

# PATIENT REGISTRATION

## PATIENT INFORMATION

Full Name \_\_\_\_\_ Preferred Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_ M \_\_\_ F  
SS# \_\_\_\_\_ Email Address \_\_\_\_\_

## RESPONSIBLE PARTY INFORMATION *Will be contacted for appointment reminders*

Full Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Birth Date \_\_\_\_\_ Sex \_\_\_ M \_\_\_ F Email Address \_\_\_\_\_  
SS# \_\_\_\_\_ Marital Status \_\_\_ Married \_\_\_ Single \_\_\_ Divorced \_\_\_ Separated \_\_\_ Widowed

## RESPONSIBLE PARTY INFORMATION

Check if NO DENTAL INSURANCE (Secondary Insurance Information on back)

Insured Full Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Birth Date \_\_\_\_\_ Sex \_\_\_ M \_\_\_ F SS# \_\_\_\_\_  
Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
Employer \_\_\_\_\_ Ins Name \_\_\_\_\_ Ins Phone \_\_\_\_\_  
Claims Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## OTHER INFORMATION

Emergency Contact \_\_\_\_\_  
(Other than self)  
Emergency Phone \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Preferred Pharmacy \_\_\_\_\_  
Pharmacy Phone \_\_\_\_\_

## How did you hear about our office? REFERRED BY (check one):

- Doctor/Dentist \_\_\_\_\_  
 Friend \_\_\_\_\_  
 Amigo Staff \_\_\_\_\_  
 School/Daycare \_\_\_\_\_  
 Phone Book  
 Website  
 Radio  
 Newspaper

\*\*\*As a courtesy, a claim will be filed to your primary insurance. The *estimated* patient portion is due when services are rendered.\*\*\*

**PATIENT REGISTRATION (CONTINUED)**

**PATIENT INFORMATION - 2<sup>nd</sup> Child**

Full Name \_\_\_\_\_ Preferred Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_ M \_\_\_ F  
SS# \_\_\_\_\_ Email Address \_\_\_\_\_

**PATIENT INFORMATION - 3<sup>rd</sup> Child**

Full Name \_\_\_\_\_ Preferred Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_ M \_\_\_ F  
SS# \_\_\_\_\_ Email Address \_\_\_\_\_

**PATIENT INFORMATION - 4<sup>th</sup> Child**

Full Name \_\_\_\_\_ Preferred Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_ M \_\_\_ F  
SS# \_\_\_\_\_ Email Address \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION**  
*(if applicable)*

Insured Full Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Birth Date \_\_\_\_\_ Sex \_\_\_ M \_\_\_ F SS# \_\_\_\_\_  
Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
Employer \_\_\_\_\_ Ins Name \_\_\_\_\_ Ins Phone \_\_\_\_\_  
Claims Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_



# DENTAL INFORMATION

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

For the following questions, please check the appropriate answer and fill out the necessary information. Your answers are for our records only as they help us provide you with a more thorough visit and will be considered strictly confidential.

## DENTAL INFORMATION

What is the reason for your child's first visit to our dental office?    \_\_\_ Consultation    \_\_\_ Emergency    \_\_\_ Preventative/Exam    \_\_\_ Other  
Parent level of apprehension?    \_\_\_ High    \_\_\_ Medium    \_\_\_ Low    \_\_\_ None  
Name of previous dentist \_\_\_\_\_ Telephone \_\_\_\_\_ May we contact previous dentist for records and X-rays?    \_\_\_ Y  
\_\_\_ N  
Has your child ever had an injury to the teeth, lips, tongue or chin in the past?    \_\_\_ Y    \_\_\_ N

## DIETARY FACTS

Does your child eat between meals?    \_\_\_ Y    \_\_\_ N  
Is your child a good eater?    \_\_\_ Y    \_\_\_ N  
Does s/he eat a balanced diet?    \_\_\_ Y    \_\_\_ N  
At what age was bottle/nursing stopped?    \_\_\_ yrs    \_\_\_ mo  
Please list your child's favorite snacks:

## FLUORIDE & TOOTH BRUSHING

Is your child taking fluoride supplements presently?    \_\_\_ Y    \_\_\_ N If Yes, what form? \_\_\_\_\_  
Has your child received fluoride supplements in the past?    \_\_\_ Y    \_\_\_ N  
Does your child drink?    \_\_\_ Bottle water    \_\_\_ well water    \_\_\_ Non-Filtered water    \_\_\_ Filtered city water  
Does your child use fluoride toothpaste?    \_\_\_ Y    \_\_\_ N  
Does your child swallow toothpaste?    \_\_\_ Y    \_\_\_ N  
Brushing frequency?    \_\_\_ 1xdaily, am    \_\_\_ 1xdaily, pm    \_\_\_ 2xdaily    \_\_\_ After each meal/snack  
What type of toothbrush does your child use?    \_\_\_ Regular    \_\_\_ Electric    \_\_\_ Cloth    \_\_\_ Other  
Dental flossing frequency?    \_\_\_ Use daily    \_\_\_ Occasionally    \_\_\_ Never  
Who is responsible for tooth brushing?    \_\_\_ Parent    \_\_\_ Child    \_\_\_ Both

## HABIT ASSESSMENT

If your child has or had any of the following oral habits, please indicate below (check all that apply):

Sucking History    \_\_\_ Still    \_\_\_ Past thumb/finger habit-stopped at \_\_\_ yrs    \_\_\_ Never had thumb/finger habit  
Was or is the habit done?    \_\_\_ Day & Night    \_\_\_ Night only    \_\_\_ When tired or sleepy  
Grinding Teeth History    \_\_\_ Still    \_\_\_ Past grinding habit-stopped at \_\_\_ yrs    \_\_\_ Never had grinding habit  
Was or is the habit done?    \_\_\_ Day & Night    \_\_\_ Night only    \_\_\_ When tired or sleepy  
Other Habits?    \_\_\_ Nail biting    \_\_\_ Lip biting    \_\_\_ Cheek and/or tongue biting    \_\_\_ Mouth breathing  
Does your child snore?    \_\_\_ Y    \_\_\_ N

Is there any specific question / topic you would like to make sure we address while you and your child visit us?

\_\_\_\_\_

# MEDICAL INFORMATION

Patient Name \_\_\_\_\_ Date \_\_\_\_\_  
 For the following questions, please check the appropriate answer and fill out the necessary information. Your answers are for our records only as they help us provide you with a more thorough visit and will be considered strictly confidential.

<b>PHYSICIAN/PEDIATRICIAN INFORMATION</b>		
Pediatrician/Physician Name _____	Address _____	
Phone _____	Fax _____	
Please list other specialists your child may be seeing:		
1. _____	Address _____	Phone: _____
2. _____	Address _____	Phone: _____
Date of last regular check-up: _____	Date of last medical visit: _____	Reason: _____

<b>MEDICAL NARRATIVE</b>																																																																					
1. Is your child:	Under the care of a doctor at the present time? <input type="checkbox"/> No <input type="checkbox"/> Yes, When? _____ Why? _____ Taking any medications at the present time? <input type="checkbox"/> No <input type="checkbox"/> Yes, What? _____ Allergic to any medications? <input type="checkbox"/> No <input type="checkbox"/> Yes, What? _____ Allergic to any foods, materials or dyes? <input type="checkbox"/> No <input type="checkbox"/> Yes, What? _____																																																																				
2. Has your child:	Had general anesthesia? <input type="checkbox"/> No <input type="checkbox"/> Yes Had any complications with general anesthesia? <input type="checkbox"/> No <input type="checkbox"/> Yes, Explain _____ Had any surgeries? <input type="checkbox"/> No <input type="checkbox"/> Yes, When? _____ Why? _____ Ever been a patient at the Emergency Room? <input type="checkbox"/> No <input type="checkbox"/> Yes, When? _____ Why? _____ Ever been hospitalized as a patient? <input type="checkbox"/> No <input type="checkbox"/> Yes, When? _____ Why? _____																																																																				
3. Does your child have, ever had or been diagnosed with any of the following: (please check all that apply)	<table style="width: 100%; border: none;"> <tr> <td style="width: 25%; vertical-align: top; padding: 2px;"><input type="checkbox"/> HIV+/AIDS</td> <td style="width: 25%; vertical-align: top; padding: 2px;"><input type="checkbox"/> Brain Surgery</td> <td style="width: 25%; vertical-align: top; padding: 2px;"><input type="checkbox"/> Heart problem/surgery</td> <td style="width: 25%; vertical-align: top; padding: 2px;"><input type="checkbox"/> Pneumonia</td> </tr> <tr> <td style="padding: 2px;"><input type="checkbox"/> Anemia/Sickle cell trait</td> <td style="padding: 2px;"><input type="checkbox"/> Cancer-type: _____</td> <td style="padding: 2px;"><input type="checkbox"/> Hemophilia</td> <td style="padding: 2px;"><input type="checkbox"/> Polio</td> </tr> <tr> <td style="padding: 2px;"><input type="checkbox"/> Allergy / Hay fever</td> <td style="padding: 2px;"><input type="checkbox"/> 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4. Does your child have any other disease, condition or medical problem not mentioned above? <input type="checkbox"/> No <input type="checkbox"/> Yes, Please list _____																																																																					

I understand the information I have given is correct to the best of my knowledge and will be held in the strictest of confidence. I understand it is my responsibility to inform this office of any changes in my child's medical status.

SIGNED \_\_\_\_\_ RELATIONSHIP TO CHILD \_\_\_\_\_ DATE \_\_\_\_\_

**CONSENT TO DISCLOSE  
PRIVATE HEALTHCARE INFORMATION  
FOR TREATMENT, PAYMENT, AND/OR HEALTHCARE OPERATIONS**

I, the undersigned, hereby authorize and consent for Amigo Children's Dental, P.A., and any of its associates, to release any and all medical, dental, and/or psychological reports or records of (child's name) \_\_\_\_\_, (child's date of birth) \_\_\_\_\_, including, but not limited to, medical/dental notes, physician narratives, office notes, operative notes, discharge summaries, Doctor's/Dentist's orders, Nurse's notes, lab reports, test results, physical therapy progress notes, patient progress reports, diagnosis, post-operative reports, post-operative diagnosis, pathology reports, x-rays, MRIs, any records reflecting treatment for substance abuse, mental illness, AIDS, HIV virus, alcohol abuse, including any x-rays, diagnostic studies, laboratory slides, clinical abstract, histories, charts, and other information contained therein, any documents and opinions relevant to past, present, or future physical and mental condition, treatment, care or hospitalizations, and any other personal health information regarding my medical/dental care as necessary to carry out treatment, obtain payment, and/or conduct other healthcare operations.

The release of the matters listed above is being authorized for purposes of obtaining medical/dental treatment, payment for such services and other health care operations.

A copy of this authorization is agreed by the undersigned to have the same effect and force as an original.

Any person, firm, or entity that releases matters pursuant to this authorization is hereby absolved from any liability that might otherwise result from the release of those matters.

I further understand that I have the right to review Amigo Children's Dental privacy notice and to request restrictions. I further understand that I may revoke this consent in the future if I should so desire.

Signed this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Signature of Parent or Legal Guardian

\_\_\_\_\_  
Printed Name of Parent or Legal Guardian

\_\_\_\_\_  
Patient's Name (printed)

Special Restrictions  
\_\_\_\_\_  
\_\_\_\_\_



# PEDIATRIC DENTISTRY INFORMED CONSENT FOR PATIENT MANAGEMENT TECHNIQUES ACKNOWLEDGMENT OF RECEIPT OF INFORMATION

## ALL IN GOOD INTENTION

It is our intent that all professional care delivered in our dental office shall be of the best possible quality we can provide for each child. We believe that any dentist can get your child's work done – our mission is to do so in a manner which leaves your child with good positive feelings about going to the dentist. The entire focus is on your child, relating to them, fostering good dental health habits and instilling a healthy, positive attitude toward dentistry for life.

All efforts will be made to obtain the cooperation of patients by the use of warmth, friendliness, persuasion, humor, charm, gentleness, kindness, and understanding. In some cases, further behavior management techniques are needed. There are several behavior management techniques that are used by pediatric dentists to gain the cooperation of patients to eliminate disruptive behavior or prevent patients from causing injury to themselves due to uncontrollable movements. These techniques are *not* a form of punishment and are in no way used as a form of punishment. These techniques are simply used only when and, if necessary, to complete a dental procedure in the safest manner possible.

Please read this form carefully and ask questions if you do not understand. Please initial next to each number to identify you understand the techniques we use.

### PEDIATRIC DENTISTRY BEHAVIOR MANAGEMENT TECHNIQUES

- 1. **Tell-Show-Do:** The dentist or assistant explains to the patient what is to be done using simple terminology and repetition and then shows the patient what is to be done by demonstrating with instruments on a model or the patient's or dentist's finger. Then the procedure is performed in the patient's mouth as described. Praise is used to reinforce cooperative behavior.
- 2. **Positive reinforcement:** This technique rewards the patient who displays any behavior which is desirable. Rewards include compliments, praise, pat on the back, a hug, or a prize.
- 3. **Voice control:** This technique uses a controlled alteration of voice volume, tone, or pace to influence and direct the patient's behavior.
- 4. **Mouth props/Rubber dams:** A mouth prop or "tooth pillow" as we call it is used to help support the patient in keeping his/her mouth open during an operative procedure (filling, etc). This allows him/her to relax and not worry about consciously keeping his/her mouth open for the procedure. A rubber dam is a "raincoat" placed on the area of work to isolate the teeth and prevent any debris from being swallowed or going to the back of the throat.
- 5. **Immobilization by the dentist:** The dentist controls the patient from movement by gently holding down the patient's hands or upper body, stabilizing the patient's head between the dentist's arm and body.
- 6. **Immobilization by the assistant:** The assistant controls the patient from movement by gently holding the patient's hands, stabilizing the head, and/or controlling leg movements.
- 7. **Immobilization by Pedi-wrap:** A passive restraint device, designed specifically for pediatric dental procedures, that is used when complete immobilization is needed for the safety of the patient and the dental team. It is used during most, not all, sedation procedures.
- 8. **Relaxation Gas:** Nitrous oxide (laughing gas) and oxygen may be administered to relax the patient and to raise his/her pain threshold. This allows the patient to sit in the chair longer, increases their attention span, and allows for more work to be done without the patient labeling something as painful. **Nitrous oxide and oxygen is not general anesthesia.** The patient is not "put to sleep" and does not become unconscious, only relaxed.
- 9. **Conscious Sedation** is recommended for mildly apprehensive and very young patients. The majority of patients respond very well for dental treatment. For various reasons, some patients may be apprehensive about dental treatment and may require some form of conscious sedation to allow treatment

### ACKNOWLEDGMENT OF RECEIPT OF INFORMATION

- 1. The listed pediatric dentistry management techniques have been explained to me.
- 2. I am clear and understand that none of the above techniques are used in any way as punishment. These procedures are standard of care in the pediatric dental community and are merely used only if necessary to provide the best dental care.
- 3. I have been encouraged to ask questions and all questions about the patient management techniques described have been answered in a satisfactory manner.
- 4. I hereby acknowledge that I have read and understand this consent.
- 5. I acknowledge that I have not been coerced/ forced to sign this consent and that I have been given the alternative to withdraw from it.
- 6. I hereby authorize and direct Dr. Hunt assisted by other dentists and/or dental auxiliaries of her/his choice, to utilize, if required, the necessary patient management techniques to assist in the provision of the required dental treatment for my child (or legal ward).
- 7. I understand that this consent shall remain in effect until terminated by me.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Person Authorized to Consent

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date



**AMIGO CHILDREN'S DENTAL, P.A.**  
Howard H. Hunt Jr., DDS



# CONSENT FOR TREATMENT

We are here to provide dental services to you and your child in the most beneficial way possible. This requires mutual understanding. Please read this form carefully. Should you have any questions, our business coordinators will be delighted to help you.

1. I hereby authorize and direct Dr. Howard Hunt, and/or any of his dental associates and/or dental auxiliaries to perform dental treatment with the use of any necessary or advisable radiographs (X-Rays) and/or any other diagnostic aids in order to complete a thorough diagnosis and treatment plan.
2. I understand certain parts of the treatment may be performed by certified paraprofessionals (Dental assistants/hygienists) other than the dentist.
3. I authorize Dr. Howard Hunt, and/or any of his dental associates and/or dental auxiliaries to take and to use photographs, radiographs, other diagnostic materials, and treatment records for the purposes of teaching, research, and scientific publication. The photographs shall be used for dental records and if in the judgment of Dr. Hunt and/or any of his dental associates, dental research, education, or science will be benefited by their use, such photographs and information relating to my child's case may be published and republished, either separately or in connection with each other, in professional journals or medical books, or used for any other purpose which s/he may deem proper in the interest of medical education, knowledge, or research; provided, however, that it is specifically understood that in any such publication or use my name or my child's name not be identified by name. The aforementioned photographs may be modified or retouched in any way that my dentist, in his/her discretion, may consider desirable.
4. I understand x-rays, photographs, models of the mouth, and/or any other diagnostic aid used for an accurate diagnosis and treatment planning are the property of the doctor but copies are available upon request for a fee.
5. In general terms, the dental procedure(s) can include but not be limited to:
  - A. Comprehensive oral examination, radiographs, cleaning of the teeth, and the application of topical fluoride.
  - B. Application of plastic "sealants" to the grooves of teeth.
  - C. Treatment of diseased or injured teeth with dental restorations (fillings), stainless steel or composite crowns, and/or root canal treatment.
  - D. Oral surgery: Extraction of one or more teeth, excision of hyper plastic and/or pericoronal tissue, frenectomy, exposure of unerupted tooth.
  - E. Placement of space maintainers and/or replacement of missing teeth with dental prosthesis.
  - F. Treatment of diseased or injured oral tissues secondary to traumatic injuries and/or accidents and/or infection.
  - G. Treatment of habits, malposed (crooked) teeth, orthodontia and/or oral, dental developmental or growth abnormalities.
  - H. Recommendation for treatment to be completed using conscious sedation or general anesthesia.
6. I understand that the doctor is not responsible for previous dental treatment. I understand that, in the course of treatment, this previously existing dentistry may need adjustment and/or replacement.
7. I realize that guarantees of results or absolute satisfaction are not possible in dental health service.
8. I have answered all the questions about my or my dependent's medical history and present health condition fully and truthfully. I have told the dentist or other office personnel about all conditions, including allergies, which might indicate that my child should not receive oral medications and/or anti-anxiety agents. I also understand if I or my dependent ever had any changes in health status or any changes in medication(s), I will inform the doctor at the next appointment.
9. I authorize Dr. Howard Hunt and/or any of his dental associates to forward a review of findings and/or any other dental information to the referring doctor (if such has been the referral source) or any other health care giver for his/her records, as well as any third parties such as insurance companies who may request information.

I hereby acknowledge that I have read and understand this consent and the meaning of its contents. All questions have been answered in a satisfactory manner and I believe I have sufficient information to give this informed consent. I further understand that this consent shall remain in effect until terminated by me.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Person Authorized to Consent

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date



**AMIGO CHILDREN'S DENTAL, P.A.**  
**Howard H. Hunt Jr., DDS**

# PARENT-DENTIST COMMITMENT

We believe good communication, understanding and respect are the basis for an admirable, worthy relationship. Because we strongly believe in our work and professional efforts and hold the relationship we develop with our patients and parents so highly, we ask that you read this document thoroughly. We ask you to sign the Parent-Dentist Commitment indicating you understand its contents and agree to honor them.

The ultimate goal of Amigo Children's Dental, P.A. is to provide the best standard of care to and be understanding of all our patients. We feel confident in our ability to provide you and your child valuable dental care that will exceed all your expectations. Our desire is to establish a long-lasting relationship with you and your child.

## Our financial policy is:

We require payment in full at the time service is rendered. We accept MasterCard, Visa, Discover, American Express, check, money order or cash. We also offer payment plans using our in house financing program – Care Credit. Should any check be returned for insufficient funds, a \$35 return check fee will be applied to your account. If you have dental insurance, it is our pleasure to assist you in maximizing your insurance benefits by filing your claims with your insurance company. It is important that you understand that as your dental care provider, our relationship is with you, not your insurance company. The range of benefits depends solely on what your employer wishes to purchase. We will give you an estimated co-payment amount which is to be paid on the day of service. If a credit appears on your account once the carrier has benefited the claim, a refund will be issued to you. Likewise, if any outstanding balance remains on your account once the carrier has benefited the claim, a statement will be sent to you for immediate payment. If for any reason, we have not received your insurance carrier's payment 60 days after the filing of the claim, the remaining balance will be due and payable by you. A \$3 processing fee for any statements sent past the 60 day limit will also be incurred.

You may receive a notification from your insurance company stating that dental fees are higher than "usual and customary". Insurance companies never reveal how they determine "usual, customary, and reasonable" (UCR) fees. They are at least determined by taking some percentage of an average fee for a particular procedure in a geographic area. Average has been defined as "The worst of the best" or "The best of the worst". **We do not provide average dentistry nor do we charge below average fees.**

The parent or guardian who brings the child to our office is responsible for payment in full. All statements will be sent to this individual. We will not bill a third party other than insurance companies.

If you have any concerns regarding the financial portion of any treatment plan, please discuss these issues with our treatment coordinator prior to starting treatment. We will not alter our normal financial arrangements once treatment has been done.

**Our Cancellation Policy** is to bring the highest level of service to our entire patient population. In order to do this we maintain a strict respect for your time and strive to see all of our patients at their appointed times. We know you respect this and strive for the same. At times we have a "waiting list" of patients wanting earlier appointments than we are able to provide. Subsequently, we request 48 hours of notice if you need to change your appointment for any reason. Cancellations provided with less than 48 hours notice may result in a \$50 cancellation fee being applied to your account and a pre-payment by you to schedule the next appointment. To assist you in your appointments, we will confirm each upcoming appointment one week in advance with a reminder 2 days prior to the appointment date. It is important that you confirm these calls with us. Failure to do so may result in the cancellation of your appointment. This policy enables us to accommodate as many needs as possible by offering the cancelled/unconfirmed appointment to others. **We reserve the right to dismiss a patient from our practice due to multiple cancellations and/or missed appointments without proper notice.**

- I have read the above internal policies and understand my financial options and obligation as well as the cancellation policy as described.

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Signature of parent/legal guardian

Date



AMIGO CHILDREN'S DENTAL, P.A.



## NOTICE OF PRIVACY PRACTICES (DENTAL)

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

The Health Insurance Portability & 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 health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- **Payment** means such activities 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.
- **Health care operations** include 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 references to individually identifiable information. 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. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

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 those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. 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 communications 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 June, 2009 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 notice 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 with our office, or with the Department of Health & 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.

For more information about HIPAA or to file a complaint:  
The U.S. Department of Health & Human Services  
Office of Civil Rights  
200 Independence Avenue, S.W.  
Washington, D.C. 20201  
Tel: 202-619-0257  
Toll Free: 877-696-6775

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Patient Name: \_\_\_\_\_

# Authorized Permissions List

We want to provide dental services for your child in the most beneficial way. This requires an understanding of who is authorized to assist us in your child's healthcare. Please read this form carefully. Should you have any questions, our business coordinators will be delighted to help you.

Please indicate below any person(s) (other than you) who you authorize to participate in your child's healthcare. Check any boxes that apply. Any boxes left unchecked will indicate that the person listed does not have the permission associated with that particular box.

Name of Authorized Person	Relationship to Patient	Bring Patient to Appointments	Schedule & Discuss Medical Information & Dental Treatment	Sign & Complete Medical & Dental Forms	Discuss Financial Information	Edit Account Information
1.						
2.						
3.						
4.						
5.						

I authorize Amigo Children's Dental to send appointment reminders and confirmations to the email addresses and telephone numbers listed in my account.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Person Authorized to Consent

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date



**AMIGO CHILDREN'S DENTAL, P.A.**  
Howard H. Hunt Jr., DDS