Account Registration Form

Please fill out and bring with you to your appointment. You may also fax it to our office.

Mother's Name Or Guardian		**Home Tel#**	
Address			
Email		**Cell #**	
Mother's DOB		**Mother's SS#**	
Employer		**Work Tel#**	
Work Address			
Father's Name or Guardian		**Home Tel#**	
Address			
Email		**Cell #**	
Father's DOB		**Father's SS#**	
Employer		**Work Tel#**	
Work Address			
Who is accompanying the child today?			
Name		**Relationship to Child**	

Emergency Contact Person & Tel #			
Do you have legal custody of this child?	**Yes**	**No**	
Whom may we thank for referring you?			
Enter Names/Ages of other Children			

Dental Insurance Information			
Primary Insurance Co.		**Group #**	
Employee		**ID#**	
Secondary Insurance Co.		**Group #**	
Employee		**ID#**	

I hereby authorize payment directly to the dentists of Broomall Pediatric Dentistry & Orthodontics, P.C. of the group insurance benefits otherwise payable to me.

X_____ *(Insured's Signature)*

It is the policy of our office that the parent or guardian who accompanies the child and requests treatment is responsible for payment of all fees at the time of service unless prior arrangements have been approved. In case of default of this account, I agree to pay collection costs on the outstanding balance.

X_____ *(Signature of Parent/Guardian)*

Updated 03-25-08LMS

Medical History Form

Please fill out and bring with you to appointment. Make sure you sign at the bottom if faxing.

Patient's Name		**Birth Date**		**Age**	
Child's Physician & Phone #					

Has the child ever had one of the following (Yes or No) Please explain YES answers

Condition	**Y/N**	**Explain "yes"**
Artificial joints or valve replacements		
Asthma		
Autism / PDD Spectrum		
Behavior Problems		
Cancer		
Cleft Lip/Palate or Facial Disorder		
Congenital Birth Defects		
Convulsions / Epilepsy / Brain Injury		
Diabetes		
Growth Problems		
Handicaps or Disabilities – what type?		
Hearing/Ear Problems		
Heart Murmur or other Heart Problems		
Hemophilia or Abnormal Bleeding		
Hepatitis		
High Fevers		
HIV+ / AIDS		
Hyperactivity, ADD or ADHD		
Kidney or Liver Problems		
LATEX Allergy?		
Learning Disability or Mental Retardation		
Rheumatic Fever		
Speech Problems		
Tuberculosis		
Vision/Eye Problems		

Describe child's learning process for his/her age: *Circle one*: **Advanced Average Slow**	**Do mother and father live together? Y or N**
List all Drug or other ALLERGIES	
List all DRUGS child is currently taking	
Any serious medical problems, operations, or hospital stays? Explain.	

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. I also authorize the dental staff to perform the necessary dental services my child may need. *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 feel free to ask us any time.

BPDO USE Only - Reviewed by: (Initials & Date) _____, _____, _____ , _____

Updated 08-09-LMS

Dental History Form

Patient's Name			**Today's Date**		
Previous Dentist Name & Address					
Is this his/her 1st Dental Visit?	**Y or N**	**Date of last dental visit?**		**Would you like us to request previous dental records?**	
Reason for your child's visit today?					
Has the child ever had a serious/difficult problem with previous dental treatment? If YES, explain					

Please answer the following (Yes or No) questions

Question	**Y/N**	**Comments**
Does child brush daily?		Do You Help? Yes or No
Does child floss daily?		Do You Help? Yes or No
Does child take a fluoride supplement?		
Does child thumb or finger suck?		
Is child still breast feeding or bottle fed?		
Does child breathe out of his/her mouth?		
Does child lip suck or bite nails?		
Does child use a pacifier?		
Does child grind his/her teeth?		
Has child had a tooth extracted?		
Has child had any injuries to the face, mouth or teeth?		
Does child require an antibiotic prior to dental treatment? If YES, please call us BEFORE the appointment.		
Is there a family history of missing or extra teeth?		
Does child have braces or orthodontics? If YES, please enter Orthodontist's name and location.		

Please complete information on both sides.

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 **March 1, 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 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 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 healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing 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 health care 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 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.

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 disclose 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 authorize 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 circumstances.

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 $.25 for each page, $40.00 per hour for staff time to locate and 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 2-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 [he 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. Jay Goldsleger
Telephone: 610-337-2325
Address: 356 S. Gulph Rd. King of Prussia, PA 19406

Upper Merion Dental Associates
Broomall Pediatric Dentistry & Orthodontics
Highpoint Pediatric Dental Associates
Bethlehem Pediatric Dental Associates

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

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

_____
Please 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)_____

_____

Broomall Pediatric Dentistry and Orthodontics
1999 Sproul Rd. Suite #14
Broomall, PA 19008
610 356-1454
fax 610 356-3658

Dear Parents:

In order to treat your child we need a parent or guardian's written permission. If you need to send a family member or child care giver with your child, please sign this form giving us permission to go ahead with treatment. Also include a phone number where we can contact you directly if necessary.

Child's name _____

Name of person bringing child _____

Relationship to child _____

Parent's Signature _____

Phone # where parent can be reached at time of appt _____