Authorization to Treat

Patient Name

I authorize Dr. Gregory C. Thiel to perform a complete dental examination and procure any necessary radiographs (x-rays).

________________________________________

signature                        date

________________________________________

relationship to patient

I authorize Dr. Gregory C. Thiel to perform a complete dental examination, procure any necessary radiographs (x-rays), and administer dental prophylaxis (cleaning of the teeth) with a topical fluoride application.

________________________________________

signature                        date

________________________________________

relationship to patient
Financial Policy

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions, please discuss them with our billing staff or office manager. We are dedicated to providing the best possible care and service to your child and regard your complete understanding of our financial policies as an essential element of care and treatment.

- Payment is due at the time of service unless other arrangements have been made in advance by either yourself or your dental plan coverage. For your convenience, we will accept cash, check, Visa, MasterCard, and American Express.

- Your insurance is a contract between you and your insurance company. As a courtesy, upon verification of coverage, we will file your insurance claim for you, collecting at the time of service any estimated co-payment, if you assign the benefits to the doctor; in other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.

- We are contracted with Delta Dental (DeltaPremier) and Blue Cross Blue Shield of Texas (DentaBlue). If you are covered by one of these plans, we will bill your plan and will only require you to pay your estimated co-payment at the time of service. Any remaining balance would be due upon receipt of our statement.

- All dental plans are not the same and do not cover the same services. In the event your dental plan determines a service to be “not covered” or over what they deem “usual and customary charges”, you will be responsible for this amount. Payment is due upon receipt of statement from our office. If payment is not made upon receipt of our statement, we will no longer file insurance and expect payment in full at the time of service.

- Your estimated portion of our fees for scheduled hospital procedures is due one week prior to the surgery date. Any balance remaining after your dental plan pays is your responsibility and payment is due upon receipt of statement from our office.

- We will look to the adult accompanying a minor for all services rendered to minor patients.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

______________________________________________________________

signature                      date

______________________________________________________________

relationship to patient
PATIENT NAME ___________________________________ NICKNAME __________________ BIRTHDAY __________________

HOME ADDRESS ___________________________________ CITY _______________ ZIP ______________

PARENT/GUARDIAN NAME _______________________________ DOB _______________ DL# ______________
WORK PHONE ___________________ CELL PHONE ___________________ HOME PHONE ___________________

EMAIL ___________________________________________ (used to confirm appointments)

EMPLOYER _______________________________ OCCUPATION _______________________________ SS# __________

PARENT/GUARDIAN NAME _______________________________ DOB _______________ DL# ______________
WORK PHONE ___________________ CELL PHONE ___________________ HOME PHONE ___________________
HOME ADDRESS IF DIFFERENT ________________________________________________________________

EMPLOYER _______________________________ OCCUPATION _______________________________ SS# __________

NEAREST RELATIVE NOT LIVING WITH YOU ___________________ RELATION ______________
HOME ADDRESS __________________________________________________________ PHONE ______________

INSURANCE COVERAGE □ YES □ NO PERSON RESPONSIBLE FOR ACCOUNT ________________________________

WHO REFERRED YOU TO THIS OFFICE? ________________________________

MEDICAL HISTORY RECORD

Is your child being treated by a physician at this time? ................................................................. □ YES □ NO

Reason: ___________________________________________________________________________________

Is your child taking any medication (prescription or over the counter), vitamins, or dietary supplements? ...... □ YES □ NO

List name, dose, frequency & date started: _______________________________________________________________________________________________

Has your child ever had a reaction to or problem with an anesthetic? ................................................................. □ YES □ NO

Describe: ___________________________________________________________________________________

Has your child ever had a reaction or allergy to an antibiotic, sedative or other medication? ......................... □ YES □ NO

Describe: ___________________________________________________________________________________

Is your child allergic to LATEX? ................................................................................................................ □ YES □ NO

Is your child allergic to any metals, acrylic, dye(s) or certain food(s)? ............................................................. □ YES □ NO

List: _______________________________________________________________________________________

Has your child or any siblings tested positive to any of the following: ...................................................... □ YES □ NO

__ Hepatitis A (infectious) __ Hepatitis B (serum) __ HIV (AIDS)

Has your child ever been hospitalized or have any health concerns that we should be aware of? ................. □ YES □ NO

Diabetes ____ Kidney ____ Liver ____ Bleeding disorder ____ other _________________________________

Describe: ___________________________________________________________________________________

Diabetes ____ Kidney ____ Liver ____ Bleeding disorder ____ other _________________________________

Describe: ___________________________________________________________________________________
MEDICAL HISTORY RECORD CONTINUED

Does your child have prolonged bleeding from cuts? ................................................................. □ YES □ NO

Does your child have seizures? ......................................................................................................... □ YES □ NO

Describe: _____________________________________________________________________________

Does your child have a history of heart trouble or a heart murmur? ............................................. □ YES □ NO

Describe: _____________________________________________________________________________

Does your child have any breathing issues? ..................................................................................... □ YES □ NO

If yes, please check all that apply:  Asthma ___  RAD ___  RSV ___  Seasonal / allergy related _____

Does your child use an inhaler or nebulizer? .................................................................................. □ YES □ NO

Describe: _____________________________________________________________________________

Does your child have any other medical conditions (mental or physical) not listed above? .............. □ YES □ NO

Describe: _____________________________________________________________________________

Physician: ________________________________________________________________________________ Phone: _____________________________

Date of last medical exam: ______________________

DENTAL HISTORY

Is this your child’s first visit to the dentist? ..................................................................................... □ YES □ NO

What is the name of the last dentist seen / family dentist? __________________________________________

Please list the date of the following:

Dental exam ___________ topical fluoride treatment ___________ x-rays ________________

Has your child experienced an unfavorable reaction from previous dental or medical care? .............. □ YES □ NO

Describe: _____________________________________________________________________________

Does your child have any mouth habits (thumb sucking, pacifier, etc.)? ........................................... □ YES □ NO

Do you desire complete, thorough dental care for your child? ........................................................ □ YES □ NO

Does your child have any dental problems or do you have any questions or concerns?

Describe: _____________________________________________________________________________

POINTS OF INTEREST

Child’s interests _____________________________________________________________

___________________________________________________________

Child’s favorite color _____________________________________________________________

Pet’s name(s) _____________________________________________________________

Siblings treated here _____________________________________________________________

To the best of my knowledge, the questions on this form have been answered accurately. It is my responsibility to inform the
dental office of any changes in medical status. I authorize my insurance company to give all necessary information required by Thiel
Pediatric Dentistry in order to process any claims.

Signature: _____________________________ Date: ________________

(Parent / Guardian)
Notice of Privacy Practices
Acknowledgement

I, __________________________ received a copy of this office’s Notice of Privacy Practices.*

________________________________________
patient name

________________________________________
please print your name

________________________________________
signature                        date

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 acknowledgement
☐ An emergency situation prevented us from obtaining acknowledgement
☐ Other (Please Specify):

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
Notice of Privacy Practices

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 duty, 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 04/01/08, 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 policy 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 and disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment
We may use/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 effect 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 to notify, as described in the Patient Rights sections 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 judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgement 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 safety or the health of 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 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 $0.75 for each page, $15.00 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 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 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 at info@thielpediatricdentistry.com.

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.

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.