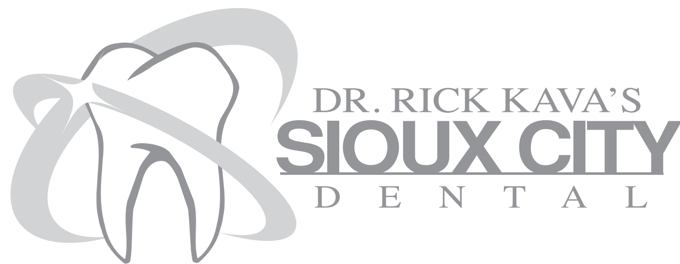

CHILD REGISTRATION

Welcome to our office. Please be kind enough to answer the following questions. Thank you so much for being our guest!

Name (Last) (First) (Middle) Date of Birth Sex (M F) Social Security Number

Email Address Cell Phone Number

Home Address (Street) (City) (State) (ZIP Code) Home Phone Number

PERSON RESPONSIBLE FOR ACCOUNT

Relationship to patient? ________________________

Name (Last) (First) (Middle) Social Security Number

Home Address (Street) (City) (State) (ZIP Code) Home Phone Number

Name of Employer Occupation Business Phone Number

INSURANCE INFORMATION

Insured Member (Last) (First) (Middle) SSN Date of Birth

Name of Employer Occupation Business Phone Number

Business Address (Street) (City) (State) (ZIP Code) Dental Insurance Co.

Group Number ______________________________ ID Number ______________________________________

In the event of an emergency, who should be notified?

Name (Last) (First) (Middle) Relationship Cell Phone Number

Home Address (Street) (City) (State) (ZIP Code) Home Phone Number

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MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your child's mouth, the mouth is a part of your entire body. Health problems that your child may have, or medication that they may be taking, could have an important interrelationship with the dentistry that they will be receiving. Thank you for answering the following questions.

Child's current physical health is: EXCELLENT ❑ GOOD ❑ FAIR ❑ POOR ❑ Name of physician ___________________
Physician's Address ______________________________ Telephone Number __________ Date of Last Physical _________
Is the child currently under the care of a physician? Yes ❑ No ❑
Is child taking any prescription, over-the-counter, or supplement drugs? Yes ❑ No ❑
If yes, names of medications and problems for which they are taken:

Medication 1)_______________ Taken for _______________ 3)_______________ Taken For_______________
2)_______________ Taken for _______________ 4)_______________ Taken For_______________

Does your child smoke or use tobacco in any other form? Yes ❑ No ❑
Has your child ever required a blood transfusion? Yes ❑ No ❑
Are they wearing contact lenses? Yes ❑ No ❑
Does your child bruise easily? Yes ❑ No ❑

Why have you come to the dentist today?
____
When was child's last dental visit? ________________
Experiencing any discomfort now? ________________
Do you desire complete dental service for your child? __________
Has your child ever responded adversely to medical or dental treatment? ______________________________
Has your child ever been on or has any physician ever told you your child needs to have premedication before dental work? Yes ❑ No ❑
Is there anything else we should know about child's dental history? ________________________
How many times a week does child floss? _______
How many times a day does child brush? _______ Type of bristles? ❑ Hard ❑ Medium ❑ Soft

Has your child ever had (please check-mark appropriate boxes):

AIDS/HIV Yes ❑ No ❑
Asthma or hay fever Yes ❑ No ❑
Allergies Yes ❑ No ❑
Artificial Heart Valves or Joints Yes ❑ No ❑
Bladder Problems Yes ❑ No ❑
Cerebral Palsy Yes ❑ No ❑
Chemical Dependency Yes ❑ No ❑
Convulsions Yes ❑ No ❑
Cancer Yes ❑ No ❑
Diabetes Yes ❑ No ❑
Epilepsy/Seizures Yes ❑ No ❑
Hearing Problems Yes ❑ No ❑
Hemophilia Yes ❑ No ❑
Heart problems Yes ❑ No ❑
Hepatitis Yes ❑ No ❑
Jaundice Yes ❑ No ❑
Kidney problems Yes ❑ No ❑
Mononucleosis Yes ❑ No ❑
Rheumatic fever Yes ❑ No ❑
Thyroid problem Yes ❑ No ❑
Tuberculosis or lung disease Yes ❑ No ❑
X-ray treatments for cancer Yes ❑ No ❑

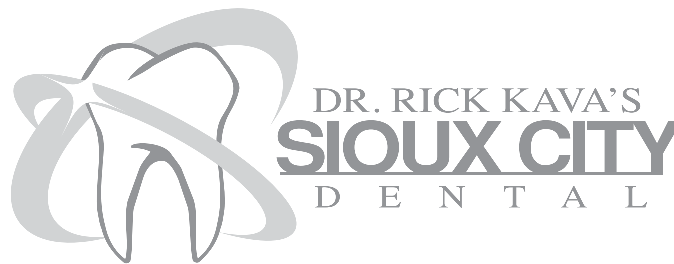
If you have entered "yes" to any of the above, please explain:______________________________
____
Is your child allergic to or have they had reactions to:

Local anesthetics like Novocaine Yes ❑ No ❑
Penicillin or other antibiotics Yes ❑ No ❑
Sulfa drugs Yes ❑ No ❑
Barbiturates, sedatives, or sleeping pills Yes ❑ No ❑
Codeine Yes ❑ No ❑
Aspirin Yes ❑ No ❑
Iodine Yes ❑ No ❑
Any metal (e.g. gold, nickel, etc.) Yes ❑ No ❑
Latex/Rubber Yes ❑ No ❑
Tylenol Yes ❑ No ❑

Other (please list) ____
Has your child had any other serious illness, hospitalization, or accident?______________________
____

*Your signature indicates you have received a copy of the HIPAA law and Dental Materials forms and release Dr. Rick Kava's Sioux City Dental to utilize any dental photographs for lecturing and educational purposes.

Signature: ______________________________ Date:________________



SOME THINGS YOU SHOULD KNOW ABOUT DENTAL BENEFITS

At Dr. Rick Kava's Sioux City Dental, we believe that you deserve the best care. That's why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of folks. Some have dental benefits, but most don't. If you have dental benefits, congratulations! You are very fortunate. If you don't, we have numerous ways to make any type of dental care affordable for you. Here are some important things you should know if you do have dental benefits…

Your dental benefits are based upon a contract made between your employer and an employee benefits company. If you have any questions regarding your dental benefits, please contact your employer or the benefits carrier directly.

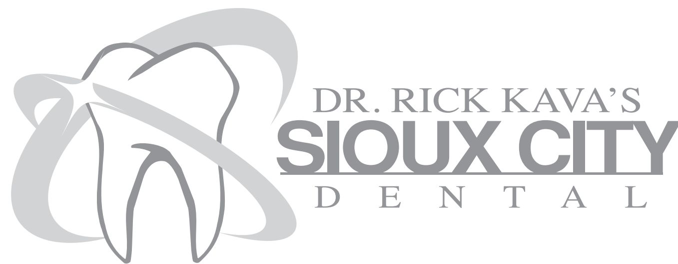
Dental benefits differ greatly from medical benefits. In 1959, most dental benefit plans had a yearly maximum cap of $1,000. You'll be surprised to know today that the average dental benefit plan has a yearly maximum cap of $1,000. There has been no significant increase in the yearly maximum cap in 50 years! However, there have been significant increases in your premiums. Dental benefit plans will never pay for completion of your dental care. It has always been meant to assist you.

Many people receive notification from their insurance company that dental fees are "above usual and customary." A dental benefits company determines their reimbursement level by surveying a geographical area and calculating the average fee, then determines that 80% of the average fee is customary. Included in this survey are discount dental clinics and managed care facilities, which have severely reduced dental fees that bring down the average. Any doctor in private practice will have fees that dental benefit companies define as "*higher than usual and customary.*"

Many dental benefit plans tell their participants that they will be covered "up to 80% or 100%" but do not clearly specify the plan fee schedule allowance, annual maximum, or limitations. It is more realistic to expect dental benefit plans to cover between 25% to 40% of dental services. Remember that the amount a plan reimburses is determined by how much your employer has paid for your dental benefit plan. You will get back only what your employer has put in, less the insurance company's profit margin.

Dental benefit companies do NOT cover many routine and newer dental services.

Our team members will gladly assist you in filling out the necessary forms to maximize your dental benefits and discuss your financial options. Excellent dental care is available with or without dental benefits. We hope you will choose the best that dentistry has to offer.



INSURANCE CLAIMS PROCESS

Our office is pleased that you have insurance benefits to help you with the cost of your dental care. We would like to help you obtain the maximum use of these benefits. With this in mind, please read the information on our insurance claims process so that we can work together to ensure this benefit.

DO YOU ACCEPT MY INSURANCE? HOW MUCH WILL THEY PAY?
We currently accept all private care insurance (plans that do not require you to select a dentist from a list or require our office to accept a reduced fee for services). This means that we work with thousands of companies. Although we can maintain computerized histories of payment by a given company, they do change; therefore, it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is ONLY AN ESTIMATE.

I THOUGHT I PAID MY PORTION BUT I GOT A BILL. WHY?
We base the patient portion of your bill on our most current data, but there are many factors that can affect this estimate. There may be a deductible (individual or family) or you may have received treatment in another office prior to visiting our office, which is not calculated into our database. Sometimes you may need to see a specialist for care, which also uses your annual benefit. Insurance companies do not (and cannot in most cases) notify us of changes to your benefits, they only notify you. If these situations apply to you, please let us know when we estimate your treatment plan so that we may adjust accordingly.

INSURANCE DIDN'T PAY. NOW WHAT?
We bill your insurance as a courtesy. If insurance does not pay within 90 days, we reserve the right to request payment in full for services from you and let you collect the insurance funds that are due you. This is rare, but it is important that you recognize the insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be, a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

FINANCIAL OPTIONS
Our office does request payment in full for your estimated portion at the time of service. All accounts not paid in full after 60 days will be charged a finance charge at a rate of 2% per month (24% per annum). If you are in need of an extended option, please just ask one of the patient services staff for an application.

We welcome you to our family and look forward to helping you get the healthy, beautiful smile you've always wanted. If there is anything we can do to make your visits here more pleasant, please don't hesitate to ask one of our staff members.

I have read, understand, and accept the terms of the above outlined policies for insurance handling and financial commitments that I may incur as a result of treatment at your office, Dr. Rick Kava's Sioux City Dental.

Name:______________________________________Date:____________________

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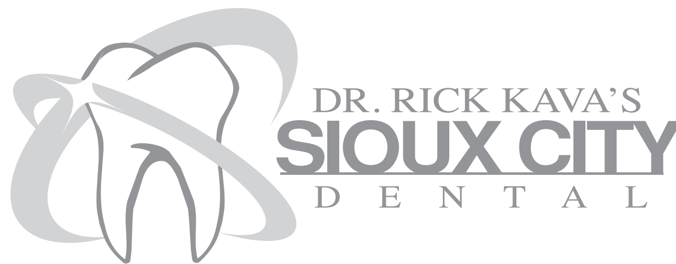


CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: ____

Address: ____

Telephone: ____________________ Social Security # ____________________

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting our office at (712) 258-6169 or by mailing us at 2930 Hamilton Boulevard, Upper F Suite 101, Sioux City, IA 51104.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the address above. Please understand that revocation of this Consent will not affect any action we took before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

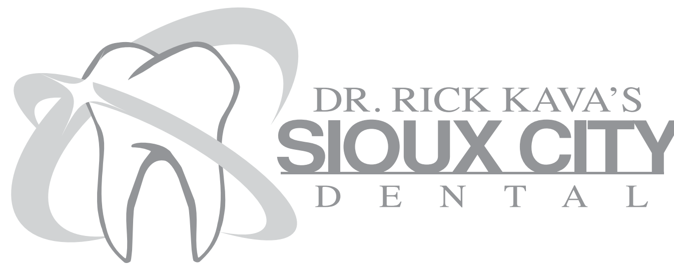
I, ____________________, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature: ______________________________ Date: ____________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ____________________ Relationship: ____________________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.



NOTICE OF PRIVACY PRACTICES. 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.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes:

- *Treatment* means providing, coordinating, or managing health care and related services by one or more health care providers. Examples would be teeth cleaning services, extraction letters, and periodontal or endodontic referrals.
- *Payment* means such activities as obtaining reimbursement for services, confirming coverage, and obtaining specific benefit information such as benefit maximums and deductibles met, etc., billing or collection activities, and utilization review.
- *Health care operations* include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individual identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain—and we have the obligation to provide—a paper copy of this notice from us at your first delivery of services date.
- The right to provide—and we are obligated to receive—a written acknowledgement that you have received a copy of our Notice of Privacy Protection Practices.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health.

This notice is effective as of April 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that our privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, about violations of their provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

By signing this form, I agree to allow the use and disclosure of my medical record information for the purposes described above. A copy of this authorization (consent) form will be given to me.

Signature:____ Date:________________________

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For more information about HIPAA or to file a complaint:
The U. S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, SW
Washington, DC 20201
202-619-0257 or Toll Free: 1-877-696-6775