WELCOME TO TOOTHTOWN PEDIATRIC DENTISTRY

What is the primary reason for your visit today? Please check one.

1. Complete exam and cleaning ☐
2. Emergency☐ Explain: _____
3. Other☐ Explain: _____

Who referred you to our office? I would like to thank them. _____

Date of last dental visit? _____ Name of dentist? _____

About Your Child

Child Lives With: ☐ Mom ☐ Dad ☐ Both ☐ Other

Child's name: _____ Home Address: _____

Child's nickname: _____ City: _____ Zip: _____

Male ☐ Female ☐ Date of Birth: _____ Emergency Contact: _____

Age: _____ Grade: _____ Emergency #: _____

School: _____ Siblings Name: _____

Parents Information

Father's Name: _____	Mother's Name: _____
Home Phone: _____ Cell Phone:_____	Home Phone: _____ Cell Phone:_____
Father's Employer: _____ E-mail: _____	Mother's Employer: _____ E-mail: _____
Work Address: _____	Work Address: _____
City:_____ Zip:_____ Work#:_____	City:_____ Zip:_____ Work#:_____
Home address same as child? Yes ☐ No☐ If not, fill out	Home address same as child? Yes ☐ No ☐ If not, fill out
Home Address: _____	Home Address: _____
City: _____ Zip: _____	City: _____ Zip: _____

Primary Dental Insurance Information	**Secondary Dental Insurance Information**
Insured's Name: _____	Insured's Name: _____
Date of Birth: _____ SS #: _____	DOB: _____ SS #: _____
Employer: _____	Employer: _____
Insurance Co. Name: _____	Insurance Co. Name: _____
Ins. Address: _____	Ins. Address: _____
Phone #: _____ Group Plan/Policy #: _____	Phone #: _____ Group Plan/Policy #: _____

Note: TOOTHTOWN would gladly file claims on your behalf with your primary insurance carrier if ToothTown is a participating member. For your secondary insurance claim, we will provide claim forms at your request.

Financial Policies and Truth-in-Lending Disclosure

The undersigned acknowledges and agrees that the primary responsibility for any charges rendered for dental services is the responsibility of the undersigned, and not of any public or private insurance company or agency. All collection costs, including staff time, attorney's fees, court costs, and office costs for collection purposes will be assessed (from 50% of amount due plus accruing interest). These charges, together with service charges at the rate of 1.5% per month, will commence 30 days after first billing. It is understood that venue of this agreement will be Palm Beach County, Florida.

Office Policy: Video recording cameras are used throughout the office for your security. Also, pictures are taken in the office and they could be used for marketing purposes. Your authorization is herby granted.

IMPORTANT INFO ABOUT APPOINTMENTS: When you make an appointment, our office makes our commitment and we reserve the time to see and treat your child. Therefore, it is of the upmost importance that you keep your reserved appointment. If you need to reschedule, we must receive **48 hours notice** prior to your reserved appointment. However, if we receive your notice to cancel **within 48 hours** of your appointment, your account will access a $35.00 broken appointment fee (subject to change).

Signature: _____ ***Date:*** _____

Relationship to Child:_____ ***Parent/Guardian SS#:***_____ - _____ - _____

TOOTHTOWN

Pediatric Dentistry PA.

Sue Yang, D.M.D.

PATIENT NAME: _____ AGE: _____ Date of Birth: _____

MEDICAL INFORMATION

Child's Physician: _____ Physician's Phone: _____ Date of Last Exam: _____

Physician's Address: _____ City & Zip: _____

MEDICAL HISTORY: Certain illness and drugs may have a direct effect on the oral cavity and, consequently, dental treatment. To render appropriate dental care, we need the following information.

DOES YOUR CHILD HAVE OR EVER HAD THE FOLLOWING? If "YES," please check all that is applicable:

_____Anemia	_____Cleft Lip/Palate	_____Heart Problems	_____Rheumatic Fever	_____Asthma
_____Convulsions	_____Jaundice	_____Sight Problems	_____Bladder Problems	_____Diabetes
_____Kidney Problems	_____Speech Problems	_____Blood Disorder	_____Epilepsy	_____Liver Problems
_____Thyroid Problems	_____Cerebral Palsy	_____Fainting	_____Mental Retardation	_____Tuberculosis
_____ Chronic Sinus	_____ Hearing Problems	_____Murmurs	_____ Other	

Please explain any of the "YES" checked above: _____

Does your child have any special needs? _____

	Yes	No		Yes	No
1. Is your child under physician care now?	___	___	4. Is child taking any Medication?	___	___
2. Is there any excessive bleeding when cut?	___	___	If yes, what medications? _____		
3. Does child have good physical coordination?	___	___	5. Has your child ever been hospitalized?	___	___
			If yes, When and Why? _____		

Does your child have allergies to any of the following? (Please check ALL that is applicable)

PENICILLIN □ LATEX □ ASPIRIN □ LOCAL ANESTHETIC □ OTHER □ _____

DENTAL HISTORY

	YES	NO
Are immunizations current?	____	____
Has your child had trouble from previous dental care?	____	____
Does your child have pain in the jaw?	____	____
Has any local anesthetic ever been administered to your child?	____	____
Is your child taking fluoride supplements?	____	____
Does your child have bad breath?	____	____
Does your child have frequent sores on lips or mouth?	____	____
Is your child experiencing any pain or sensitivity in their mouth or teeth?	____	____

Does your child have any of the following habits?

	YES	NO
Lip sucking/biting	____	____
Nail biting	____	____
Breathing through mouth	____	____
Clenching/grinding teeth	____	____
Thumb/finger sucking	____	____
Used pacifier	____	____
Tongue/cheek biting	____	____
Tongue thrust	____	____
Breast fed	____	____
Frequent bottle use or sleeps with bottle at night?	____	____

Is there any other problem not covered in this section that you would like to discuss? Please specify: _____

Since this patient is a minor, it is necessary that we obtain the signed permission from the parent or guardian before any dental service can be performed and as such, authorization is hereby granted by you. Furthermore, I will be responsible financially for any bill incurred on the patient for dental treatment or, if I indicated someone else is responsible, permission is granted for verification. I authorize TOOTHTOWN to release my child's health information to the insurance carrier(s) named on the form provided and to any third party involved in conducting normal healthcare operations.

Signature: _____ ***Date:*** _____

Relationship to Child: _____ ***Parent / Guardian SS#:*** _____-____-_____

ToothTown Pediatric Dentistry

FINANCIAL POLICY

Our philosophy is to make your child's dental visit as personalized and pleasant as possible. In an effort to keep fees reasonable with high quality care, we have established the following policies:

- All routine dental treatment ($155-$350) must be paid in full at the time of the treatment.
- Cash or major credit cards are acceptable forms of payment (no checks).
- For large treatment plans, you can request our front desk for an ESTIMATE of the expected fees.

For patients who have DENTAL INSURANCE:
Deductibles and co-payments are due at the time of the appointment.

A. Dental insurance should help you cover SOME BUT NOT ALL of the fees for services rendered to your child (Your dental coverage is determined by the policy selected by your employer).
B. Please be aware that NO INSURANCE PAYS 100% OF ALL PROCEDURES.
C. We treat every patient with equal care and firmly believe your child deserves established, routine, and acceptable dental procedures.
D. For your child's best interest, his/her treatment should not be influenced by insurance.
E. While we will do our best to get coverage from your insurance plan, you are ultimately responsible to verify your children's insurance coverage.
F. If the payment from your insurance company is not received within 30 days of submittal, you will be responsible for the entire fee and the balance is due in full immediately.
G. The following procedures are often not covered by most insurance plans:
    - Composite (white, tooth-colored) filling on back teeth.
    - Involved nerve treatments such as pulpectomies.
    - Sealants in non-permanent molars.
    - Laughing gas (N2O) and Safety Blanket (papoose).
    - Orthodontic treatment such as space maintainers and fixed appliance therapy.

"I have read and understood ToothTown's financial policy. I am aware that a 1.5-% interest rate will be charged on all unpaid balance on a monthly basis until the balance is paid in full. If the balance remains unpaid after 30 days, I fully understand that I will be responsible for all late fees and collection costs (up to an additional 50% of the past-due balance). If I have insurance, I hereby authorize the release of any information relating to any claims and I assign payments of the dental benefits directly to ToothTown Pediatric Dentistry, P.A."

Please sign below if you have read and understood the financial policy

_____ _____
Signature of Parent or Guardian Date

TOOTHTOWN

Pediatric Dentistry
Sue Yang, D.M.D.
Notice of Privacy Practices

THIS NOTICE DECRIBES 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 laws 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 the Notice while it is 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 below 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 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. If you give us an authorization, you may revoke it in writing at anytime. Your revocation will not affect any use of 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 health information to you, or assist in the notification of (including identifying or locating) a family member, friend or other person to the extent necessary to help with our healthcare or with payment for your healthcare or with your payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may or disclose health information to you, 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 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 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 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 officials 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 also 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 contract 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 $1.00 for each page, $25 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 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. If dental records are requested, we will charge a $25 processing fee, and may take from 5-7 business days to complete. Contact us using the information listed at the end of this Notice for a full explanation of our policy.

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 request.

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 so, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request the right that we communicate 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 (request must be made 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 website 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 other 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 to have us communicate with our 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.

We support your right to privacy of your health information. We will not retaliate if you choose to file a complaint with us or with the U.S.

Department of Health and Human Services.
Mr. Abraham Lee
c/o ToothTown Pediatric Dentistry, P.A.
1037 South State Road 7, Suite 215
Wellington, Florida 33414
Telephone: 561-333-4568

TOOTHTOWN

Sue Yang, D.M.D., Pediatric Dentistry
1037 S. SR7 / US441 Suite 215 Wellington, FL 33414 Phone: (561) 333-4568

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"You May Refuse to Sign This Acknowledgement"

I, _____, have received the attached copy of this Office's Notice of Privacy Practice.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION B: PATIENT GIVING CONSENT

Patient Name: _____

Parent/Guardian: _____ Parent/Guardian SS#: _____

SECTION B: TO THE PATIENT- PLEASE READ CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.
Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment, activities, and healthcare operations, of uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.
We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.
Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above, Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we receive your revocation, and that we may decline to treat or to continue treating you/your child if you revoke this Consent.
I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to you use and disclosure of my protected health information to carry treatment, payment activities, and healthcare operations. I release, hold harmless and agree to indemnify the Practice, its employees and agents for any and all liability arising out of our occurring under this consent.

Parent/Guardian Signature: _____ Date: _____

Relationship to Patient: _____

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
- Communication barriers
- An emergency situation
- Other (specify) _____