Severn Pediatric DENTISTRY

PATIENT INFORMATION

Last Name:_____ First Name:_____ Preferred Name:_____

Date Of Birth:_____/ _____/ _____ Gender:☐ Male☐ Female

Address:_____ Apt #_____

City:_____ State:_____ Zip Code:_____

How did you hear/find out about Severn Pediatric Dentistry?☐ Facebook ☐ Google ☐ Other:_____

DENTAL HISTORY

Date of last dental exam: _____/ _____/ _____ X- Rays taken?☐ Yes☐ No

Has the patient ever had any complications with dental treatment?☐ Yes☐ No _____

Does your child use a:☐ Bottle ☐ Sippy Cup Is your child Nursing?☐ Yes☐ No

Please check the habits that apply to your child currently:

☐ Lip Sucking ☐ Lip Biting ☐ Nail Biting ☐ Thumb Sucking ☐ Finger Sucking ☐ Pacifier

PATIENT HEALTH

ADD/ADHD	☐ Yes☐ No	Anxiety	☐ Yes☐ No	Asthma	☐ Yes☐ No
Diabetes	☐ Yes☐ No	HIV	☐ Yes☐ No	Nervous Disorder	☐ Yes☐ No
Autism	☐ Yes☐ No	Blood Disease	☐ Yes☐ No	Cancer	☐ Yes☐ No
Epilepsy	☐ Yes☐ No	Hepatitis	☐ Yes☐ No	Tumors/Growths	☐ Yes☐ No
Heart Murmur	☐ Yes☐ No	Seizures	☐ Yes☐ No	Seasonal Allergies	☐ Yes☐ No
Mental Disorder	☐ Yes☐ No	Thyroid Disease	☐ Yes☐ No	Other	☐ Yes☐ No
Developmental Delay	☐ Yes☐ No	Respiratory Disease	☐ Yes☐ No	Excessive Bleeding	☐ Yes☐ No

Please list any serious illness not listed above: _____

Does the child have any health problems that need further clarification?☐ Yes☐ No _____

Is the child currently taking any medications?☐ Yes☐ No _____

Is the child allergic to any drugs / medications? ☐ Yes☐ No _____

Is the child allergic to latex?☐ Yes☐ No

Name Of The Child Pediatrician: _____ Pediatrician Phone Number: _____- _____- _____

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

X_____ _____/ _____/ _____

Signature Of Patient, Parent, Or Guardian Today's Date

Severn Pediatric
DENTISTRY

PARENT OR GUARDIAN INFORMATION

Last Name:_____ First Name:_____ Date Of Birth:_____/ _____/ _____

Relationship To Patient:☐ Parent ☐ Guardian☐ Other:_____ SSN:_____ - _____ - _____

Cell Phone #_____ - _____ - _____ Home Phone #_____ - _____ - _____

Is Your Address The Same As The Patient:☐ Yes☐ No

Address:_____ Apt #_____

City:_____ State:_____ Zip Code:_____

Email Address (Please Print Clearly):_____

I agree that the Severn Pediatric Dentistry may communicate with me electronically and send me an electronic copy of my child's record at the email address below.
I am aware that there is some level of risk that third parties might be able to read unencrypted emails.

PARENT OR GUARDIAN INFORMATION

Last Name:_____ First Name:_____ Date Of Birth:_____/ _____/ _____

Relationship To Patient:☐ Parent ☐ Guardian☐ Other:_____ SSN:_____- _____- _____

Cell Phone #_____ - _____ - _____ Home Phone #_____ - _____ - _____

Is Your Address The Same As The Patient:☐ Yes☐ No

Address:_____ Apt #_____

City:_____ State:_____ Zip Code:_____

Email Address (Please Print Clearly):_____

I agree that the Severn Pediatric Dentistry may communicate with me electronically and send me an electronic copy of my child's record at the email address below.
I am aware that there is some level of risk that third parties might be able to read unencrypted emails.

INSURANCE INFORMATION

Primary Dental Insurance:_____ Insurance ID:_____

Policy Holder Full Name:_____ Date Of Birth:_____/ _____/ _____

Secondary Dental Insurance:_____ Insurance ID:_____

Policy Holder Full Name:_____ Date Of Birth:_____/ _____/ _____

SOCIAL MEDIA CONSENT

I, (Parent / Guardian)_____☐ do ☐ do not give consent to Severn Pediatric Dentistry to use photographs of my child / children on their social media tools which includes but is not limited to their Facebook page. I understand that these images will not be used for any other commercial purposes and my child will not be tagged or identified.

To the best of my knowledge, all of the preceding answers and information provided are true and correct.

X_____ _____/ _____/ _____

Signature Of Patient, Parent, Or Guardian Today's Date

Severn Pediatric
DENTISTRY

OFFICE POLICIES

- An appointment written in our schedule, with your child / children's name on it, is a bond of trust that we will be here to serve you and that you will be present and on time for that appointment. For all of us, time is important and we do our best to ensure that you are seen promptly. Working with small children, as we do, there are no guarantees. We appreciate your patience. Please be assured that your child will also receive the same extra attention.

- As a courtesy to our patients, we will attempt to confirm your scheduled appointment. Feel free to text us or leave a message on our 24 hour voicemail if you have any questions or concerns. However, once you have made an appointment, remembering and keeping it is your responsibility. Confirmation is simply a courtesy to you.

- We make every effort to be on time, we hope you will also. If you must change an appointment, we request 48 hours advance notice. In the event of illness, call the office as soon as possible. Feel free to text us or leave a message on our 24 hour voicemail. We have many children waiting for earlier appointments. To prevent "same day" only scheduling please attend all of your scheduled appointments. We reserve the right to charge a $50 fee for every missed appointment.

- Our office provides dental care as determined by the American Dental Association and the American Academy of Pediatric Dentists. Insurance companies may have limits or exclusions for the recommended treatment. It is up to you to know your insurance policy and any possible limitations and exclusions.

- We accept most insurance plans and we will bill your primary and/or secondary insurance for you. If you have dental insurance we collect the estimated amount not covered at each appointment. You need to provide us complete insurance information and answer any insurance inquiries. In the event of insurance delays or disputed claims beyond 45 days, you will need to pay your account in full and arrange for reimbursement by your carrier. Please remember that insurance companies only assist in payment and rarely cover your full costs. If your dental plan does not pay the amount we have estimated, the balance is your responsibility.

- Finance charges are not assessed on current accounts. For accounts 45 days past due, a finance charge will be imposed on services not paid in full. The finance charge is a monthly rate of 1.50%, which is equal to a yearly rate of 18%. Plus a mailing fee of $5.00 per month.

- A claim will be submitted to the insurance carrier, if applicable, and authorize the release of any necessary information to them. I understand that if Dr. David Pfeuffer and Dr.Soe Mon are not a participating/preferred provider with my insurance plan then I am responsible for any balance not covered by such plans. I authorize my insurance company to send payment directly to Severn Pediatric Dentistry. I agree to pay all costs of collection, including, but not limited to, reasonable attorney fees.

- Severn Pediatric Dentistry accepts cash, check, or credit/debit cards for payments. A $38.00 fee is charged to your account for any bank returned check (NSF). If my account is deemed delinquent there will be a processing fee of $85.00 added to the account and I will be dismissed from the practice. We will refund any credit back to you as soon as we can. All refunds will be made to the account holder and address we have on file.

I acknowledge I have read and understand the office policies and I am responsible for all charges whether or not paid by insurance. If I have insurance, I hereby authorize payment of the dental benefits, otherwise payable to me, directly to Severn Pediatric Dentistry.

X_____ _____/ _____/ _____

Signature Of Patient, Parent, Or Guardian Today's Date

Severn Pediatric DENTISTRY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, (Parent / Guardian Full Name) _____ have received a copy of Severn Pediatric Dentistry Notice of Privacy Practices.

To the best of my knowledge, all of the preceding answers and information provided are true and correct.

X_____ _____/ _____/ _____

Signature Of Patient, Parent, Or Guardian Today's 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)

_____

_____

_____

Severn Pediatric
DENTISTRY

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can obtain access to this information.
Please review it carefully.

Introduction
Severn Pediatric Dentistry is required by law to maintain the privacy of "protected health information". "Protected health information" includes any identifiable information that we obtain from you or others that relates to your physical or mental health, the health care you have received, or payment for your health care. As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of protected health information. This notice also discusses the right to change the terms of this notice from time to time and to make the revised notice effective for all protected health information we maintain. You can always request a copy of our most current privacy notice from our office.

Permitted Uses & Disclosures
Severn Pediatric Dentistry may use or disclose medical information about you, without your authorization, for purposes related to/for:

***Treatment:** Treatment means the coordination of your care between various healthcare providers and specialists for consultations. For example, a dentist treating you for gum disease may need to know if you have diabetes because diabetes may slow the healing process. Therefore, the dentist may review your medical records to assess whether you have potentially complicating conditions such as diabetes.

***Payment:** Payment refers to activities related to verifying your level of insurance benefits, requesting authorizations for treatment and referrals for special tests, and billing/administrative purposes. For example, prior to providing health care services, we may need to provide your insurer information about your medical condition to determine whether the proposed course of treatment will be covered.

***Health Care Operations:** The function of health care operations relates to treatment and payment such as quality assurance, case management, patient complaints, audits, and doctor reviews. For example, we may use your medical information to evaluate the performance of our staff caring for you.

***Friends/Family:** When friends/family are involved in your care or payment for your care, we will allow them to pick up medical supplies, x-rays, or unfilled prescriptions on your behalf. If you are available, we will allow you to object to any of these disclosures. If you are unavailable, we will determine what is in your best interest and will allow these individuals to act on your behalf.

***Appointments And Other Health Benefits:** We may contact you to remind you about your appointments and bring to your attention alternative treatment suggestions and other health related benefits.

***Organ & Tissue Donation:** Under law, we can use and disclose your medical information to organizations that handle organ and tissue procurement and donations.

***Military & Veterans:** If you are a member of the armed forces, we may release medical information about you to military authorities, and to foreign military authorities, when applicable.

***Workers Compensation:** We may disclose medical information to programs that provide benefits for work-related injuries or illness.

***Public Health Risks:** We may disclose your medical information to public health officials for purposes related to prevention and control of disease, injury, disability, and reports of births, deaths, abuse, and neglect.

***Health Oversight:** We may disclose your medical information to federal or state agencies that oversee our activities for purposes related to monitoring our healthcare system, government programs, and compliance with civil rights laws.

***Lawsuits And Disputes:** We may disclose your medical information in response to a court subpoena or administrative order.

***Law Enforcement:** We may disclose your medical information to law enforcement officials to aide in the search of a criminal or fugitive, or a criminal investigation.

***Coroners, Medical Examiners, & Funeral Directors:** We may disclose your medical information to identify a deceased person, determine cause of death, and to help funeral directors carry out their duties.

***Purposes Of National Security:** We may disclose your medical information to authorized federal authorities for national security activities permissible by law.

***Protection For Federal Officials:** We may disclose your medical information to protect the President and/or other authorized persons or foreign heads.

***Inmates:** We may provide a correctional facility with an inmate's medical information for their health care and to protect the health and safety of others.

***Research:** We may disclose your medical information to researchers that have received proper approval.

Patient Rights
As a patient of Severn Pediatric Dentistry, you have the right to:

*Request restrictions on our use of your medical information for any of the services listed above; however, we are not required to accept your request.

*Request confidential communication of your protected health information.

*Request copies of your medical information to be delivered to other locations. You will be responsible for any expenses incurred by us for these services, i.e., copying, mailing, etc.

*Request to view your medical records except for notation compiled for potential legal proceedings, medical documentation if you are a prison inmate, information being obtained as a part of a research study that you signed an initial participation consent, information kept by a federal agency, or if the medical information was obtained under a confidentiality agreement made with another provider or entity.

*Request an addition or amendment be made to your medical information, subject to certain conditions.

*Request an accounting of disclosures of medical information, except for disclosures to carry out treatment, payment, or health care operations.

*Receive this Notice of Privacy Practices.

As permitted by applicable law and ethical conduct, Severn Pediatric Dentistry may use and disclose medical information if the staff believes, in good faith, that such use or disclosure is necessary to prevent serious harm to you and to others. Other uses and disclosures of your protected health information will be made with your authorization and you reserve the right to refuse such authorization.
We are required by law to maintain the privacy of your protected health information, and to provide you with a copy of our Privacy Practices. We are required by law to abide by the statements within this Notice of Privacy Practices, effective April 14, 2003. We reserve the right to make any necessary changes and updates to our Privacy Practices, and these new provisions affect all protected health information that we maintain. Should we see the need to change our Privacy Practices; an updated Notice of Privacy Practices will be mailed to you.

Should you have a complaint, questions, or feel that your privacy rights have been violated, please contact our Privacy Officer, David Pfeuffer, D.D.S. at 410-995-8000. You may also file a complaint with the Department of Health and Human Services.

PLEASE KEEP THIS COPY