WELCOME TO MALCOLM PEDIATRIC DENTISTRY

Patient Information   *Preferred Language: ___________________________

First Name:	Last Name:	Middle Initial:
Address:	City/State/Zip:	
Birthdate:	Primary Phone: ( ) -	
Social Security #:	Secondary Phone: ( ) -	
Primary Dr:	Preferred Pharmacy:	
Head Start/Foster/DCFS Child? NO____ YES ____ if yes, Organization Name:		
Case Worker Contact Name & Phone Number:		

Responsible Party Information (Parent or Guardian)

First Name:	Last Name:	Middle Initial:
Address:	City/State/Zip:	
Birthdate:	Social Security Number:	
Primary Phone: ( ) _	E-mail:	
Relation to Patient:	May we leave you a voicemail? Yes ☐ / No ☐	
Anyone Else that May be accompanying your Child and their relationship: (parent/grandparent/guardian/relative)		

If you don't have a physical copy of your **dental insurance card**, you may e-mail us a picture of the front & back to **MalcolmPD@yahoo.com**

If you e-mail us or have a physical copy of your insurance card, **we will still need you to fill out the following information below**

Primary Insurance Information:		
Policy Holder's Name: (first)	(last)	DOB:
Policy Holder Social Security Number:		
Place of Employment:		
Dental Insurance Name:		
Address:	Phone #:	
Group Number:	ID Number:	

Secondary Insurance Information: (if applicable)		
Policy Holder's Name: (first)	(last)	DOB:
Policy Holder Social Security Number:		
Place of Employment:		
Dental Insurance Name:		
Address:	Phone #:	
Group Number:	ID Number:	

Office Use Only:

Parent/Guardian Name: ______________________________

Medical History Form ______ **Established Family?**

Patient's Name :		**Birth date & Gender**	/ / **M / F** (circle)
Reason for office visit?		**DATE OF LAST CLEANING**: / /	

Has your child ever had any of the following: Please write either (Y or N) & explain any "yes" answers

Y / N	**Condition (please circle if multiple)**	**Explain "yes" and level of**	**Y / N**	**Condition (please circle if multiple)**	**Explain "yes" and level of**
	Heart Murmur/ Valve Complication *(circle)*			Heart Complications	
	Cancer/ Chemotherapy			Convulsions / Epilepsy Fainting / Dizzy Spells *(circle)*	
	Diabetes			Abnormal Bleeding	
	Thyroid Disorder			Hearing Impairment Or Ear Problems	
	HIV+ / AIDS			Sight or Speech disorder *(circle)*	
	Hemophilia			Herpes	
	Asthma/Breathing Problems			Kidney or Liver Problems *(circle)*	
	Hepatitis			Physical Handicaps	
	Tuberculosis			Latex Allergy	
	ADD or ADHD *(circle)*			Stomach/Lung and/or Intestinal Problems *(circle)*	
	Blood Disease/ Transfusions			Cold Sores / Hives/ Rash *(circle)*	
	Tumors/Growths Ulcers			Neck/Back/Jaw Pain	
	Intellectual Disability			Tonsillitis	
	BiPolar/ODD/ OCD/PDD *(circle)*			Down Syndrome	
	Autism			Sensory Issues	
	Cerebral Palsy			Behavioral Problems	

Is your child a part of: DCFS, Foster Care, or Head Start? (if yes, please circle)

Please detail any serious medical problems, hospital stays and/or surgeries:

Does your child have any Developmental Delays/Disorders, Type?				
Does your child have any Emotional Disabilities, Type?				
Does your child have any Learning Disabilities, Type?				
Does your child have any history of Child Abuse, Mental/Physical?				
List all drugs child is currently taking				
Does your child have any drug Allergies or other Allergies Y/N	(if yes please list)			
Does the child have any of the following habits? →	Thumb or finger sucking?	Lip Sucking or Biting, Nail biting?	Still Nursing or use a Bottle?	Uses a Pacifier?
	Y / N	Y / N	Y / N	Y / N

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform the office of any changes in my child's medical status.

X____ *date:* ________________________

Thank you for filling out this form completely, it will enable us to give your child the best dental care possible. If you or your child has any questions, please don't hesitate to ask.

Effective date of notice: 5-15-2007

NOTICE OF PRIVACY PRACTICES

Malcolm Pediatric Dentistry, 163 Cadillac Court – Suite 3, Belvidere, IL 61008
Office: 815-544-0909-Fax: 815-544-0922
E-mail:MalcolmPD@yahoo.com

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; 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; 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 don't 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. We will accommodate these requests if they are reasonable. If you want to ask for confidential communications, send a written request to send a written request to our office.
- 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 our office.
- 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, & 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 our office, e-mail, or fax number.
- get a list of the disclosures that we have made of your health information within the past 6, or less years 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're 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 tour office, e-mail, or fax.

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 our office, e-mail, or fax. 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. You may also e-mail or send a fax requesting this information.

ACKNOWLEDGEMENT OF RECEIPT

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

Patient(s) Name:____

Parent/Guardian Name: ____

Parent(s) Signature______________________________**Date:**______________

OFFICE POLICIES

Welcome to Malcolm Pediatric Dentistry! We are glad you made the choice to allow us the opportunity to work with you & 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.

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 reserve the right to charge a cancellation fee of $50 as an out of pocket expense.

APPOINTMENTS

We request that, should you have to cancel or reschedule your child's appointment, you provide us at least 24 hours notice. We 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.**

PAYMENT/FINANCIAL POLICIES

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.

PAST DUE ACCOUNT POLICIES All accounts having a past due balance for 90 days or more will have a Finance charge of 1.5% added to their account & a $25 charge per month on past due accounts (this includes outstanding insurance claims). If an account becomes past due for more than 120 days, your account may be turned over to any 3rd party Collection Agency and/or placed with an attorney to obtain judgment. In this event, all collection costs, attorney fees, filing fees, interest, and court costs will be added to the total amount due.

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*.** You may be asked to pay the difference between what your insurance company pays & 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.**

PARENT PARTICIPATION

Parents are always welcome and encouraged to accompany their child in the treatment areas during routine visits. During Treatment Procedure Appointments, parent participation may be decided upon by either Dr. Malcolm or Parents/Guardians.

APPOINTMENT REMINDERS/ACCOUNT/TREATMENT/INSURANCE MESSAGES

By signing below, you Malcolm Pediatric Dentistry (& our service providers, successors, assigns, affiliates, or agents) permission to contact you at any telephone number associated with my account(s), including cell phone numbers that may result in charges to me, & allow us to leave a message regarding our reason for calling that may include you or your child's information.

By signing below, you have read, understand, & agree to our Office & Financial Policies at Malcolm Pediatric Dentistry.

Signature:	Date:

THANK YOU FOR CHOOSING MALCOLM PEDIATRIC DENTISTRY!