WELCOME

Legacy DENTAL GROUP
Family and Cosmetic Dental Center

Health History Form

For your convenience... Print this form, complete all information, and bring it with you on your first visit to our office. The parent or Guardian who accompanies the child is responsible for payment at the time of service.

1. Tell Us About Your Child

Child's Name _____ (Last / First / MI)

Nickname_____ ○ Male ○ Female

Siblings that we treat _____

Child's Birthdate ____/____/____ Child's Age _____

Child's Home # (_____)_____

SS#_____

Child's Home Address:_____

_____ APT. / CONDO #

_____ City / State / Zip

2. Mother's Information

Name _____

☐ Stepmother ☐ Guardian Birthdate ____/____/____

Employer _____

Work # (_____)_____ Ext. _____

Home # (_____)_____

Cellular Phone # (_____)_____

SS # _____ DL# _____

3. Father's Information

Name _____

☐ Stepfather ☐ Guardian Birthdate ____/____/____

Employer _____

Work # (_____)_____ Ext. _____

Home # (_____)_____

Cellular Phone # (_____)_____

SS # _____ DL# _____

Marital Status ○ Single ○ Married ○ Separated ○ Widowed ○ Divorced

4. Who is Accompanying the Child Today?

Name _____

Relationship_____

Do you have legal custody of this child? ○ Yes ○ No

5. Person Responsible for Account

Name_____

Relationship_____

Billing Address _____

_____ City / State / Zip

Home # (_____)_____

Work # (_____)_____

E-mail _____

6. Primary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

_____

Insurance Co. Phone # (_____)_____

Group # (Plan, Local, or Policy #) _____

Policy Owner's Name _____

Relationship to Patient_____

Policy Owner's Birthdate _____/_____/_____

Social Security # _____

Policy Owner's Employer _____

7. Secondary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

_____

Insurance Co. Phone # (_____)_____

Group # (Plan, Local, or Policy #) _____

Policy Owner's Name _____

Relationship to Patient_____

Policy Owner's Birthdate _____/_____/_____

Social Security # _____

Policy Owner's Employer _____

8. Dental History

Is this your child's first visit to the dentist? ○ ○

If not, how long since the last visit to the dentist? _____

Were any x-rays taken at previous dental visits? _____

Have there been any injuries to the teeth, face or mouth? _____

_____

If yes, please explain _____

_____

_____

Why did you bring the child to the dentist today? _____

_____

_____

Does the child have any of the following habits?

○Y○N Lip Sucking / Biting ○Y○N Nail Biting

○Y○N Nursing Bottle Habits ○Y○N Thumb / Finger Sucking

Has the child ever had a serious or difficult problem associated with previous dental work? ○Yes ○No

If yes, please explain _____

_____

Is the child's water fluoridated? ○Yes ○No

Is the child taking fluoride supplements? ○Yes ○No

Has the child ever had any pain or tenderness in his/her jaw/joint? (TMJ/TMD)? ○Yes ○No

Does the child brush his/her teeth daily? ○Yes ○No

Floss his / her teeth daily? ○Yes ○No

9. Health History

Has the child ever had any of the following conditions?

○Y ○N Abnormal Bleeding	○Y ○N Handicaps/Disabilities
○Y ○N Allergies to any Drugs	○Y ○N Hearing Impairment
○Y ○N Any Hospital Stays	○Y ○N Heart Murmur
○Y ○N Any Operations	○Y ○N Hemophilia
○Y ○N Asthma	○Y ○N Hepatitis
○Y ○N Cancer	○Y ○N HIV + / AIDS
○Y ○N Congenital Heart Disease	○Y ○N Kidney/Liver Conditions
○Y ○N Convulsions/Epilepsy	○Y ○N Rheumatic/Scarlet Fever
○Y ○N Pregnancy	○Y ○N Allergies to Latex Product

Please discuss any serious medical conditions the child has had

_____

_____

Please list all drugs the child is currently taking _____

_____

Please list all drugs the child is allergic to _____

_____

Child's Physician _____

Phone (_____) _____

Is the child currently under the care of a physician? ○Yes ○No

Please describe the child's current physical health...

○ Good ○ Fair ○ Poor

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA the CDC, and the ADA.

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

_____

10. 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 this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

_____ _____

Signature of Parent or Guardian Date Relationship to Patient

For Office Use Only

I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein.

Initials _____ Date _____

Insurance Verification: Effective Date _____/_____/_____

Preventive _____% Deductible $_____

Basic _____% Maximum $_____

Major _____% Electronic Claims ○Yes ○No

Doctor's Comments _____

_____

_____

_____

Does insurance cover sealants (1351)? ○Yes ○No

If yes, what do they fall under? _____

Ben A. Bratcher, D.D.S.
J. Michael Hackney, D.D.S.
Glenn A. Stern, D.D.S.
Gerard Macy, D.D.S.

Legacy DENTAL GROUP
Family and Cosmetic Dental Center

Financial Policy

It is our goal to provide the best possible dental care for you, and at the same time avoid any confusion regarding your treatment, fees, insurance and payments. For this reason we have created a financial policy statement based on some frequently asked questions.

Q. ***When is payment due?***
A. Payment is expected when services are rendered. We will try to provide you in advance of treatment with the amount of payment that will be required at each visit so that you have the opportunity to discuss treatment alternatives or payment arrangements if finances are a concern.

Q. ***What about insurance? I have coverage. Will your office accept my insurance benefits and then bill me after insurance has paid its portion?***
A. We gladly file and accept your insurance. Please understand that at the time of your appointment you will be asked to pay your deductible as well as any portion of the treatment fees that we estimate will not be covered by your insurance.

If you assign your benefits to be paid directly to our office, we ask that you sign an authorization for direct payment. Our office allows a maximum of ***90* days** for collection of payment from an insurance company. If after that period of time insurance has still not been paid, direct payment from the patient is required.

Q. ***Are fees available for examination?***
A. Absolutely! After an examination, we can determine the type of treatment you need and will be delighted to discuss our fees with you. Please contact our financial coordinator if you have any questions in this regard.

Q. ***Do you allow payment plans?***
A. We do realize that, on occasion, financial circumstances are unavoidable. However, we have a limited time that we extend our payment plans and all outstanding balances are subject to 1.5%/month finance charges in addition to collection fees. If you have a financial concern, we ask that you speak with our financial coordinator.

Q. ***Do you accept credit cards payments?***
A. We are pleased to accept most major credit cards.

There is a $25.00 service fee on all returned checks.

Should your account be turned over to a collection agency due to non-payment, you will be responsible for any and all collection fees.

I have read and agree to the above terms.

_____ _____/_____/_____
Responsible party's 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 **4/14/03,** 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 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 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 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 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 $0.___ for each page, $___ 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 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: **Health Professions Council** **Telephone: 1-800-821-3205**

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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)

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Announcing
Smile Reminder

We are committed to providing the highest level of service and as such we have recently implemented a new technology solution that will allow us to send you important, timely messages without interrupting your busy schedule.

This exciting new service gives us the ability to send text messages to the device of your choice (your cell phone or email). Since we send text you don't have to answer a call. Simply read it and respond at your convenience. We think this is the best solution for reminding you of your appointments and keeping in touch.

We will continue sending you reminder cards and touch base with you by phone.

Sending reminders to your mobile devices allows us to remind you even when you're not at home. We know that no one wants to miss appointments, but sometimes activities of the day get overwhelming for all of us and we forget. With this in mind we are excited to be able to remind you the same day of your appointment. Think of this as a "tap on the shoulder" simply telling you that we are excited to see you for your appointment.

In addition, we will be sending out messages with special opportunities for discounts or new services!!

If you would like to take advantage of this wonderful service, please fill out the following fields to receive text messages and emails from our office:

If you prefer not to receive these messages, please check here ☐

Name: _____ Email: _____

Cell Phone: _____

Thanks for being such a great patient!

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*We will file dental insurance claims as a courtesy to our patients.

*Please note that these prices are **ONLY ESTIMATES** based off the current information we have received from you and your insurance company and you agree that you are responsible for the fees associated with your treatment. We cannot guarantee what your insurance company will pay on your claim.

*It is patients responsibility to know your insurance policy and any frequency and limitations your policy may have. Please contact your insurance company or your plan policy booklet for an explanation of benefits.

*Please note that these **ESTIMATED** prices are only good for 9 months from the day we diagnose the treatment. If your insurance coverage changes it may affect the treatment plan estimates. Please inform us of any changes to your insurance and request a new treatment plan estimate.

*Total patient portion is due at time of service unless pre-approved financial arrangements have been made with our financial coordinator.

Signature_____

Date_____