Sunshine Pediatric Dentistry of Evansville

701 N Weinbach Ave, Suite 910, Evansville, IN47711
T: 812-477-2836 www.sunshineofevansville.com

Child's Name:_____ Nickname:_____ Sex: (M) (F) Birth Date:___/___/___

Address: _____
Street City Zip

Mother (full name)_____ Father (full name)_____

Mom Cell #: ( )_____ Mom Work #: ( )_____ Dad Cell #: ( )_____ Dad Work #: ( )_____

Home Phone #: ( )_____ Email:_____

Purpose of visit:_____ Concerns:_____

Name and age of siblings:_____ Is your child adopted? Y N

Does your child have any special needs?_____ Any phobias? _____

Child's school:_____ Who can we thank for referring you to us? _____

HEALTH HISTORY

Child's Pediatrician:_____ Kaiser # (if applicable)_____ Last Physical:___/___/ Phone #: ( )_____ Pediatrician's Address: _____

Is your child under a physician's care now? Y N If yes, reason:_____ Immunization up to date? Y N

Current Medications? Y N If yes, please list: _____

_____ Allergic to medication? Y N If yes, please list: _____

Does your child have an allergic reaction to any of the following: (please circle) Foods Pollen Dust Latex Eggs Soy Other_____?

Has your child had a history or difficulty with any of the following:

TMJ Problems	Y N	Premature Birth	Y N	Speech Disorder	Y N	Diabetes	Y N
Bleeding	Y N	Sinus Problems	Y N	Brain Injury	Y N	Allergies to Medications	Y N
Liver/Jaundice	Y N	Hepatitis	Y N	Tuberculosis	Y N	Ear aches/Infections	Y N
Heart	Y N	Immune Disorders	Y N	Bruising	Y N	Rheumatic Fever	Y N
ADHD/ADD	Y N	Cancer/Malignancies	Y N	Seizures	Y N	Autism	Y N
Down's Syndrome	Y N	Depression/Anxiety	Y N	Arthritis	Y N	Kidney	Y N
Cerebral Palsy	Y N	Delayed Development	Y N	Hearing	Y N	Asthma	Y N
Bone Disorder	Y N	Nosebleeds	Y N	Bladder	Y N	Last Asthma Attack: _____	
Eating Disorder	Y N	Emotional/School Problems	Y N	Snoring	Y N	Other: _____	

If YES to any of the above, please explain: _____

DENTAL HISTORY

Is this your child's first dental visit? Y N If no, previous dentist:_____ Phone number: ( )_____

Date of last visit:_____ How was his/her experience?_____ Were any x-rays taken? Y N

Child's attitude towards the dentist or dental care: _____

Has your child had any injuries to teeth, mouth, or head? Y N If yes, please describe: _____

Does your child have any of the following habits?: (please circle)

Thumb/Finger Pacifier Nail Biting Lip Sucking Mouth-breathing Snoring Teeth Grinding Nursing Bottle-feeding

Is your water fluoridated? Y N Does your child take fluoride supplements? Y N Does your child use fluoridated toothpaste? Y N

How often does your child brush his/her teeth? x/day How often does your child floss? x/day With adult supervision? Y N

How may we help to make this visit a positive experience for your child? _____

Please continue to the back side…

A PARENT OR LEGAL GUARDIAN MUST ACCOMPANY YOUR CHILD ON THIS FIRST VISIT.

GENERAL INFORMATION

Mother's Date of Birth: ___/___/___ Mother's Social Security Number: _____ Mother's Driver's License #: _____

Father's Date of Birth: ___/___/___ Father's Social Security Number: _____ Father's Driver's License #: _____

Parents are: (please circle) Married Divorced Single Widowed Partners Child lives with: (please circle) Mother Father Legal Guardian

Person financially responsible for child's dental care: _____

Father's Employer: _____ Occupation: _____

Employer Address: _____

Mother's Employer: _____ Occupation: _____

Employer Address: _____

Emergency Contact: _____ Address: _____ Phone: ( ) _____

INSURANCE INFORMATION

Do you have dental insurance coverage for your child? Y N

Father's Dental Insurance Company: _____

Insurance Phone #: ( ) _____ Insurance ID #: _____ Group or Policy Number: _____

Mother's Dental Insurance Company: _____

Insurance Phone #: ( ) _____ Insurance ID #: _____ Group or Policy Number: _____

I hereby give the dentist permission to complete an oral exam and radiographs (x-rays) for diagnostic purposes. I understand this visit will include a cleaning and fluoride treatment, as well. 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 health status.

I hereby authorize the dentist to release any information including diagnosis and records to the third-party payer and/or other health care practitioners. I authorize and request my insurance to pay directly to the above named dentist, otherwise payable to me but not to exceed the charges shown on the claim. This office is not responsible for any insurance company's arbitrary determination of payment, which procedures are covered under the plan, frequency of procedures performed, or period of time taken to process claims. You are responsible for payment in full regardless of any insurance you may have. As a courtesy to you, we will complete and file insurance forms relative to dental treatment and will do our best to collect all fees due from your insurance carrier. However, fees not paid by your insurance company within 60 days are due and payable by the patient's parent or guardian. I realize that the failure to keep this account current may result in the dentist being unable to provide additional dental services except for dental emergencies or where there is a prepayment for additional services. I understand a late charge of 1.5% per month will be applied to unpaid balances over 60 days past due and where appropriate, a credit bureau report may be obtained. In case of default on payment of this account, I agree to pay the collection costs and reasonable attorney fees incurred in attempting to collect on this account of any future outstanding account balances. I consent to the dental practice using my cell phone number to call or text regarding appointments and to call regarding treatment, insurance, and my account. I understand that I can withdraw my consent at any time.

Responsible Party Policy:

Because of a large percent of the population involves a divorce situation, it is the policy of this office to collect from the parent who brings the child in for dental services.

Office Policies:

Unless appointments are cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. We do attempt to confirm appointments, but do so only as a courtesy. The Parent/Guardian is ultimately responsible for any scheduled appointments made for the child.

I acknowledge that I have read and agree to the above policies.

SIGNATURE: _____ Relationship: _____ Date: _____

Acknowledgment of receipt of NOTICE OF PRIVACY PRACTICES (HIPAA)

You may refuse to sign this portion of the acknowledgment

I, _____ have received a copy of or have had the opportunity to review this office's NOTICE OF PRIVACY PRACTICES (HIPAA).

Print Name: _____ SIGNATURE: _____ Date

A PARENT OR LEGAL GUARDIAN MUST ACCOMPANY YOUR CHILD ON THIS FIRST VISIT.

SUNSHINE PEDIATRIC DENTISTRY OF EVANSVILLE
701 N. WEINBACH AVENUE SUITE 910
EVANSVILLE IN 47711
812-477-2836

LISTED BELOW ARE THE FINANCIAL POLICIES OF THE OFFICE. PLEASE READ CAREFULLY

1. It is the responsibility of the guarantor to be aware of what their dental plan covers. Preventative (routine cleaning/exams) will be submitted to insurance. If the plan pays less than the full amount, a statement will be mailed to you. Payment IS DUE AT THE TIME OF SERVICE for ALL operative appointments.

2. The staff sends a pre-treatment estimate prior to operative appointments. It may take up to three to four weeks for the insurance company to respond. If the appointment takes place before the estimate arrives 50% will be due at the appointment.

3. Missed appointments may result in a $35.00 missed appointment fee. Insurance companies do not pay for missed appointments, so the parent/legal guardian/patient will be responsible for payment.

4. Past due account balances will be turned over to a collection agency. The parent/legal guardian/patient is responsible for all agency, attorney fees and or court costs.

   We appreciate your cooperation☺

_____ _____
SIGNATURE DATE

SUNSHINE PEDIATRIC DENTISTRY OF EVANSVILLE
701 N WEINBACH AVE, SUITE 910
EVANSVILLE, IN 47711

Patient Name:_____ **DOB:**_____

- We appreciate the confidence you have shown us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.
- Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. **We expect these payments at time of service**. If your insurance carrier denies any part of your claim, or if you or your dentist elects to continue past your approved period, you will be responsible for your balance in full.
- The staff sends a pre-treatment estimate prior to operative appointments. It may take up to 3 to 4 weeks for the insurance company to respond. If the appointment takes place before the estimate arrives, 50% WILL BE DUE at the time that you schedule your appointment.
- The portion of work done that is not covered by your insurance **WILL be due BEFORE the appointment**. You will either be billed for the remaining balance (if more) or be refunded (if over paid).
- I have read and understood the above policy regarding my financial responsibility to Sunshine Pediatric Dentistry of Evansville services to the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. Any amount due after payment has been made by my insurance carrier I will be responsible for.
- Past due account balances will be turned over to a collection agency (Medical & Professional Collection Services). The parent/legal guardian/patient is responsible for all agency, attorney fees and/or court costs. In addition, I understand that if my account goes to a collection agency or placed with an attorney to obtain judgement or otherwise satisfy payment of my account, a collection equal to 33% of the unpaid balance will be added to my account. I agree to pay these fees.

Deductible/Co-Pay Policy

- Some dental insurance carriers require the patient to pay a deductible/co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay the deductible AND the portion that your insurance does not cover. Thank you for your cooperation in this matter.

Cancellation/No Show Policy

- We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to give a 48 hour notice if you are unable to make the appointment scheduled.
- Giving less than a 24 hour notice **WILL** result in a $35.00 missed appointment fee.
- I understand that if I no show for an appointment without calling I may be dismissed from the office. I also understand that if I miss two or more appointments without proper notice, then I may be dismissed from the office. The practice will notify you in writing, via mail, if you are dismissed from care.
- I understand that it is my responsibility to inform the office of any changes in my home address, telephone number or insurance information and to know when my scheduled appointments are. Our office APPRECIATES IT VERY MUCH when you confirm your appointments. 😊 Our office does make every effort to remind you of your appointments as a courtesy.
- I have read and understand the above information and I agree to the terms described:

Patient/Guarantor Signature:_____ Date:_____

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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

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 duties, 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 / / , 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 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 addition- al 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 or disclose your health information to a physician or other healthcare provider pro- viding treatment to you.

Payment: We may use and 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 affect 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, as described in the Patient Rights section 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 judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reason- able 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 dis- close your health information to the extent necessary to avert a serious threat to your health or safety or the health or 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 official having lawful custody of protected health information of inmate or patient under certain circum- stances.

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 $0.__10____for each page,$___10___per hour for staff time to 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 it 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.

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.

Contact Officer: Dr. Aditi Jindal

Telephone: 812-477-2836 Fax:812-477-1011

E-mail: hello@sunshineofevansville.com

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