PATIENT FORM - MINOR

BASIC INFORMATION

Full Name:	Gender: ☐ Male ☐ Female ☐ Other ☐ Prefer not to self identify
Preferred Name:	Date of Birth:
Does your child have any special needs?	School:
Referral source: ☐ Google ☐ Facebook ☐ Friend/Family ☐ Drive by/Walk by ☐ Our Website ☐ Other	

PARENT/GUARDIAN INFORMATION

Full Name:	Relation:
Mobile phone:	Street address:
Home phone:	City:
Email:	State, ZIP:
Date of Birth:	SSN #:
Do you have Legal Custody? ☐ YES ☐ NO *if no, then STOP and see Front Desk*	

COMMUNICATION CONSENTS

EMAIL CONSENT PURPOSE: This form is used to obtain your consent to communicate with you by email regarding your Protected Health Information. Learman Dental offers patients the opportunity to communicate by email. Transmitting patient information by email has a number of risks that patients should consider before granting consent to use email for these purposes. Learman Dental will use reasonable means to protect the security and confidentiality of email information sent and received. However, Learman Dental cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information. I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email between Learman Dental and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Learman Dental.

☐ I consent and accept the risk in receiving information via email.

☐ I do not want to receive information via email.

TEXT MESSAGE TO MOBILE CONSENT PURPOSE: This form is used to obtain your consent to communicate with you by mobile text messaging regarding your Protected Health Information. Learman Dental, offers patients the opportunity to communicate by mobile text messaging. Transmitting patient information by mobile text messaging has a number of risks that patients should consider before granting consent to use mobile text messaging for these purposes. Learman Dental will use reasonable means to protect the security and confidentiality of mobile text messaging information sent and received. However, Learman Dental cannot guarantee the security and confidentiality of mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information. I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of mobile text messaging between Learman Dental and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Learman Dental.

☐ I consent and accept the risk in receiving information via mobile text messaging.

☐ I do not want to receive information via text messaging.

✎ Guardian's signature: _____ Date: _____

DENTAL INSURANCE INFORMATION

Do you have a dental insurance? ☐ Yes ☐ No	
Patient's relationship to the Insurance Holder:	Policy Holder's Address:
Policy Holder's Name:	Policy Holder's City:
Policy Holder's Date of Birth:	Policy Holder's State:
Policy Holder's SSN:	Policy Holder's ZIP:
Policy Holder's Phone Number:	Policy Holder's Employer:
Dental Insurance Company:	
ID Number:	Group Number:
Phone number on the back of your insurance card:	

FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment. It is our hope that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choices related to your care.

INSURANCE: Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services, including a pre-treatment estimate which we send to the insurance company at your request. It is physically impossible for us to have the knowledge and keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you. If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf. Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion.

PAYMENT: Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by the dentist.

FULL PAYMENT is due at the time of service. If insurance benefits apply, ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES are due at the time of service, unless other arrangements are made.

UNPAID BALANCE over 90 days old will be subject to a monthly interest of 1.0% (APR 12%). If payment is delinquent, the patient will be responsible for payment of collection, attorneys' fees, and court costs associated with the recovery of the monies due on the account.

MISSED APPOINTMENTS: Unless we receive notice of cancellation 24 business-hours in advance, you will be charged $75.00 per hour scheduled. Please help us maintain the highest quality of care by keeping scheduled appointments.

I have read, understand, and agree to the terms and conditions of this Financial Agreement.

✎ Guardian's signature: _____ Date: _____

PRIVACY POLICY CONSENT

CLIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time (HIPAA).

1. Tell your provider if you do not understand this authorization, and the provider will explain it to you.

2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to the provider at the following address: 4141 Shrestha Dr, Bay City, MI 48706, USA:

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, payment, enrollment, or your eligibility for benefits. However, you may be required to complete this authorization form before receiving treatment if you have authorized your provider to disclose information about you to a third party. If you refuse to sign this authorization, and you have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a patient in their practice.

4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA. If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations; the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

5. You may inspect or copy the protected dental information to be used or disclosed under this authorization. You do not have the right of access to the following protected dental information: psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act (CLIA) prohibits access or information held by certain research laboratories. In addition, our provider may deny access if the provider reasonably believes access could cause harm to you or another individual. If access is denied, you may request to have a licensed health care professional for a second opinion at your expense.

6. If this office initiated this authorization, you must receive a copy of the signed authorization.

7. Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes. HIPAA provides special protections to certain medical records known as Psychotherapy Notes. All Psychotherapy Notes recorded on any medium by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separately from the rest of the clients' medical records to maintain a higher standard of protection. Psychotherapy Notes are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the Psychotherapy Notes definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. Except for limited circumstances set forth in HIPAA, in order for a medical provider to release Psychotherapy Notes to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other dental records.

8. You have a right to an accounting of the disclosures of your protected dental information by the provider or its business associates. The maximum disclosure accounting period is the six years immediately preceding the accounting request. The provider is not required to provide an accounting for disclosures: (a) for treatment, payment, or dental care operations; (b) to you or your personal representative; (c) for notification of or to persons involved in an individual's dental care or payment for dental care, for disaster relief, or for facility directories; (d) pursuant to an authorization; (e) of a limited data set; (f) for national security or intelligence purposes; (g) to correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody; or (h) incident to otherwise permitted or required uses or disclosures. Accounting for disclosures to dental oversight agencies and law enforcement officials must be temporarily suspended on their written representation that an accounting would likely impede their activities.

✎ Guardian's signature: _____ Date: _____

CONSENT FOR DENTAL TREATMENT

As the parent and/or legal guardian of the patient, I do hereby request and authorize Learman Dental and their staff to examine, clean, and provide dental treatment on my child. I further request and authorize the taking of dental x-rays as may be considered necessary to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or child's teeth for diagnostic or educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them understand the treatment in terms appropriate for their age. We will provide an environment that will help your child learn to cooperate during treatment including praise, explanations, and demonstrations of procedures and instruments, and using variable voice tones. The usual and most frequent risks or complications occurring from dental operative treatment include but are not limited to, the possibility of pain or discomfort during the treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of a temporomandibular joint disorder, temporary or permanent numbness, and allergic reactions.

I understand I will be responsible for any charges incurred for my child for dental treatment. I affirm that the information above is correct to the best of my knowledge. I understand it is my responsibility to inform Learman Dental of any changes in my child's medical status.

✎ Guardian's signature: _____ Date: _____

GUARDIAN AUTHORIZATION

I authorize the person listed below to accompany my child, to his/her dental appointment.

Authorized Person's Name	Authorized Person's Relation

I agree to the following treatment to be performed in my absence

- ☐ Examination
- ☐ Radiographs (x-rays) deemed necessary
- ☐ Cleaning
- ☐ Fluoride
- ☐ Silver diamine fluoride
- ☐ Necessary restoration of decayed teeth
- ☐ Extractions
- ☐ Emergency treatment as necessary

GUARDIAN AUTHORIZATION CONSENT

I request that I be contacted at the phone number below if treatment needs or recommendations change during treatment. If treatment recommendations change during treatment and I am not able to be reached I authorize the person accompanying my child to make an informed decision and authorize Learman Dental to perform the necessary and recommended treatment. I understand this guardian authorization will remain in effect until revoked in writing.

✎ Guardian's signature: _____ Date: _____

Legal Guardian's Contact phone # _____

HEALTH HISTORY - MINOR

Today's Date _____Patient Name: _____ Date of Birth: _____

Are you currently under the care of a physician? ☐ Yes ☐ No	Last physical exam:
If yes, please explain:	
Physician Name:	Physician Phone:

Have you ever had a serious head/neck injury?	○ Yes ○ No
Have you ever been hospitalized or had a major operation?	○ Yes ○ No
Are you taking any other medications, pills, or drugs? If yes, please list…	○ Yes ○ No

Are you allergic to any of the following?

Aspirin	○ Yes ○ No	Latex	○ Yes ○ No
Penicillin	○ Yes ○ No	Sulfa Drugs	○ Yes ○ No
Codeine	○ Yes ○ No	Barbiturates / Sedatives	○ Yes ○ No
Acrylic	○ Yes ○ No	Local Anesthetics	○ Yes ○ No
Metal	○ Yes ○ No	Other?	○ Yes ○ No

Do you have any of the following?

Visual Changes	○ Yes ○ No	Easily Upset / Irritated	○ Yes ○ No
Wear Contact Lenses or Eyeglasses	○ Yes ○ No	Unhappy / Depressed	○ Yes ○ No
Hearing Loss	○ Yes ○ No	Snore or Gasp	○ Yes ○ No
Pain/Discomfort around Ears	○ Yes ○ No	Tired during the day	○ Yes ○ No
Emotional Problems	○ Yes ○ No	Clench or Grind Teeth	○ Yes ○ No

Do you have, or have you had, any of the following?

AIDS/HIV Positive	○ Yes ○ No	Heart Surgery / Trouble / Disease	○ Yes ○ No
Anemia	○ Yes ○ No	Hepatitis A, B, or C	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No	High / Low Blood Pressure	○ Yes ○ No
Asthma / Breathing Problems	○ Yes ○ No	High Cholesterol	○ Yes ○ No
Bruise Easily	○ Yes ○ No	Hives or Rash	○ Yes ○ No
Cancer/Chemotherapy/Radiation	○ Yes ○ No	Human Papilloma (HPV)	○ Yes ○ No
Cold Sores / Fever Blisters	○ Yes ○ No	Kidney Problems	○ Yes ○ No
Diabetes	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No
Epilepsy or Seizures	○ Yes ○ No	Pain in Jaw Joints	○ Yes ○ No
Excessive Bleeding	○ Yes ○ No	Psychiatric Care	○ Yes ○ No
Fainting Spells/Dizziness	○ Yes ○ No	Recent Weight Loss	○ Yes ○ No
Fibromyalgia	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No
Frequent Headaches	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Hay Fever / Sinus Trouble	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Heart Murmur / Irregular Heartbeat	○ Yes ○ No	Tumors/Growths/ Ulcers	○ Yes ○ No

Have you ever had any serious illness not listed above? ○ Yes ○ No

✎ Guardian's signature: _____ Date: _____

Reviewed by: _____ Date: _____