Welcome

FREEMAN pediatric dentistry

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we'll be glad to help you. We look forward to working with you in maintaining your child's dental health

Patient Information

Date _____

Name of Minor/Child _____
Last Name First name Initial

Sex ☐ M ☐F Age _____ Birthdate _____ Nickname _____ Hobbies _____

Home Address _____
Street City State Zip

Mailing Address _____
(if different) Street City State Zip

Person Financially Responsible _____ Home Phone _____ Work Phone _____

Whom may we thank for referring you? _____

Primary Email Address _____ Primary Cell Phone Number _____

Insurance

Father's/Guardian's Name _____

Address (if different) _____

_____

Hm Phone _____ (if different) Wk Phone _____ (if different)

Employer _____

Soc Sec # _____ Birthdate _____

Do you have ins. coverage for minor/child? ☐ Yes ☐No

Plan Name _____

Phone Number _____

Address _____

Group # _____ Policy # _____

Mother's/Guardian's Name _____

Address (if different) _____

_____

Hm Phone _____ (if different) Wk Phone _____ (if different)

Employer _____

Soc Sec # _____ Birthdate _____

Do you have ins. coverage for minor/child? ☐ Yes ☐No

Plan Name _____

Phone Number _____

Address _____

Group # _____ Policy # _____

Dental History

Date of last Dental Visit _____ For what service _____

Date of last X-rays were taken: _____

Has your child complained about dental pain? …… ☐ Yes ☐No

Is fluoride taken in any form? …… ☐Yes ☐No

Any injuries to mouth, teeth, or head? …… ☐ Yes ☐No

Any unhappy dental experiences? …… ☐Yes ☐No

Any mouth habits – thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc? …… ☐Yes ☐No

(Please complete both side)

Medical History

Minor Child Physician _____ City/State _____ Phone _____

Date of Last Exam _____ Findings _____

Is child under care of Physician now? ……..…… ☐ Yes ☐ No Medications _____

Receiving any medications or drugs? ……... ☐ Yes ☐ No _____

Ever been hospitalized? ……..…….. ☐ Yes ☐ No _____

Ever had surgery? ……..…… ☐ Yes ☐ No Drug Allergies _____

Is there excessive bleeding when cut? ……..… ☐ Yes ☐ No _____

HAS MINOR/CHILD HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING? IF YES PLEASE CHECK (☒)

☐ Abnormal Bleeding	☐ Bladder Problems	☐ Diabetes	☐ Hemophilia	☐ Sickle Cell Disease/Traits
☐ ADHD/ADD	☐ Cancer	☐ Down Syndrome	☐ Hepatitis	☐ Seasonal Allergies
☐ AIDS/HIV	☐ Cerebral Palsy	☐ Fainting	☐ Kidney Disease	☐ Sinus Problems
☐ Anemia	☐ Congenital Heart Defect	☐ Hearing Problems	☐ Latex Allergy	☐ Tuberculosis
☐ Asthma	☐ Convulsion/Epilepsy	☐ Heart Murmur	☐ Liver Disease	☐ Other
☐ Autism	☐ Developmental Delay	☐ Heart Problems	☐ Mononucleosis	☐ Other

In the event of an emergency, whom should we contact?

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Authorization

The information I have given is correct to best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child medical status. I authorize the dental staff to perform the necessary dental services to my minor/child.

_____ _____

Signature of Parent/Guardian Date

I certify that I am covered by insurance with _____

(Name of Insurance Company)

and assign directly to Dr. Freeman all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____

Signature of Parent/Guardian Date

FREEMAN
pediatric dentistry

2567 Appling Road, Memphis, Tennessee 38133 901.383.7337 ChildDentalCare.com

Practice Financial Policy

We are committed to providing your child with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial and insurance policies is important to our professional relationship.

- All patients must complete the Patient Information & Medical Form before seeing the Doctor.
- Full payment is due at the time of the service unless other arrangements are made.
- Twenty-four hour notice is required when re-scheduling or canceling appointment.
- For your convenience, we accept CASH, PERSONAL CHECKS, ATM DEBIT PAYMENTS, VISA, and MC.
- In addition, we offer third party financing with a convenient monthly payment plan for larger balances.
- Interest of 18% will begin accrue on balances over 60 days.
- I understand it is my full financial responsibility to pay all court cost, all collection fees and/or attorney fees if my account is turned over for collections
- In the event that your account is placed with a Collection Agency, a collection-fee in the amount of 33.3% of the then outstanding balance may be added to your account and shall become a part of the Total Amount Due. You will be responsible for any and all cost of collection including attorney fees and court cost.
- You agree, that in order for us to service your account or to collect any amounts you may owe, we and our collection agencies may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We and our collection agencies may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

As a convenience to you, we will be happy to submit your insurance claims. The insurance company, not our office, determines the dental benefits that you will receive. The estimated insurance coverage is not a guarantee of payment and is between you and the insurance company. All charges are your responsibility. Please keep your insurance information current by notifying us of any changes in employment, insurance coverage, etc.

The adult accompanying a minor and/or the parent (or guardian of the minor) is responsible for payment at the time of appointment.

_____ _____

Signature Date

FREEMAN pediatric dentistry

2567 Appling Road, Memphis, Tennessee 38133 901.383.7337 ChildDentalCare.com

NOTICE OF PRIVACY PRACTICE

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 April 14, 2003 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 health care 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 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 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 must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

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 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 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.

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 letters).

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 $0.25 for each page, $15 per hour for staff time 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 the 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 of location your 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 OR 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 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.

Contact officer: Cynthia Freeman
Telephone: (901) 383-7337
info@childdentalcare.com
Address: 2567 Appling Rd, Memphis, TN 38133

FREEMAN
pediatric dentistry
2567 Appling Road, Memphis, Tennessee 38133 901.383.7337 ChildDentalCare.com

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

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

Name (Please Print) _____

Signature _____
Date _____

_____

For Office Use Only

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

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

_____

Name (Please Print) _____

Signature _____
Date _____