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GREAT SMILES START HERE!
PEDIATRIC DENTISTRY
Dr. John M. Willis, D.D.S.

Welcome to our practice! We thank you for choosing Falmouth Pediatric Dentistry.

Enclosed you will find a Registration form, Insurance form, Medical History form, Office Policies, and a HIPAA form to be filled out and brought with you on the day of your appointment. Having this completed *before* you arrive will make your visit much quicker. Any missing or incomplete information may require us to reschedule your child's appointment.

You must also bring a valid **Photo ID** as well as complete insurance information. In addition, **a parent or legal guardian must be present at the first appointment**.

Please feel free to write down any questions that you may have so we may discuss them with you.

If your child was referred to us, we have scheduled a get acquainted appointment where we will spend some time getting to know you and your child, do an examination, and discuss a treatment plan for your child. If your child needs to return for restorative work at our office, we will provide you with an estimate.

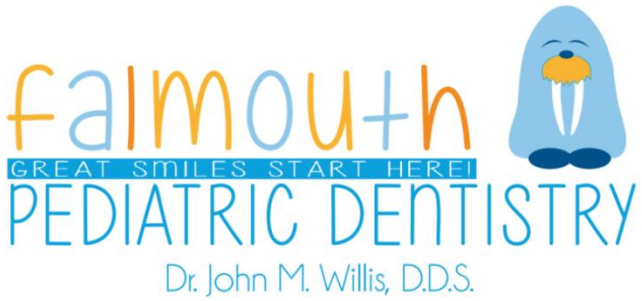
We aim to develop a strong bond with your child – a relationship that will lead to good oral health. We encourage parental involvement, and want you to be aware of your child's oral health. For cleaning appointments, we welcome parents into the room so that we can discuss any challenges you may encounter with homecare and to get to know your family. For restorative appointments, we find that children do best when we have their undivided attention and ask that parents remain in the waiting room. We are always happy to discuss this philosophy with you in person if you have any questions.

As a courtesy, we will prepare and submit your insurance claim forms. Please provide us with an insurance card showing proof of dental insurance coverage.

Please call our office if you require any additional information before your next appointment. We look forward to seeing you soon.

Best,
Falmouth Pediatric Dentistry

(207)781-2272 (207)781-3605
6 Fundy Road Falmouth Maine 04105
info@falmouthpediatricdentistry.com
www.falmouthpediatricdentistry.com



Patient Registration – Please fill out all fields

Today's Date: ___/___/____

Patient Name:_____ Date of Birth: ___/___/____
Last First Middle Circle one: Male / Female

Legal Guardian Name:_____Date of Birth: ___/___/___
Last First Middle

Mailing Address: Street_____ City_____ State_____ Zip_____

Telephone: Home_____ Work_____Mobile_____

Email_____@_____ Drivers License Number: _____

Parent Employed by _____ Position_____

Social Security Number: _____-_____-_____

Legal Guardian Name :_____ Date of Birth: ___/___/___
Last First Middle

Mailing Address: Street_____ City_____ State_____ Zip_____

Telephone: Home_____ Work_____Mobile_____

Email_____@_____ Drivers License Number: _____

Parent Employed by _____ Position_____

Social Security Number: _____-_____-_____

Other Family Members in This Practice: _____

Who may we thank for this referral: _____

In case of emergency, if we cannot reach you, who should we contact: _____

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Insurance Information – All fields must be filled out or payment will be required at time of service

Name of Legal Guardian _____

Method of Payment (Circle all that apply): Insurance Cash Credit/Debit MaineCare
Is your child covered under MaineCare (circle only one): Yes No

Primary Dental Insurance Company: _____
Name of Policy Holder: _____ Policy Holder Date of Birth ____/____/_____
Policy or ID Number: _____ Group Number (if applicable):_____
Insurance Company Address:_____ Phone Number:_____

Secondary Dental Insurance Company: _____
Name of Policy Holder: _____ Policy Holder Date of Birth ____/____/_____
Policy or ID Number: _____ Group Number (if applicable):_____
Insurance Company Address:_____ Phone Number:_____

****

I consent to the diagnostic procedures and treatment by Falmouth Pediatric Dentistry necessary for proper care of my child(ren). I consent to the use and disclosure of my child's records to carry out treatment, to obtain payment and for those activities and healthcare operations that are related to treatment and payment in keeping with HIPAA regulations. My consent to the disclosure of records shall be effective until I revoke such in writing. I authorize payment directly to Falmouth Pediatric Dentistry of insurance otherwise payable to me. I understand that my dental insurance carrier or payor of my dental benefits may pay less than the amount billed for services and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous statements to the contrary and agree to be responsible for payment of services not paid by my dental care payor.

I attest to the accuracy of the information on this page

Legal Guardian Signature: _____ Date:_____

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Medical History

Patient's Name: _____Date of Birth:___/___/____ Sex (circle one): Male or Female

Legal Guardian's Name: _____

Race/Ethnicity: _____ Preferred Language: _____

Dental History

Is this your child's first visit to a dentist? ..... Yes / No

Date of last dental appointment: _____ Date of last dental x-rays: _____

Has your child ever had a cleaning at school or a pediatrician's office? If yes, what is the date: ..... Yes / No

Have cavities been noted in the past? ..... Yes / No

Is there a family history of cavities? ..... Yes / No

Have there been any injuries to the teeth such as falls, blows, chips or lost teeth? ..... Yes / No

Does your child snore or have sleep apnea? ..... Yes / No

Does your child suck on a pacifier, thumb or fingers? ..... Yes / No

Does your child use tobacco products such as cigarettes or smokeless tobacco? ..... Yes / No

Does anyone in the household smoke or use tobacco products? ..... Yes / No

Health History

Is your child in good health? ..... Yes / No

Date of last well child visit_____Physician's Name: _____ Phone Number: _____

Are you aware of any allergies? If yes please list: ..... Yes / No

Are you aware of any allergies to medications? If yes please list: ..... Yes / No

Does your child take any medications? (Including OTC's, Vitamins, Herbals) ..... Yes / No

If yes please list: _____

Has your child had any surgery or hospitalizations? If yes please list: ..... Yes / No

Was your child born prematurely? (Less than 37 weeks) ..... Yes / No

Please circle if your child has been diagnosed and/or treated for any of the following:

ADD/ADHD	Congenital Birth Defects	HIV/AIDS
Anxiety	Cleft lip/palate	Kidney Disease
Asthma	Developmental Delays	Liver Disease
Aspergers	Diabetes	MRSA
Autism	Eczema	Speech/hearing impairments
Behavioral/Learning problems	Heart Conditions	Seizures/Epilepsy
Cancer	Heart Murmur	Rheumatic Fever
Cerebral Palsy	Hepatitis	Tuberculosis

Please use this space to list any other medical conditions:

_____

_____

I certify the above information is complete and accurate to the best of my knowledge.

Legal Guardian's Signature: _____ Relationship to the patient: _____

I verbally reviewed the medical and dental information above: Provider's initials: _____Date :_____

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Office Policies

- **A parent or legal guardian must be present for the first visit.**
- While we highly encourage parents to attend every visit, we understand the need for family members to help out. If a family member is bringing your child, they must bring a note declaring that the family member is allowed to bring the patient. Any treatments under the care of this family member are still your financial responsibility.
- Please bring a picture identification card with you to each visit. If we are unable to identify you, you will be asked to reschedule.
- Please verify your current dental insurance prior to dental visits. While we submit claims to insurance companies, **we are not in-network with any insurance company other than Delta Dental. We do not accept HMO insurance plans.**
- We require 48 hours notice to cancel or change any appointment.
- We allow one failed appointment, after that your family will be dismissed from the practice.
- Please arrive 10 minutes before your appointment start time. This allows ample time to update your information and ensure a smooth check-out process.
- If you arrive 10 minutes past your appointment time, you will be asked to reschedule. We will do our best to reschedule your appointment to the next available time slot.
- While we do allow parents in the room for cleanings, we do not allow parents in operatory rooms during dental restorations.
- Co-payments are due in full at the time of service. Pre-treatment estimates will be sent to your insurance company to determine your out of pocket cost for dental restorations. While we make every attempt to work with your insurance company and provide an accurate estimate, it is only an estimate.
- Any balance due must be paid within 30 days of receiving a bill. After 30 days a 1.5% per month finance charge will be assessed on the first day of the month. Balances that are unpaid after 90 days will be turned over to a collection agency and charged an additional 40% collection fee.
- As this is a pediatric practice, we ask that you use age appropriate language in all areas of the office. Anyone violating this policy will be asked to leave.

I have read, understood, and agree to the above listed policies.

Printed Name:_____

Signature: _____ Date:_____

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

SECTION A: The Patient.

Name: _____

Address: _____

Telephone:_____E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: Acknowledgement of Receipt of Privacy Practices Notice.

I, _____ , acknowledge that I have received a Notice of Privacy Practices from the above-named practice.

Signature:_____ Date: _____

If a personal representative signs this authorization on behalf of the individual; complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

SECTION C: Good Faith Effort to Obtain Acknowledgement of Receipt.

Describe your good faith effort to obtain the individual's signature on this form:

_____

_____

_____

Describe the reason why the individual would not sign this form:

_____

_____

SIGNATURE.

I attest that the above information is correct.

Signature:_____Date:_____

Print name:

_____ Title: _____

Include this acknowledgement of receipt in the individual's records.

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES 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

Federal and state law requires us to maintain the privacy of your health information. That law also requires us 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 we describe in this notice while it is in 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 applicable law permits the changes. 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 at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and health care operations. For example:

Treatment: We may use your health information for treatment or disclose it to a dentist, physician or other health care provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to the federal Privacy Rules for its payment activities.

Health Care Operations: We may use and disclose your health information for our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. We may disclose your health information to another health care provider or organization that is subject to the federal privacy rules and that has a relationship with you to support some of their health care operations. We may disclose your information to help these organizations conduct quality assessment and improvement activities, review the competence or qualifications of health care professionals, or detect or prevent health care fraud and abuse.

On Your Authorization: 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 affect any uses 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 may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may use our professional judgment 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. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

Disaster Relief: We may use or disclose your health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Public Benefit: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- as required by law;
- for public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;
- to report adult abuse, neglect, or domestic violence;
- to health oversight agencies;

- in response to court and administrative orders and other lawful processes;
- to law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- to coroners, medical examiners, and funeral directors;
- to an organ procurement organizations;
- to avert a serious threat to health or safety;
- in connection with certain research activities;
- to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- to correctional institutions regarding inmates; and
- as authorized by state workers compensation laws.

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 request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you a reasonable cost-based fee that may include labor, copying costs, and postage. 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 may—but are not required to—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 more information about fees.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information over the last 6 years (but not before April 14, 2003). That list will not include disclosures for treatment, payment, health care operations, as authorized by you, and for certain other activities. 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. Contact us using the information listed at the end of this notice for more information about fees.

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). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. Your request is not binding unless our agreement is in writing.

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. You must specify in your request the alternative means or location, and provide satisfactory explanation how you will handle payment 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 it must explain why we should amend the information. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.
If you believe that:

- we may have violated your privacy rights,
- we made a decision about access to your health information incorrectly,
- our response to a request you made to amend or restrict the use or disclosure of your health information was incorrect, or
- we should communicate with you by alternative means or at alternative locations,

you may contact us using the information listed below. 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.