PATIENT REGISTRATION FORM

This form must be properly filled out to ensure proper payment

Today's Date _____

1. Patient Name: _____ Date of Birth: _____ Gender M F

Social Security Number: _____ Medicaid Number: _____

2. Patient Name: _____ Date of Birth: _____ Gender M F

Social Security Number: _____ Medicaid Number: _____

3. Patient Name: _____ Date of Birth: _____ Gender M F

Social Security Number: _____ Medicaid Number: _____

4. Patient Name: _____ Date of Birth: _____ Gender M F

Social Security Number: _____ Medicaid Number: _____

5. Patient Name: _____ Date of Birth: _____ Gender M F

Social Security Number: _____ Medicaid Number: _____

6. Patient Name: _____ Date of Birth: _____ Gender M F

Social Security Number: _____ Medicaid Number: _____

****How did you hear about our office?**_____

PARENT / LEGAL GUARDIAN INFORMATION

Mother's Name: _____ Social Security Number: _____

Date of Birth: _____ E-mail: _____

Address: _____ City: _____ State: _____Zip: _____

Home Phone: (____)_____ Work Phone: (_____)_____ Cell Phone: (____)_____

Father's Name: _____ Social Security Number: _____

Date of Birth: _____ E-mail: _____

Address: _____ City: _____ State: _____Zip: _____

Home Phone: (____)_____ Work Phone: (_____)_____ Cell Phone: (____)_____

Nearest Relative or Close Friend and Phone Number_____

INSURANCE INFORMATION

Primary Dental Insurance: _____

Employer: _____

Group or Plan Number: _____ Insurance ID Number: _____

Insurance Company Address: _____Insurance Company Phone #_____

Policy Holder's Name (Person that holds the insurance plan): _____Date of Birth _____

Policy Holder's Social Security Number: _____Relationship to Patient: _____

Secondary Dental Insurance: _____

Employer: _____

Group or Plan Number: _____Insurance ID Number_____

Insurance Company Address: _____Insurance Company Phone #_____

Policy Holder's Name (Person that holds the insurance plan): _____Date of Birth_____

Policy Holder's Social Security Number: _____ Relationship to Patient: _____

To Our Patients and Families

Thank you for choosing Piedmont Pediatric Dentistry for your child's dental care! We wish to support and respect your needs while your child is under our care. We want you to understand your rights and responsibilities as families and patients at PPD. Your signature on this form provides consent for treatment and payment and acknowledges receipt of other general information. If you have any questions, please ask your provider.

Consent for Treatment:

I hereby authorize and request the performance of dental services for my minor child. I understand that at the first appointment (exam, cleaning, x-rays), the doctor will explain the child's treatment needs and the various behavior management approaches. At this appointment, the doctor's staff will review any associated fees. I also realize that any restorative treatment will be accomplished at a later date.

Parents in the Back:

You may choose whether or not you accompany your child to the treatment room for his/her appointment. Although we are sensitive to the fact that you may have more than one child and that more than one family member may want to participate, we ask that only one adult come to the back. Our goal is to not only provide the highest quality of care but also to effectively communicate with your child to build rapport and provide as much dental education as possible. This is difficult if both you and your child are distracted by other siblings or when a child is trying to get the attention of both of their parents at the same time. We highly encourage patient independence to build a trusting & positive relationship.

Missed /Broken Appointments:

Due to the limited space in our schedule and the need to provide timely service to all patients it is important that you keep your scheduled appointments. It is understandable that occasionally you may need to reschedule due to an emergency or illness. We ask that you give us the courtesy of a 24 hour notice so that we will have the opportunity to use your appointed time to provide treatment for others in need. If you cancel your appointment without 24 hours notice or if you "No-Show" for your appointment, you will be required to pay a **$50.00 Non-Refundable Fee**. If this happens more than twice, your scheduling options will be limited & we may elect to dismiss your family from our practice.

Insurance, Assignment of Benefits (AoB) and Release of Information (RoI):

- I consent to and authorize that payment of benefits for healthcare related services be made to PPD. This consent specifically authorizes PPD to release Protected Health Information (PHI) to insurers, governmental agencies and their agencies for billing purposes and determination of benefits.
- I assign any benefits payable for provider services to the provider or organization providing the services.
- I understand that there is no guarantee of reimbursement or payment from any insurance company or payer.

At this office, we follow the guidelines for the American Academy of Pediatric Dentistry in regard to frequency of X-rays, cleanings, fluoride treatments and restorative care. As specialists we consider these guidelines to be the standard of care and the best treatment for your child. These guidelines are not dictated by dental insurance and it is your responsibility to understand whether your particular insurance plan will reimburse you for these services. Please call your insurance company with any questions regarding frequencies. If and when there are any changes to my insurance plans, I will notify PPD staff and sign a new agreement.

Payment

I acknowledge full financial responsibility for, and agree to pay, all charges of PPD and of providers rendering services not otherwise paid by my health insurance or other payer. All charges and deductibles due are payable on the date of service. If payment is not made within 90 days after receipt of the bill, a 1.5% service charge (annual interest rate of 18%) will be added. I agree to pay all costs of collection including attorney fees, collection fees and court costs. The terms of this AoB and RoI will be until final payments are made for all services. There will be a $20 charge for all returned checks.

_____ _____

Print Patient's Name(s) Date

_____ _____

Signature Printed name

PIEDMONT
Pediatric Dentistry

NOTICE OF PRIVACY PRACTICES

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information over the last 6 years (but not before April 14, 2003). That list will not include disclosures for treatment, payment, health care operations, as authorized by you, and for certain other activities. 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. Contact us using the information listed at the end of this notice for more information about fees.

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 an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. Your request is not binding unless our agreement is in writing.

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. You must specify in your request the alternative means or location, and provide satisfactory explanation how you will handle payment under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why we should amend the information. 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 using the information listed at the end of this notice.

If you believe that:

- We may have violated you privacy rights,
- We made a decision about access to you health information incorrectly,
- Our response to a request you made to amend or restrict the use or disclosure of your health information was incorrect, or
- We should communicate with you by alternative means or at alternative locations,

You may contact us using the information listed below. 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 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.

Piedmont Pediatric Dentistry
2600 A Oakcrest Ave
Greensboro, NC 27408

Patient: I have read and understand the above Patient Rights to Privacy Information.

_____ _____

Patient Signature (or Parent/Guardian if child) Date

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Pediatric Dentistry

CONSENT FOR DENTAL TREATMENT

Your child's treatment plan may consist of diagnostic, restorative, and surgical treatment. Restorative treatment may include fillings, crowns, nerve treatment and/or space maintainers. Surgical treatment may include extractions of teeth or gum surgery. Local anesthetic and/or nitrous oxide may be used during your child's appointments to help make them more comfortable. Physical restraint will only be used when necessary to protect your child from self-injury and only with parental consent.

Your child's specific treatment needs will be explained to you and reviewed prior to each appointment. We request that you ask questions if you do not completely understand our recommendations. By signing this, you are acknowledging that dental treatment is done to help save your child's teeth and improve their oral health, however, there is no guarantee that treatment will be successful, and your child may still have dental problems post treatment. In addition, the treatment plan may change if the dentist finds more or different dental problems after the initial exam.

I understand that DENTAL TREATMENT is associated with inherent risks, including, but not limited to, the following:

1. **Injury to the nerves as a result of local anesthesia:** This would include injuries causing numbness of the lips, the tongue, or other tissues of the mouth or face. This numbness is usually of a temporary nature, but permanent numbness is a possibility. If numbness persists more that 24 hours postoperatively, please call our office.
2. **Soreness of the gums:** Temporary soreness may result from the placement of a rubber dam, or any restoration that extends below the gumline (e.g., stainless steel crowns). This soreness usually goes away within 48 hours.
3. **Sensitivity of teeth:** Placement of any dental restoration can result in a tooth that is sensitive to hot and/or cold. If these symptoms persist for more than a few weeks, it may be an indication that further treatment is necessary.
4. **Breakage, dislodgement, or bond failure:** Due to the fact that teeth are subjected to extreme forces from chewing, grinding, and possible trauma, it is possible that bonded restorations (white fillings) can be fractured or dislodged, resulting in leakage, recurrent decay, or infection. The dentist has no control over the forces to which the tooth/restoration is subjected.
5. **Aesthetics:** Although dental materials are constantly improving, it is possible that bonded restorations may wear down, lose their luster, or discolor. The dentist has no control over these factors.
6. For **dental extractions**:
   - Bleeding, bruising, or swelling: bleeding may persist for several hours. If profuse, please call our office. Some swelling is normal, but if severe, please call our office. Bruising may persist for some time, but generally heals uneventfully.
   - Injury to adjacent teeth or restorations: This is a possibility no matter how carefully the surgery is performed.
   - Infection: Due to the non-sterile nature of the mouth, or perhaps due to an existing infection, post-operative infection is a possibility. Some infections can be very serious. If severe swelling occurs, particularly if associated with fever or malaise, please call our office as soon as possible.
7. For **endodontically treated teeth**:
   - Pulpotomies: In a small percentage of cases, the patient's body "rejects" the nerve treatment, resulting in a failed pulpotomy and the need for extraction. The dentist has no control over the body's biological response to treatment.
   - Pulpectomies: For teeth requiring a pulpectomy, the long-term prognosis is guarded. A significant percentage of pulpectomized baby teeth will ultimately need to be extracted. This treatment is generally used when short term retention of a primary tooth is important to long term dental health.
8. **IT IS MY RESPONSIBILITY TO SEEK ATTENTION SHOULD ANY COMPLICATIONS OCCUR POST- OPERATIVELY AND I SHALL DILIGENTLY FOLLOW ANY INSTRUCTIONS GIVEN TO ME BY THE DENTIST.**
9. **For those children receiving nitrous oxide analgesia:** Potential side effects include dizziness, nausea, and vomiting. Nitrous oxide should be avoided if your child has just eaten a large meal.

INFORMED CONSENT: I have been given the opportunity to ask questions regarding the proposed treatment and have received answers to my satisfaction. I have been given alternatives to this treatment, including the option of rendering *no* treatment. I understand and assume any and all risks associated with the procedures, and I understand that no guarantees have been made regarding the outcome of the treatment. I understand that medical immobilization may be necessary for my child and provider safety. By signing this form, I am freely giving my consent to allow and authorize Dr. Lane and Dr. Macdonald render treatment, including any anesthetics or medications.

_____ _____

Print Patient's Name(s) Date

_____ _____

Signature Printed Name of Legal Guardian

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Pediatric Dentistry

In case someone other than you (the parent/ legal guardian) accompanies your child to future dental appointments, may this person (if over 18 years) give consent by proxy to possible treatment plan changes? For example: the patient's sister or aunt brings the child to the appointment and a tooth that was planned to receive a filling needs a crown. May this person decide for you this change?

☐ YES ☐ NO

If NO, what should we do?

☐ Reschedule. A parent will come with the patient to the next appointment.

☐ Call (____) _____ to discuss the change with a parent.

If nobody can be reached, we will reschedule.

I give permission to the following person(s) to bring my child(ren) to his/her dental appointments at Piedmont Pediatric Dentistry. In my absence, they are allowed to make dental and medical procedure decisions for my child, until further notice.

Authorized person(s): _____

Parent Signature _____ Date_____

PHOTO RELEASE FORM

I, _____, the parent or legal guardian of _____ (Child's name) grant Piedmont Pediatric Dentistry, Dr. Lane & Dr. Macdonald my permission to use the photographs taken in the office for use, including but not limited to: identification purposes in dental chart, publicity, copyright purposes, illustration, advertising, Web content, and our social media pages.
Furthermore, I understand that no royalty, fees, or other compensation shall become payable to me by reason of such use.

Child's Name: _____

☐ I do not give permission to have my child's/children's photograph taken.

Parent/Guardian's Signature: _____Date_____