WE SHARE YOUR PHOTOS?

- ☐ Facial Photo
- ☐ Mouth and/or Teeth
- ☐ Use of both listed above
- ☐ Educational purposes only
- ☐ On Our Website
- ☐ On Dayspring Dental's Facebook/Instagram

_____	_____	_____
Patient's Name (Please Print)	Signature	Date

DAYSPRING DENTAL

NOTICE OF PRIVACY PRACTICES

PATIENT ACKNOWLEDGEMENT

Privacy Officer,

DATE: _____

PATIENT NAME: _____

D.O.B: _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides, in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

Understand that this practice reserves the right to change the terms of its Notice of Privacy Practices and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of PRivacy Practices on request.

_____ _____

Signature Date

_____

Relationship to Patient
(if signed by a personal representative of patient)

DAYSPRING DENTAL

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means such as sending correspondence to the individual's office instead of the individual's home.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (Please check all that apply)

- ▢ Home Phone
  - ▢ OK to leave message with detailed information
  - ▢ Leave message with call-back number only
- ▢ Work Phone
  - ▢ OK to leave message with detailed information
  - ▢ Leave message with call-back number only
- ▢ Written Communication
  - ▢ OK to mail to my home address
  - ▢ OK to mail to my work/office address
  - ▢ OK to fax to this number _____
- ▢ Other _____

_____ _____

Patient's Signature Date

_____ _____

Print Name D.O.B

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of and requests for PHI to the minimum necessary to accomplish the intended purpose.
These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.
Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

DAYSPRING DENTAL

PATIENT RECORD OF DISCLOSURES (CONT)

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

DATE	DISCLOSED TO WHOM ADDRESS/FAX NUMBER	DESCRIPTION OF DISCLOSURE/PURPOSE OF DISCLOSURE	BY WHOM DISCLOSED