

Sarrell Regional Dental Center Office Policy

Welcome to our office! We would like to thank you for giving us the opportunity to provide you and your child/children with the most up-to-date dental care possible. It is our commitment to provide your child with the best treatment, and care available.

Please understand that our average patient is between the ages of 3 and 5 and we can only work as fast as each child will allow. With that said, please note we can only provide you with an estimate of your child's appointment time.

PARENTS, it is our policy to try to encourage a one-on-one relationship between your child and our staff. To obtain this we often ask the parent to wait in the lobby until their presence is needed and requested by the doctor or staff. This does not mean you are not allowed to check in on your child at any time, but please keep in mind your child's reaction to your entrance. It has been our experience that most children often behave better in this one-on-one environment.

For children under the age of 18 years, a PARENT/GUARDIAN must remain on the premises at all times while treatment is under way. We understand the conflict of work schedules and appointments, but your child cannot and will not be treated unless someone who is able to make LEGAL decisions is present.

Please consider your scheduled appointments carefully. These appointments are reserved exclusively for your child. Missed/cancelled/rescheduled appointments (broken appointments) without a 24-hour notice leaves "care-time" unused, time that could be used for another child. We also have special doctors who commute solely for special cases. Without a 24 hour notice these doctors make a special trip and set aside time specifically for child and thus this time goes unused.

Thanks again for trusting Sarrell Regional Dental Center and giving us the privilege to serve your child's dental needs. If you have any concerns, please feel free to ask our qualified, professional staff.

Patient Information

Patient Name _____ Date: _____
Last, First MI (Preferred Name) Gender: _____ Family Status: _____
Social Security #: _____ Birth Date: _____
Phone (Home): _____ (Work): _____ (Cell) _____
Preferred appointment times: Morning Afternoon Evening Any Time M T W T F S
Address: _____
Street Apartment #
City State Zip Code

Health Information

Have you ever had any of the following? Please check those that apply:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Growths | <input type="checkbox"/> Mitro Valve Prolapse | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> STD |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Head Injuries | Due date: _____ | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Respiratory Problems | OTHER: |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Sinus Problems | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach Problems | |

- Have you ever had any complications following dental treatment? Yes No
If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
If yes, please explain: _____
- Are you now under the care of a physician? Yes No
If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? Yes No
If yes, please explain: _____
- Please list any medications you/your child is currently taking: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian _____ Date: _____

Child's Habits

How often does your child brush? _____ How often does your child floss? _____
Date of Last Dental Visit _____ Reason? _____ Dentist? _____
Is your child's water fluoridated? Yes No Does your child take fluoridated? Yes No

Does your Child:

Suck thumb/finger ? <input type="checkbox"/> Yes <input type="checkbox"/> No	Suck/bite lip? <input type="checkbox"/> Yes <input type="checkbox"/> No	Bite/chew nails ? <input type="checkbox"/> Yes <input type="checkbox"/> No
Chew hard objects? <input type="checkbox"/> Yes <input type="checkbox"/> No	Grind teeth ? <input type="checkbox"/> Yes <input type="checkbox"/> No	Clench Jaws ? <input type="checkbox"/> Yes <input type="checkbox"/> No

Parent or Guardian Information

The following is for: parent legal guardian

Name: _____

Male Female

Married Single Child Other _____

Social Security #: _____ Birth Date: _____

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

Address: _____

Street

Apartment #

City

State

Zip Code

Employment Information

The following two sections only apply if the patient has an insurance other than Medicaid or All-Kids

Please list the following information on the person holding the insurance for the child.

Employer Name _____ Occupation: _____

Address: _____

Street

City

State

Zip Code

Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? Yes No

Last

First

MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street

City

State

Zip Code

Insured's Employer Name: _____

Address: _____

Street

City

State

Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Consent for Services

To the best of my knowledge the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status and new medications. I authorize the dentist to release any information including the diagnosis and records of any treatment of examination rendered to my child during the period of such dental care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group, insurance benefits otherwise payable to me. I understand that my dental insurance may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss related matters to this form.

I have read the above conditions of treatment and payment and agree to their content.

Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

Permission for Dental Examination/Treatment of a minor

I am the parent/guardian of _____, who is a minor child and do hereby consent to dental procedures which may be performed during treatment by or under the direct/indirect supervision of the dentist/dentists at the Sarrell Regional Dental Center, his/her associates, staff, members, or agents as he/she deems necessary. Dental procedures may include but are not limited to emergency treatment/services, radiographic examination, administration of local anesthesia/sedative, oral surgical treatment/procedures, impression making or photographs. I further authorize and consent that the dentist has permission to choose and employ assistance as deemed fit. This authorization will remain in effect until cancelled in writing by me.

Please initial each of the following giving permission for use.

____ Mouth Prop (assists child in holding their mouth open)

____ Papoose board (passively immobilizes child to reduce risk of injury, similar function to seatbelts in an automobile)

____ Nitrous oxide/oxygen (commonly called "laughing gas", a mild sedative that is inhaled and reduces anxiety)

Date: _____ Parent/Guardian: _____ Witness: _____

HIPPA OFFICE POLICY: PLEASE READ AND SIGN THE FOLLOWING PAGE

Effective April 14, 2003

We are required by law to maintain the privacy of your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related care services. We are required to abide by the terms of our Notice of Privacy Practices ("Notice") currently in your protected health information ("PHI"). We will post each revised Notice in our office, make copies of the revised Notice available upon request and post the revised Notice on our web site.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION WITHOUT YOUR CONSENT.

Treatment. We may use or disclose your PHI to provide and coordinate your health care and related services. This may include communications with other health care professionals regarding your health care, including referral to another health care provider. For example, we may share PHI with other health care providers involved in your treatment, such as disclosing certain PHI to a laboratory that is conducting your tests or with a pharmacy when calling in your prescription.

Payment. We may use or disclose your PHI to obtain payment or be reimbursed for the health care and related services we provide for you. Such disclosures can be made to billing services, collection departments or credit bureaus. For example, even before you receive services, we may disclose your PHI with your health plan(s) to determine coverage eligibility.

Health Care Operations. We may use or disclose PHI in connection with certain administrative, financial, legal and quality improvement activities that are necessary for us to run our practice and to support our functions of treatment and payment. For example, we may use or disclose your PHI for quality assessments and improvement activities, employee training programs, licensing requirements, or conducting a medical review or audit.

Incidental Use or Disclosure. An "incidental use or disclosure" is a use or disclosure that cannot reasonably be prevented, is limited in nature and occurs as a result of another permissible or required use or disclosure. We have set up reasonable safeguards that protect against impermissible uses and disclosures and limits incidental uses or disclosures. We also have policies and procedures that set limits to ensure that, as applicable, only the reasonable minimum necessary amount of your PHI is used, disclosed and requested for certain purposes.

You can object to Certain Uses or Disclosures. For each of the uses or disclosures of your PHI listed below, if you present and able, we will either (1) obtain your oral permission, (2) give you the opportunity to object, or (3) reasonably infer from the circumstances, based on our professional judgment, that you do not object. If you are unable to object, we will use our professional judgment to disclose only such PHI as is directly related to such person's involvement in your health care. For uses or disclosures:

- to a relative, friend or other person identified by you only your PHI that is directly relevant to the person's involvement in your health care or payment for health care or payment for health care;
- to a family member, personal representative, or other person responsible for your care only your PHI necessary to notify such individuals of your location, general condition or death; or
- to a private or public agency for disaster relief purposes. (Even if you object, we are still permitted to share your PHI as necessary for emergency circumstances.)

Required Uses or Disclosures. We are required by law to disclose your PHI to you pursuant to your patient right of access and accounting as described below. We are also required to disclose your PHI to the Secretary of the Department of Health and Human Services when required for their investigation of our compliance with privacy laws.

Our Contact with You. We may use or disclose your PHI to provide with appointment reminders (such as sending postcards or leaving a voicemail message, etc.) to provide you information regarding treatment alternatives or other health-related benefits and services that may be of interest to you, and to raise funds for us.

Business Associates. We may use and disclose your PHI with our business associates. A "business associate" is a person or entity that provides certain functions, activities or services on our behalf pursuant to a written agreement that contains terms regarding protection of your PHI.

Your PHI may be used or released for the following:

- for medical research;
- to coroners, medical examiners or funeral directors;
- for cadaveric organ, eye or tissue donation purposes;
- to avert a serious threat to the health or safety of a person or the public;
- for specialized governmental functions; or
- for workers compensation.

ALL OTHER USES AND DISCLOSURES OF YOUR PHI REQUIRES YOUR WRITTEN AUTHORIZATION. You may authorize us to use or disclose your PHI for other purposes. You may revoke this authorization in writing at any time; however, your revocation will not apply to any uses or disclosures that were being processed before we receive your revocation.

YOUR PATIENT RIGHTS.

Restrictions. You have the right to ask us to restrict our uses or disclosures of part or all of your PHI for treatment, payment, health care operations or to individuals involved in your care. However, we are not required to agree to your requested restriction. If we do agree to your restriction, we will only use and disclose your PHI in accordance with such restriction, unless otherwise permitted or required by law. (You may request a restriction by contacting our Privacy Officer.)

Confidential Communications. You have the right to request that communications about your PHI be delivered by an alternative means or at alternative locations. For example, you may request that we contact you at your workplace about appointments, you must make such requests in writing. We will accommodate reasonable requests, but may condition such accommodations upon receipt of satisfactory explanation of how payments for your services will be handled and an alternative address or other method of contact. (Please contact our Privacy Officer to request a Confidential Communications Request Form.)

Access. You have the right to inspect and obtain a copy of you PHI contained in clinical, billing and certain other records used to make decisions about you, except in certain limited situations. Your request must be in writing and we will charge you reasonable cost-based fees for expenses (such as copying and employee time). Instead of copies we may provide you with a summary of your PHI, if you agree to the form and cost of such summary. We may, in some cases, deny your request and will notify you in writing of the reasons for our denial and provide you with information regarding your rights to have our denial of your request reviewed. (You may request to see and receive a copy of PHI by contacting our Privacy Officer.)

Amendments. You have the right to request an amendment to your PHI contained in clinical, billing and certain other records used to make decisions about you, except in certain limited situations. You request must be in writing and provide a reason to support the requested amendment. We may, in some cases, deny your request for amendment and will notify you in writing of the reasons for our denial, provide you with information regarding your rights to submit a written statement disagreeing with such denial and provide information on how to file such statement. (You may request an amendment of your PHI by contacting our Privacy Officer.)

Accounting. You have the right to receive a listing of disclosures of your PHI made for purpose other than treatment, payment, health care operations, upon your request, your authorization, to individuals involved in your care or as allowed by law. You may request all such disclosures made during the last 6 years (but not any disclosures made prior to April 14 2003). If you request this list more than once in a 12-month period, we may charge you reasonable cost-based expenses to comply with you additional requests. (You may request a listing of disclosures by contacting our Privacy Officer.)

Electronic Notice. If you received this notice by email or off our web site, you have the right to receive this notice in written form upon your request. You may request a written copy of this Notice by contacting our business office.

Questions and Complaints.

If you have any questions or feel that your privacy rights have been violated by us or want to complain to us about our privacy practices, you can contact our Privacy Officer by writing to the following address:

Sarrell Regional Dental Center 230 E. 10th St. Suite 106 Anniston, AL 36207

Sarrell Regional Dental Center
230 E. 10th Street Suite 110
Anniston, AL 36207
(256) 741-7340

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICIES/ HIPPA POLICIES

I have had access to and read the HIPPA/Privacy Practices of this office.
I understand and agree to the said policy.

SIGNATURE: _____

DATE: _____

- _____ Responsible party refused to sign.
- _____ An Emergency Situation prevented us from obtaining a signature.
- _____ Other. Explain _____

**NOTICE: THE SARRELL REGIONAL DENTAL CENTER RESERVES THE
RIGHT TO REFUSE DENTAL TREATMENT TO ANYONE**