

Demographic Information

Patient's Name: _____ Today's Date: _____

Name child would like to be called _____ Home Phone: _____

Birthday: _____ Age: _____ Sex: _____ Cell Phone: _____

Guardian's Email: _____

Home Address: _____

Street City State Zip Code

Names & ages of other children in family: _____

School: _____ Grade _____

Guardian 1: _____ Relationship to patient: _____

Employer: _____ Phone: _____

Guardian 2: _____ Relationship to patient: _____

Employer: _____ Phone: _____

Who has legal custody of patient? _____ Dental Insurance: YES NO

Person responsible for payment of account: _____ SS#: _____ DOB: _____

Name of child's physician/group: _____ City/State: _____ Phone#: _____

Whom may we thank for referring you to us? _____

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

Health History

Yes No Is your child in good health? Date of last physical exam: _____

Yes No Has your child ever had a health problem? _____

Yes No Has your child ever been hospitalized? Please give reason & dates: _____

Yes No Is your child allergic to anything? _____

Yes No Is your child currently taking any medications? Please give medication, dose & reason _____

Yes No Were there any problems at birth? _____

Please circle if your child has been treated for any of the following:

- | | | | |
|------------------|--------------------------|---------------------|------------------------|
| Heart disease | Bleeding/transfusions | Asthma/breathing | Blood dyscrasias |
| Liver/GI disease | Anemia | Diabetes | HIV/AIDS |
| Kidney disease | Rheumatic fever | Hepatitis | Mental delays |
| Speech/hearing | Seizures | Cleft lip/palate | Physical delays |
| Eyesight | Congenital birth defects | Personality/social | Other problems |
| Cancer/tumors | Recurrent headaches | Frequent infections | Adverse drug reactions |
| Cerebral palsy | Significant injuries | Endocrine/growth | Autism |



Please elaborate on any items circled:

TRIANGLE DENTISTRY

SMITH, TART & ASSOCIATES

Patient's Name: _____ Birthdate: _____

Do you consider your child to be; ___ advanced in the learning process
 ___ progressing normally
 ___ slow in the learning process

Was your child; ___ breast fed ___ bottle fed At what age was this stopped? _____

Dental History

Yes No Has your child ever been to the dentist? Date of last x-rays (if taken): _____
 Name of dentist & date: _____

Yes No Has your child experienced any unfavorable reaction from previous dental care?
 Explain: _____

Yes No Does your child suck a finger, thumb or pacifier?

Yes No Does your child have pain with chewing, yawning, or wide opening?

Yes No Does your child's jaw make noise & is pain associated with the sounds?

Please circle if your child is having problems with any of the following:

- | | | |
|--------------|----------------|-----------------|
| Cavities | Toothache | Teeth sensitive |
| Trauma | Gum infections | Color of teeth |
| Orthodontics | Jaw sounds | Other |

Comments: _____

Fluoride History

Yes No Is your home water supply fluoridated?
 Yes No Does your child use fluoride toothpaste?
 Yes No Does your child participate in a school fluoride rinse program?
 Yes No Do you give your child any other form of fluoride? What? _____

Office Use Only

Fluoridated City Water

Private well

Public well

Consent for Dental Treatment

I request & authorize Triangle Dentistry to examine, clean, and provide dental treatment on my child's teeth. This treatment may include sealants, restorations (fillings) or crowns if necessary. I further request & authorize the taking of dental x-rays as may be considered necessary by Triangle Dentistry to diagnose &/or treat my child's dental problem(s). I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Triangle Dentistry will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation & demonstration of procedures & instruments, & using variable voice tone. I will be responsible for any charges incurred on this child for dental treatment.

Signature _____	Date _____
Signature _____	Date _____
Signature _____	Date _____
Signature _____	Date _____
Signature _____	Date _____
Signature _____	Date _____

To Our Patients:

What is HIPAA? The Health Insurance Portability and Accountability Act

- Why?**
1. HIPAA protects you and the privacy of your health information.
 2. This permits us to file your electronic insurance claims which protects the privacy of your information and allows for faster reimbursement.
 3. This is required by law.

Attached:

- **Notice of Privacy Practices - at your leisure please read the complete explanation of HIPAA**
- **Acknowledgement of Receipt of Notice of Privacy Practices – please complete & give to a staff member**

** It is of note: Your signature simply states that you have received this Notice of Privacy Practices.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

Please Print Name

Signature

Date

FOR OFFICE USE ONLY

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

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

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TRIANGLE DENTISTRY

SMITH, TART & ASSOCIATES

Patient Financial Policy

Thank you for choosing Triangle Dentistry for your dental needs. Your dental health is important to us, and we want to ensure that you receive the treatment you need. We realize that every person's financial situation is different. For this reason, we have the following payment options from which you may choose.

**Cash or Check
MasterCard, Visa, Discover or American Express
Care Credit**

Insurance Filing

We may accept assignment of your insurance benefits; however, we require that your estimated portion and deductible be paid at time of service. Since your insurance policy is an agreement between you and your insurance company, please realize that it is your responsibility to follow up on claims and payments. We will send a statement to you each month your account has an outstanding balance. Payment in full is appreciated on all statements.

The patient is responsible for payment of all fees not covered by insurance regardless of any insurance company's arbitrary determination of usual and customary fees.

I have read, understand and agree to the payment terms of this financial policy.

Date

Patient or Responsible Party Signature

Note: A 1.5% finance charge per month will be assessed on all balances over 60 days old. All accounts over 120 days past due will be forwarded to our collection service. All fees and costs associated with the collections process (including all legal fees) will be the responsibility of the patient.

PAYMENT IS EXPECTED AT TIME OF SERVICE

Please give us a minimum of 48 hours' notice to cancel your appointment. Failure to do so may result in a \$48 cancellation fee.

TRIANGLE DENTISTRY

SMITH, TART & ASSOCIATES

Request for Release of Dental Records

DATE: _____

PATIENT NAME: _____

DATE OF BIRTH: _____

I HEREBY REQUEST RELEASE OF MY DENTAL RECORDS FROM THE OFFICE:

Phone: _____ BWX: _____ Panorex: _____ FMX: _____

We prefer jpeg attachments sent via email.

Please include the date they were taken.

To avoid repeat requests, please email us if the patient does not have current records at your office.

PLEASE SEND TO: Triangle Dentistry
Smith, Tart, & Associates
120 Northway Court
Raleigh, NC 27615

EMAIL ADDRESS: Triangledentistry@mindspring.com

PATIENT AUTHORIZATION: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU 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

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 4/14/03, 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 the 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.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

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 a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

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 and 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 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 was 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 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 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 judgement in 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 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.

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.



TRIANGLE DENTISTRY

SMITH, TART & ASSOCIATES

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 institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or emails).

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 using the contact information listed at the end of this Notice. 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 to the address at the end of this Notice. If you request copies, we will charge you per page and for staff time per hour to locate and copy your health information and postage if you want the copies mailed to you. If you request an alternative 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 using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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 an emergency).

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 how payments will be handled 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 the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, 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 using the contact information listed at the end of this Notice. 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.

Contact Officer:	James E. Smith, DMD
Telephone:	(919) 847-6000 Fax: (919) 847-3159
Email:	triangledentistry@mindspring.com
Address	120 Northway Court Raleigh, NC 27615

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