GREAT SMILES

PEDIATRIC DENTISTRY & ORTHODONTICS

Health History Form

Patient Name _____
Last First MI

Preferred Name _____ Birthdate _____ Gender (circle one): Male Female

Phone (Home)_____ (Cell)_____ Email _____

Health Information

Date of Last Dental Visit _____ Reason for this Visit _____ Date_____

Name of your child's Pediatrician _____ Phone _____

Has your child ever had any of the following? (Please check all that apply)

□ AIDS/HIV
□ Allergies _____
_____
□ Anemia
□ Anxiety Disorder
□ Arthritis
□ Artificial Joints
□ Asthma
□ Autism Spectrum Disorder
□ Autoimmune Disorder
□ Bleeding Disorder
□ Blood Disease
□ Bone Disorder
□ Cancer _____
□ Cerebral Palsy
□ Diabetes
□ Digestive Disorder
□ Epilepsy
□ Excessive Bleeding
□ Fainting/Dizziness
□ Hay Fever
□ Head Injuries
□ Heart Disease
□ Heart Murmur
□ Hepatitis
□ Herpes Virus
□ High Blood Pressure
□ Kidney Disease/Jaundice
□ Liver Disease
□ Mental Disorders
□ Nervous System Disorder
□ Pacemaker
□ Pregnancy _____
(Due date)
□ Radiation Treatment
□ Respiratory Problems
□ Rheumatic Fever
□ Sinus Problems
□ Skin Disorder
□ Stroke
□ Tuberculosis
□ Tumors
□ Vision Disorder
□ Codeine Allergy
□ Penicillin Allergy
Other
□ _____
□ _____

Is your child taking any medications? If so, please list _____
_____

Does your child have any health problems that need further clarification? □ Yes □ No

If yes, please explain _____

Name of Physician _____ Phone _____

Has your child ever been admitted to the hospital or needed emergency care? □ Yes □ No

If yes, please explain _____

Has your child ever had any complications following dental treatment? □ Yes □ No

If yes, please explain _____

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

_____ Date_____
Signature

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CONFIDENTIAL PATIENT INFORMATION

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Home phone _____ Birthdate _____ SS# _____

If patient is a minor, give parent/guardian name _____

Whom may we thank for referring you to our office? _____

CONFIDENTIAL RESPONSIBLE PARTY INFORMATION

Name _____ Marital Status _____
Last First Middle

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____ Email Address _____

Home phone _____ Work phone _____ Cell phone _____

Social Security # _____ Birthdate _____ Relationship to patient _____

Employer _____ Occupation _____ No. years employed ____

Spouse's Name _____ Relationship to patient _____
Last First Middle

Employer _____ Occupation _____ No. years employed ____

Social Security # _____ Birthdate _____ Work phone _____

DENTAL INSURANCE INFORMATION

Policy Holder's Name _____ SS# _____

Policy Holder's Date of Birth _____ Relationship to Patient _____

Policy Holder's Address _____ Home Phone _____

Insurance Company _____ Group No. _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

Do you have dual coverage? No ☐ Yes ☐ If yes:

Policy Holder's Name _____ SS# _____

Policy Holder's Date of Birth _____ Relationship to Patient _____

Policy Holder's Address _____ Home Phone _____

Insurance Company _____ Group No. _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____ Date _____

GREAT SMILES

PEDIATRIC DENTISTRY & ORTHODONTICS

Great Smiles Pediatric Dentistry & Orthodontics is dedicated to providing our patients the best possible care and service. With this in mind, the following consent regarding patient care and your financial obligation is an essential element in the care of your family. We encourage you to ask any questions or concerns regarding this policy.

Consent for Services

I hereby authorize Great Smiles Pediatric Dentistry & Orthodontics, Dr. Crystal Angelopoulos & Associates to render dental treatment for my child, _____. I further understand that during the course of treatment, the treatment plan may change as determined by the Doctor. If possible, I will be informed of these changes and charges. **(Initial) _____**

If your child has dental anxiety or extensive dental treatment needs, the doctors offer several forms of sedation such as nitrous oxide/oxygen, oral sedation, in-office and hospital general anesthesia. Our ultimate goal is to provide your child a pleasant, comfortable and safe experience in a controlled environment.

Occasionally a child's behavior during treatment requires assertive management to protect him or her from possible injury. For the safety of your child, physical restraint devices such as a papoose board may be utilized, if required, as well as behavioral management techniques such as voice control, tell-show-and-do, etc. **(Initial) _____**

Financial

I understand that I am financially responsible for all charges incurred. **(Initial)** _____

The practice depends upon the reimbursement from patients for the costs incurred in their care. As a condition of the treatment provided by our practice, FULL PAYMENT IS DUE AT THE TIME OF SERVICE. For your convenience, we accept Cash, Check, Visa, MasterCard, Discover and American Express. Returned checks are subject to a $25 fee. Unpaid balances accrue an interest charge of 18% per annum. In consideration for the professional services rendered my child, I further agree to pay all costs collections, interest, late charges and attorney fees incurred if suit be instituted hereunder. I also understand that my unpaid account may be reported to the credit bureau.

I understand that the fee estimate given to me for any dental treatment can only be extended for a period of 90 days from the date of the patient examination**. (Initial) _____**

Insurance

The practice is a contracted provider with a few dental insurance plans. **(Initial) _____**

The practice and all doctors working at this practice are OUT OF NETWORK providers for most plans. **(Initial) _____**

All insurance plans must be a "preferred provider program" (PPO) in order for the practice to bill your insurance. **(Initial) _____**

I understand that insurance is my benefit and is a contract between myself and my insurance carrier. I agree to pay Great Smiles Pediatric Dentistry & Orthodontics in full at the time of service unless prior arrangements are made. **(Initial) _____**

I understand that Great Smiles Pediatric Dentistry & Orthodontics provides insurance billing as a courtesy. Great Smiles Pediatric Dentistry & Orthodontics makes every effort to help you determine your insurance coverage and benefits by contacting your insurance company whenever possible. However, in many instances, an insurance company will not advise or guarantee coverage and/or payment. Upon occasion some insurance company representatives do not provide accurate information. **(Initial) _____**

I authorize the release of information necessary to process my dental benefit claims. **(Initial) _____**

Appointment

The practice respects that your time is valuable, therefore we make every effort to see our patients at their scheduled time. As a courtesy to our other patients and staff, if you are 15 minutes late for your scheduled appointment, we may need to reschedule your appointment for another date and time. We request that our patients **call our office** at least **24-hours prior** regarding any changes in their appointment. Appointment changes with less than 24-hours-notice are considered a broken appointment and may be subject to a **broken appointment fee between $75-$250.** In the event of numerous broken appointments, a deposit or pre-payment may be required to reschedule the appointment.

Communications

My email address is _____.

Please check one of the following options:

_____ I consent and accept the risk of receiving information via email. I understand I can withdraw my consent at any time.

_____ I do not consent to receiving any information via email. I understand that I can change my mind and provide consent later.

I grant my permission to the practice, to telephone me at home, work or mobile phone or by email or text to discuss matters related to this form. **(Initial) _____**

I have read, understand and consent to treatment, financial, insurance, appointment, communications policy and agree to abide by its terms. I understand, where appropriate, credit bureau reports may be obtained. I also understand this policy may be amended from time-to-time by the practice.

_____	_____	_____	_____
Parent/Guardian Name	Signature	Relationship to Patient	Date

GREAT SMILES

PEDIATRIC DENTISTRY & ORTHODONTICS

INFORMATION FOR OUR PATIENTS WITH DENTAL INSURANCE

Since we feel strongly that our patients deserve the best dental care we can provide, and in an effort to maintain a high quality of care, we would like to share some facts about dental insurance with you.

As a courtesy to our patients, we will submit all dental insurance claims on your behalf and will handle any correspondence that you receive from your insurance company. We have you pay the estimated patient portion at the time of service. If there is a residual balance after your insurance pays, we will send you a statement for payment. There are a few insurance companies (such as Delta Dental or Blue Cross) who will only pay the subscriber. If you have a plan through one of those companies, we ask that you pay the full amount at the time of service as these plans will not reimburse our office. We will submit the claim and they should send you your benefit within 10-30 days. If you do not receive payment, please contact our office so we can contact the insurance company for you.

We consider our relationship with you to be of primary importance and will always make our treatment recommendations based on what we believe is the very best treatment for the patient regardless of your insurance company. We hope you understand that your insurance coverage is a contract between you and your insurance company or between your employer and the insurance company. We will assist you in any way possible to maximize your dental insurance benefits.

- Dental Insurance is not meant to be a "PAY-ALL"; it is only meant to be an aid.
- Many plans tell their insured that they will be covered "up to 80%" or "up to 100%". In spite of what you are told, we have found many plans cover 40% to 50% of an average fee. Some plans pay more…some pay less. The amount your plan pays is determined by the contribution you and your employer make to your dental plan. The smaller the contribution paid into the plan for "insurance", the less you'll receive. It is your responsibility to advise us of your insurance coverage and restrictions.
- It has been the experience of many dentists that some insurance companies tell their customers that "fees are above the usual and customary fees" rather than saying to them that "our benefits are low". The insurance companies create fees based on zip codes and call them "usual and customary fees". They do not figure out what it costs to do that procedure in the area where the service is provided. Remember you get back only what you and your employer put into your insurance coverage less the profits of the insurance company. In dealing with over 1000 dental insurance plans, most plans cover a percentage of our fees.
- Each plan utilized in our office has different percentages, deductibles, maximums, covered procedures, and varying fees that the plan will allow. We will do our very best to make as close a calculation as possible of what your insurance plan will cover. However, as we cannot estimate precisely, there may be variances for which the patient is individually responsible.
- Insurance carriers DO NOT cover many routine dental services. We make our recommendations based on your needs and not on what your insurance may or may not cover.

Please do not hesitate to ask us any questions about our office policies. We want you to be comfortable in dealing with these matters and we urge you to consult us if you have any questions regarding our services.

Patient Name(s) _____

_____

Parent/Guardian Name Signature Relationship to Patient Date

GREAT SMILES
PEDIATRIC DENTISTRY & ORTHODONTICS

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 09/23/2013, 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

o Prevent or control disease, injury or disability;

o Report child abuse or neglect;

o Report reactions to medications or problems with products or devices;

o Notify a person of a recall, repair, or replacement of products or devices;

o Notify a person who may have been exposed to a disease or condition; or

on Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or

administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.
Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

Amendment. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if 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.

Our Privacy Officials: Christopher Hydo & Crystal Angelopoulos
Telephone: (858) 755-4223 Address: 530 Lomas Santa Fe Drive Suite H, Solana Beach, CA 92075
E-mail: orthodontics@greatsmiles.org or pediatricdentistry@greatsmiles.org

GREAT SMILES

PEDIATRIC DENTISTRY & ORTHODONTICS

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* You May Refuse to Sign This Acknowledgment*

I have received a copy of this office's Notice of Privacy Practices.

Print Name:_____

Signature:_____

Date:_____

For 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 the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

GREAT SMILES

PEDIATRIC DENTISTRY & ORTHODONTICS

Carlsbad 760.944.5115 Solana Beach 858.755.4223

PATIENT PHOTOGRAPH AND TESTIMONIAL AUTHORIZATION FORM

I hereby give my consent for **Great Smiles Pediatric Dentistry & Orthodontics** to take photographs, slides and/or videotape of *(Print full name of patient)* _____ face, jaw, and teeth. I understand that some of these images may be used by laboratories for fabrication of appliances, retainers, or Invisalign trays/retainers and these images will become part of the patient record.

If I have provided a written testimonial about my experience with **Great Smiles Pediatric Dentistry & Orthodontics**, the testimonial may be used in whole or in part as indicated below.

Please circle "do" or "do not" for each statement, and initial.

I	do	do not	consent to the use of these images in professional articles and presentations.	_____
I	do	do not	consent to the use of these images within the dental practice to be seen only by individuals who walk into the practice.	_____
I	do	do not	consent to the use of these images to promote the dental practice through various media, including but not limited to print advertising, brochures, and the Internet.	_____

By consenting to the use of these photographs and testimonial as described above, I do not expect compensation, financial or otherwise, from **Great Smiles Pediatric Dentistry & Orthodontics**. I hereby release and discharge **Great Smiles Pediatric Dentistry & Orthodontics** from any and all claims and demands arising out of or in connection with the use of my name, photograph, personal testimonial, or other information provided by me, including any and all claims for libel and invasion of privacy.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment, or eligibility for benefits.

_____

Print Patient's or Legal Guardian's/Representative's Name

_____ _____

Patient's or Legal Guardian's/Representative's Signature Date