WELCOME

Tell Us About Your Child Today's Date: _____/_____/_____

Name: _____ Male or Female

Birthdate: _____/_____/_____

Phone #_____

Address: _____

City: _____ State: _____ Zip: _____

Other family members seen by us _____

Who may we thank for referring you?

Name: _____

Person Responsible for Account*Must be the parent/legal guardian who created the account with the practice*

Name: _____

Relationship: _____

Email Address: _____

Parents Information

Mother Stepmother Guardian Birthdate: _____/_____/_____ Phone #_____ Alternate Phone #_____

Name: _____ Address: (if different from child's) _____

Occupation: _____ Employer: _____ Social Security #_____

Father Stepfather Guardian Birthdate: _____/_____/_____ Phone #_____ Alternate Phone #_____

Name: _____ Address: (if different from child's) _____

Occupation: _____ Employer: _____ Social Security #_____

Insurance Information

Insurance Co. Name: _____ Id#: _____ Group #: _____ Phone #_____ Subscriber: _____

Sec. Insurance Co. Name: _____ Id#: _____Group #: _____ Phone #_____ Subscriber: _____

Medical History

Please list any serious medical problems or recent hospitalizations: _____

Please list all drugs the child is currently taking: _____

Please list all drugs that cause the child allergic reactions: _____

Has the child had/experienced any of the following: PLEASE MARK AN ANSWER FOR ALL QUESTIONS BELOW:

Y/N	Y/N	Y/N	Y/N
☐☐Abnormal Bleeding	☐☐ Chicken Pox	☐☐Kidney Problems	☐☐ Speech Delay
☐☐ADHD	☐☐Congenital Heart Defect	☐☐Lice	☐☐ Tonsillitis
☐☐Aids/HIV+	☐☐Convulsions	☐☐Liver Problems	☐☐ Tuberculosis (TB)
☐☐Allergies (List Below)	☐☐Developmental Delay	☐☐Lupus	
☐☐Anemia	☐☐ Diabetes	☐☐Measles	
☐☐Asthma	☐☐ Handicaps/Disabilities	☐☐Mitral Valve Prolapse	
☐☐Autism/Related Disorder	☐☐Hearing Impairment	☐☐Mononucleosis	
☐☐Blood Disorders	☐☐Heart Murmur	☐☐Rheumatic Fever	
☐☐Blood Pressure High/Low	☐☐ Premed Required	☐☐Scarlet Fever	
☐☐Blood Transfusion	☐☐ Hemophilia	☐☐Seizure Disorder	
☐☐Cancer	☐☐ Hepatitis	☐☐Sickle Cell Anemia	
☐☐Cerebral Palsy	☐☐ Hives	☐☐Skin Rash	

(Continued on back)

Dental History

Reason for today's visit/specific dental concerns: _____ Is the child currently in pain?_____
Previous/Present Dentist: _____
What was done at the last visit? _____
When was the last cleaning? _____
How often do you brush? _____
Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? _____
Has the child ever had any injuries to his/her teeth, mouth, head or jaws? _____
If yes, please describe_____
Has the child experienced problems with previous dental work? _____
If yes, please explain _____
Is the child's water fluoridated? _____ Is the child taking fluoridated supplements? _____
Does the child brush daily? _____ Does an adult assist with brushing? _____
Does the child floss daily? _____ Does an adult assist with flossing? _____

Does/did the child have any of the following habits? PLEASE MARK AN ANSWER FOR ALL QUESTIONS BELOW:

Y/N	Y/N	Y/N
☐☐Lip Sucking/Biting	☐☐Thumb/Finger Sucking - until age ___	☐☐ Tongue/Cheek Biting
☐☐Nail Biting	☐☐Used Pacifier - until age ____	☐☐Tongue Thrust
☐☐Chewing on Objects	☐☐Nursing/Bottle Habits - until age ____	☐☐Speech Problems
☐☐Mouth Breather	☐☐Breast Fed - until age ____	
☐☐Clenching/Grinding Teeth	☐☐Still in Sippy Cup	

Medical Information

Child's Physician: _____ Phone # _____

Address: _____

Is the child currently under the care of a physician? ____ If yes, please explain_____

Please describe your child's physical health? Good Fair Poor

Are immunizations current? _____

Authorizations

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest 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. It is also my responsibility to inform this office of any changes in my insurance coverage. I understand that payment is due at the time services are rendered.

_____

Signature of Parent or Guardian Date

Drs. Ellis, Green and Jenkins
Financial Agreement and Office Policies

The dentists and staff of Drs. Ellis, Green and Jenkins are dedicated to providing the best possible care and service. Understanding our financial agreement is an important part of your care and treatment.

- Your **estimated** patient responsibility (co-insurance and deductible) is due in full at the time of service.
- We accept cash, checks, money orders, all major credit cards, and Care Credit.
- Major credit card payments can be processed over the phone. You can also pay on our website via PayPal.

Insurance:

By providing your insurance information, you have agreed to be responsible for services provided. It is very important that you know the terms of your plan, including benefits, limitations, co-insurance, deductible, remaining max and out of pocket expense before each scheduled appointment.

- While many insurance companies are only allowing bitewings once a year, our doctors may recommend taking x-rays more frequently. Bitewing x-rays and fluoride treatment may be performed at each routine cleaning for patients 4 years and older, unless the patient, parent or guardian informs the assistant at the beginning of their visit that they do not wish to have bitewings taken and/or have fluoride applied.
- The bitewing x-rays allow the doctor to see any decay that may be in-between the patient's teeth, which the dentist otherwise would not be able to see.
- Fluoride application is also recommended every six months, as it helps strengthen the enamel of your teeth and it helps prevent decay.

We will file dental claims to most insurance companies. If there is secondary coverage, that information must be provided before the scheduled appointment. If provided after the appointment, you will be responsible for filing the claim to your secondary insurance.

We will collect your portion due (co-insurance) and deductible as estimated based on our system at the time services are rendered. Any pre-estimate or treatment plan provided to you is **not** a guarantee of payment. Payment is determined by your insurance company upon receipt of a claim. Payment is due in **full** at the time services are rendered **if** the patient is under a pre-existing clause or has reached the annual maximum.

For our self-pay patients, payment is due in full at the time of service.

Past Due Accounts:

If your account becomes past due, we will take necessary steps to collect the balance owed. If we have to refer your account to a collection agency, you are required to pay all of the collection costs which are incurred.

Separation/Divorce:

In the situation of a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for their treatment fees. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent. As always, the person bringing the child to the appointment will be expected to pay as required.

Returned Checks:

In the rare case of a returned check for insufficient funds, we will electronically debit your account for the amount of the check plus a processing fee of $30.00. Unpaid returned checks will be forwarded to the Richland County Solicitor's Office.

Confirming of Appointments:

We will make every attempt to contact you about an appointment. However, your confirmation reminder is a courtesy to you; we encourage you to record the scheduled information on your calendar.

Missed/Canceled Appointments:

The second time a patient misses an appointment, or cancels with less than 24 hours' notice from the appointment time, we may assess a fee. This fee must be paid before a new appointment is scheduled. Patients with multiple missed appointments will be asked to transfer their records to another office. Exceptions will be considered on an individual basis.

Missed/Canceled Appointments for patients with South Carolina Healthy Connections Coverage:

The second time a patient misses an appointment, or cancels with less than 24 hours' notice from the appointment time, we may notify your insurance company of the missed appointment. Patients with multiple missed appointments will be asked to transfer their records to another office. Exceptions will be considered on an individual basis.

Scheduling:

We try, whenever possible, to accommodate your need for appointment times that fit your schedule. There are certain types of procedures and ages of children, however that we schedule at specific times in order to provide the best care possible.
For additional information, please visit our website: www.wecaredentalsc.com.

DRS. ELLIS, GREEN and JENKINS

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

Your medical record may contain personal information about your health. This information may identify you and relate to your past, present or future physical or mental health condition and related health care services and is called Protected Health Information (PHI). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI. We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of the Notice of Privacy Practices while it is in effect. This Notice takes effect (10/06/2014), and will remain in effect until we replace it. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

USES AND DISCLSOURES HEALTH INFORMATION

Treatment: Your PHI may be used and disclosed to those who are involved in your care for the purpose of providing, coordinating, or managing your services. This includes consultation with clinical supervisors or other team members. Your authorization is required to disclose PHI to any other care provider not currently involved in your care. Example: If another dentist referred you to us, we may contact that dentist to discuss your care. Likewise, if we refer you to another dentist, we may contact that dentist to discuss your care or they may contact us.

Payment: Your PHI may be used and disclosed to any parties that are involved in payment for care or treatment. If you pay for you care or treatment completely out of pocket with no use of any insurance, you may restrict the disclosure of your PHI for payment. Example: Your payer may require copies of your PHI during the course of a medical record request, chart audit or review.

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, and certification, licensing or credentialing activities. We may share your PHI with third parties that perform various business activities, provided we have a written contract with the business that requires it to safeguard the privacy of your PHI.

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.

Without Authorization: Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. Examples of some of the types of uses and disclosures that may be made without your authorization are those that are: Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audit or investigations (such as the health department).

Required by Court Order

Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat, it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission: We may use or disclose your information to a family member, friend or other person(s) that are directly involved in your receipt of services with your verbal permission.

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 institutions or law enforcement officials having lawful custody of PHI of inmates or patients under certain circumstances.

Appointment Reminders: We may use or disclose your PHI to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing by using the contact information listed at the end of this Notice:

Right of Access to Inspect and Copy: You have the right, which may be restricted only in exceptional circumstances or with documents released to us, to inspect and copy PHI that may be used to make decisions about service provided.

Right to Amend: If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information, although we are not required to agree to the amendment. Your request must be in writing, and it must explain why the information should be amended.

Right to an Accounting of Disclosures: You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.

Right to Request Restrictions: You have the right to request a restriction or limitation on the use or disclosure of your PHI for services, payment, or business operations. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Right to Request Confidential Communication: You have the right to request that we communicate with you about PHI matters in a specific manner (e.g. telephone, email, postal mail, etc.)

Right to a Copy of this Notice: You have the right to a copy of this notice.

WEBSITE PRIVACY

Any personal information you provide us with via our website, including your e-mail address, will never be sold or rented to any third party without your express permission. If you provide us with any personal or contact information in order to receive anything from us, we may collect and store that personal data. We do not automatically collect your personal e-mail address simply because you visit our site. In some instances, we may partner with a third party to provide services such as newsletters, surveys to improve our services, health or company updates, and in such case, we may need to provide your contact information to said third parties. This information however, will only be provided to these third-party partners specifically for these communications, and the third party will not use your information for any other reason. While we may track the volume of visitors on specific pages of our website and download information from specific pages, these numbers are only used in aggregate and without any personal information. This demographic information may be shared with our partners, but it is not linked to any personal information that can identify you or any visitor to our site. Our site may contain links to other outside websites. We cannot take responsibility for the privacy policies or practices of these sites and we encourage you to check the privacy practices of all internet sites you visit. While we make every effort to ensure that all the information provided on our website is correct and accurate, we make no warranty, express or implied, as to the accuracy, completeness or timeliness, of the information available on our site. We are not liable to anyone for any loss, claim for damages caused in whole or in part, by any of the information provided on our site. By using our website, you consent to the collection and use of personal information as detailed herein. Any changes to this Privacy Policy will be made public on this site so you will know what information we collect and how we use it.

BREACHES

You will be notified immediately if we receive information that there has been a breach involving your PHI.

QUESTIONS AND COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at Drs. Ellis, Green and Jenkins. If you have questions and would like additional information, you may contact us at (803) 788-9593. You may also 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.

Acknowledgement of our Notice of Privacy Practices, Financial Agreement and Office Policies

Patient's Last Name ***(Please Print)*** Patient's First Name ***(Please Print)*** (M.I.)

Please read the following, initial each section, sign and date the bottom of this form.

_____ Full payment is due at the time of service unless arrangements have been made prior to the start of any treatment.
_____ Insurance balances are ultimately the patient's obligation. We will file most primary insurances at no cost to you as a courtesy. However, insurance balances which are not paid within 60 days may be billed to you. Please keep your walk-out statements and follow up with your insurance carrier to ensure prompt payment.
_____ Some of your treatment may not be covered by your insurance carrier. The cost for such charges will be your responsibility.
_____ Major services may require a deposit equal to at least one half of the estimated patient portion at the time the appointment is made.
_____ Patients are asked to confirm their appointments at least 48 hours in advance by directly contacting our office or by responding to our confirmation contact. Failure to confirm your appointment may result in a charge for the time reserved.
_____ I have received a copy of this office's Notice of Privacy Practices

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I give permission to share appointment, billing or dental information with the person named below:

Name: _____

I have read and understand the aforementioned policies of Drs. Ellis, Green and Jenkins and I agree to comply with its terms. I understand that I am financially responsible for all charges whether or not they are covered by insurance and agree such terms may be amended from time-to-time by the practice.

_____
Patient/Parent/Legal Guardian ***(Please Print)***

_____ _____
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:

☐ Patient / Parent or Legal Guardian refused to sign form

☐ Other

_____ _____
Signature of Practice Manager Date

Email Forms: info@wecaredentalsc.com