BIENVENIDO A NUESTRA OFICINA

Malcolm Pediatric Dentistry
Forma de Inscripción

Información del Paciente

Primer Nombre:________________________________Apellido:____________________________ Inicial:______

Dirección: ____Teléfono de Hogar:_____________________

Ciudad/Estado/Código Postal:____Teléfono Cel:___________________

Fecha de Nacimiento:____________________________ Número Seguro Social:_______________________________

Información del Padre/Madre o Tutor Legal

Primer Nombre:________________________________Apellido:____________________________ Inicial:______

Dirección: ____Teléfono de Hogar:______________________

Ciudad/Estado/Código Postal:____Teléfono Cel:_____________________

Fecha de Nacimiento:____Teléfono de Trabajo:____________________

Número Seguro Social:__________________________________ Relación a Paciente:___________________________

Información del Seguro

Nombre del Asegurado: Primer_____________________ Apellido:_______________________

Fecha De Nacimiento:_____________Número Seguro Social del Asegurado:_________________________________

Empleador:______________________________________Dirección:____

Nombre de Aseguradora Dental (compañía): ______________________________________

Dirección:____Teléfono_______________________________

No. de Grupo:__________________________________ No. de identificación:____________________________________

Información del Seguro Secundario (si es aplicable)

Nombre del Asegurado: Primer________________________ Apellido:__________________________

Nacimiento:____________ Número Seguro Social del Asegurado:_______________________________________

Empleador:____Dirección:____

Nombre de Aseguradora Dental: (compañía)____

No. de Grupo:_______________________________________ No. de identificación:________________________________

Forma de Historia Médical

Nombre del Paciente		Fecha de Nacimiento & Edad	
Razón por la visita hoy?			

¿Ha tenido su hijo(a) cualquiera de lo siguiente? (Sí o No). Explique las respuestas con "sí."

S / N	Condición	Explique "sí"	S / N	Condición	Explique "sí"
	Murmullo en el corazón/ Complicación de válvula			Complicaciones en el corazón	
	Cáncer/ Quemoterapia			Convulsiones/Epilepsia Desmayos/Vahídos	
	Diabetis			Sangrado anormal	
	Fiebre reumática			Discapacidad auditiva o problemas de oído	
	HIV positivo / AIDS			Trastorno de Vista o Habla	
	Hemofilia			Herpes	
	Asma/Problemas de respirar			Problemas de Riñón o Hígado	
	Hepatitis			Impedimento físico	
	Tuberculosis			Alergia de Látex	
	ADD o ADHD			Problema de Estómago /Pulmón/Intestinal	
	Enfermedad Hematológica/ Transfusiones			Herpes (labial)/Urticaria/Erupción	
	Tumores/Úlceras			Ictericia amarilla	
	Dolor de Cuello/Espalda/Mandíbu la			Amigdalitis	
	Bipolar/ODD/OCD			Síndrome de Down	
	Autista/Retraso Mental			Problemas sensoriales	
	Parálisis (perlesía) cerebral			Problemas de comportamiento	

Por favor, detalle cualquier problema medical serio o estancias hospitales:

¿Tiene su hijo(a) algunos Trastornos / Problemas del Desarrollo, Tipo?	
¿Tiene su hijo(a) algunas Problemas Emocionales, Tipo?	
¿Tiene su hijo(a) algunas Problemas de Aprendizaje, Tipo?	
¿Tiene su hijo(a) alguna historia de Abuso de Menores, Mental/Físico?	
Liste todos los medicamentos que toma actualmente su hijo(a).	
Liste cualquiera alergia a los medicamentos o alergias en general que tiene su hijo(a).	

¿Tiene su hijo(a) algunos de hábitos siguientes? S / N	¿Chuparse el dedo?	Chuparse el labio o morderse, Morderse las uñas?	Todavía amamantando o usando el biberón?	Se usa el chupete?
	S / N	S / N	S / N	S / N

Yo entiendo que la información que he dado es correcta al conocimiento que yo sepa, que estará guardada en la más alta confianza, y es mi responsabilidad informar la oficina de cualquier cambio en el estado medical de mi hijo(a).

*X*____ *fecha:*____________________

Gracias por llenar esta forma completamente. Nos permitirá dar la mejor atención dental posible a su hijo(a). Si tiene usted o su hijo(a) algunas preguntas, por favor no dude en preguntarnos en cualquier momento.

Malcolm Pediatric Dentistry
Andy J. Malcolm, D.D.S, PC
163 Cadillac Court, Suite 3
Belvidere, Il 61008

Authorization for Release of Identifying Health Information

Patient Name:____

Patient Address:____

Patient Phone Number:____

I authorize the professional office of my dentist named above to release health information identifying me (including, if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services) under the following terms and conditions:

1. Detailed description of the information to be released:
2. To whom may the information be released (names or classes of recipients):
3. The purpose(s) for the release (if the authorization is initialed by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):
4. Expiration date or event relating to the individual or purpose for the release:

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.
If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked.
When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.
Authorizations include, as applicable: We will receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.
I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient/Guardian Signature:____

Date:____

Effective date of notice: 5-15-2007

NOTICE OF PRIVACY PRACTICES

Malcolm Pediatric Dentistry, P.C.
163 Cadillac Court – Suite 3 Belvidere, IL 61008
Office: 815-544-0909

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we will ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I reviewed a copy of Dr Andy Malcolm's Notice of Privacy Practices:

Patient Name:

Parent Name:

Parent Signature: Date:

Malcolm Pediatric Dentistry

OFFICE POLICIES

Welcome to Malcolm Pediatric Dentistry! We are glad you made the choice to allow us the opportunity to work with you and your child. Please do not hesitate to contact one of our staff members if you need anything or have a suggestion about how to make your next visit more enjoyable.

OFFICE HOURS
Monday – Thursday 7:30-4:30, Lunch 1:00-2:00

PAYMENT
We will file your primary insurance for you. You will be responsible for the remaining balance not covered by your insurance company. **Payment is required at the time services are rendered.** We accept cash, check, Master Card, Visa, Discover, American Express and debit cards as forms of payment. There will be a $35 fee for returned checks.

TREATMENT PLANS
Should your child require dental treatment, these needs will be discussed with you by one of our staff members. In most cases, an additional appointment(s) will be needed to complete the treatment. The payment amount provided to you on your child's treatment plan is an *estimate only*, and you may be asked to pay the difference between what your insurance company actually paid and the fees incurred at the time of service.

Please note that we try very hard to inform you of what procedures will be performed, how much they cost, and what your particular insurance will cover. However, if a service is provided that is not covered for any reason (i.e., repeat treatment, over-extension of allotted funds, etc), then **you will be responsible for payment at the time of service.**

SPECIAL PROCEDURES
Conscious Sedation - Should your child require a conscious sedation appointment, a down payment for the sedation fee is required prior to appointment. Please understand that most insurance companies do not cover sedation fees and these will be an out-of-pocket expense.

General Anesthesia – At Malcolm Pediatric Dentistry, we have the ability to treat patients under General Anesthesia in a hospital/surgery center. Should your child require such treatment, these options will be discussed with you in detail. Once the appointment is scheduled, if you choose to cancel or reschedule the appointment this deposit is non-refundable. The deposit is required to schedule the appointment for both conscious sedation and GA Sedation; however, for GA appointments your estimated portion for treatment MUST be paid at least 3 days prior to the scheduled appointment.

APPOINTMENTS
We request that, should you have to cancel or reschedule your child's appointment, you provide us at least 24 hours notice. **If 2 broken/missed appointments occur or 2 cancellations without at least 24 hours notice, we reserve the right NOT to schedule any subsequent appointments. We also reserve the right to charge a cancellation fee of $50 as an out of pocket expense.** We also reserve the right to schedule certain types of appointments (fillings, extractions, cleanings, etc.) at specific times of the day. **If our office is unable to confirm or leave a message with you for an upcoming appointment due to a disconnected or invalid number, we reserve the right to cancel your appointment.**

PARENT PARTICIPATION
Parents are always welcome and encouraged to accompany their child in the treatment areas during routine visits.
Please ask a staff member if you have any questions or need clarification on any of our policies.

Thank you for choosing Malcolm Pediatric Dentistry!