TIMBERLANE DENTAL GROUP

Pediatric & Adolescent Dentistry
Eliza M. Callwood, DMD
Gary B. Davis, DDS, MS
Shon C. DiGuglielmo, DDS
Lauren C. Gulka, DMD
Theron J. Main, DDS
Thomas J. Ruescher, DMD

Orthodontics
Christopher L. Lundberg, DDS, MS
Matthew M. Rogers, DDS
Fred D. Ziegler, DMD

CHILD'S NAME_____ NICK NAME_____ DATE_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____ PHONE_____

AGE_____ DATE OF BIRTH_____ PLACE OF BIRTH_____ SEX_____

NAME AND AGE OF BROTHERS_____ PATIENT WEIGHT_____

NAME AND AGE OF SISTERS_____ PATIENT HEIGHT_____

CHILD'S PHYSICIAN OR PEDIATRICIAN_____ ADDRESS_____

DATE OF LAST VISIT_____ PHONE NUMBER_____

FAMILY DENTIST_____

WHOM MAY WE THANK FOR REFERRING YOU TO US_____

REASON FOR THIS APPOINTMENT_____

NAME OF CHILD'S PET AND/OR HOBBY_____

PARENTS		
NAME		
DOB		
SSN		
HOME PH#		
CELL PH#		
EMPLOYED BY		
WORK PH#		
EMAIL		

PERSON FINANCIALLY RESPONSIBLE (IF OTHER THAN PARENT)_____ RELATIONSHIP TO CHILD_____

WHO HAS LEGAL CUSTODY OF CHILD?_____

CHILD MEDICAL HISTORY

1a. IS YOUR CHILD BEING TREATED BY A PHYSICIAN NOW?

IF YES, EXPLAIN_____

1b. IS YOUR CHILD CURRENTLY TAKING MEDICATIONS?

IF YES, LIST MED'S AND DOSE_____

2. HAS YOUR CHILD EVER BEEN HOSPITALIZED OR TREATED IN AN EMERGENCY ROOM FOR AN ILLNESS OR SIGNIFICANT INJURY?

EXPLAIN_____

3. IS THERE ANY ALLERGY TO MEDICATIONS OR ANY ADVERSE DRUG REACTIONS?_____

4. ANY OTHER ALLERGIES: LATEX, FOOD, HAY FEVER, DUST OR OTHER?_____

_____

5. HOW WOULD YOU DESCRIBE YOUR CHILD'S TEMPERAMENT?_____

6. HAS YOUR CHILD EVER RECEIVED A BLOOD TRANSFUSION?_____ IF YES, GIVE DATE_____

7. HAS YOUR CHILD HAD ANY HISTORY OF:

	Y	N		Y	N		Y	N
DIABETES	☐	☐	EPILEPSY OR SEIZURES	☐	☐	ASTHMA	☐	☐
KIDNEY PROBLEMS	☐	☐	BLOOD OR BLEEDING DISORDERS	☐	☐	CEREBRAL PALSY	☐	☐
FREQUENT SORE THROATS	☐	☐	BEHAVIORAL/LEARNING PROBLEMS	☐	☐	GASTROINTESTINAL PROBLEM	☐	☐
EAR ACHES/OTHER INFECTIONS	☐	☐	HEART PROBLEMS OR MURMUR	☐	☐	RHEUMATIC FEVER	☐	☐
EYE PROBLEM	☐	☐	SPEECH OR HEARING PROBLEMS	☐	☐	BIRTH DEFECTS OR GENETIC DISORDERS	☐	☐
TUBERCULOSIS (TB)	☐	☐	HIV (+) / AIDS	☐	☐	CANCER	☐	☐
BONE OR JOINT PROBLEMS	☐	☐	IMMUNE SYSTEM PROBLEMS	☐	☐	INFECTIOUS DISEASES	☐	☐
HEPATITIS	☐	☐	RECURRENT HEADACHES	☐	☐	DEVELOPMENTAL DELAYS	☐	☐
LUNG PROBLEMS	☐	☐	LIVER PROBLEMS	☐	☐	AUTISM	☐	☐
ENDOCRINE (GLAND) PROBLEMS	☐	☐	CHEWING TOBACCO	☐	☐	SMOKING	☐	☐
OTHER MEDICAL PROBLEMS	☐	☐						

7. HAS YOUR CHILD HAD? ☐ MUMPS ☐ CHICKEN POX ☐ ROSEOLA ☐ MEASLES ☐ HIGH FEVER

8. IS THE PATIENT PREGNANT AT THIS TIME? ☐ YES ☐ NO ☐ ☐

(PLEASE FILL OUT REVERSE SIDE.)

DENTAL HISTORY

		Y	N
1.	Are you currently on a fluoridated water system or is your child taking a daily fluoride supplement? If supplement, what is the dosage?_____	☐	☐
2.	Has your child had a recent dental problem? What?_____	☐	☐
3.	Give date of last dental care_____ Where?_____ Date of last Dental X-Rays?_____		
4.	Do you consider your child high strung or nervous?_____	☐	☐
5.	Has your child had an unfavorable experience at a dental or medical office?_____	☐	☐
6.	How do you think your child will respond to dental care?_____ _____		
7.	Any history of injuries to the teeth, face or head?	☐	☐
8.	Is there any history of headaches, grinding, or TMJ (joint) problems?	☐	☐
9.	Does your child have a history of thumb-sucking, nail biting, tongue habits or pacifier? Current_____ Past_____ Until what age?_____	☐	☐
10.	Was your child bottle-fed?_____ Until what age?_____		
11.	Was your child nursed?_____ Until what age?_____		
12.	Does or did your child use a sippy cup?_____ Until what age?_____		
13.	Has mother or father had a lot of tooth decay?	☐	☐
14.	Is there a family history of dental problems? Please describe_____	☐	☐
15.	Are your child's teeth brushed daily? How often?_____	☐	☐
16.	Do you assist your child with brushing? How often?_____	☐	☐
17.	Are dental floss or disclosing agents used?_____	☐	☐
18.	Is there anything else I should know about your child?_____ _____		

BECAUSE YOUR CHILD IS A MINOR, IT BECOMES NECESSARY THAT A SIGNED PERMISSION IS OBTAINED FROM A PARENT OR GUARDIAN BEFORE ANY AND/OR ALL NECESSARY DENTAL SERVICE CAN BE STARTED.

AUTHORIZATION IS HEREBY GRANTED. I WILL BE RESPONSIBLE FOR ANY FEE INCURRED FOR TREATING THIS CHILD UNLESS IT IS LEGALLY THE RESPONSIBILITY OF ANOTHER AGENCY.

SIGNED_____

DATE_____

Dentist's remarks and summary:_____

_____

_____

Reviewed by:_____

TIMBERLANE
DENTAL GROUP

Thank you for choosing Timberlane Dental Group for all your dental needs. We offer a full range of services such as pediatric dentistry, orthodontic care, adult dentistry, and periodontal services. We take pride in our history of excellence in providing outstanding dental care. The following policies are intended to benefit our patients and enable us to continue to provide outstanding care.

Please review the policies below:

- Fees for dental services are payable at the time of visit including deductibles and co-pays. We will gladly provide you with the estimated cost of treatment prior to each appointment so that you are prepared to pay for the services provided. We offer several options for payment including cash, check, major credit cards, as well as CareCredit.

- If you are covered by insurance, we will ask for a copy of your insurance card at your first visit and pre-authorize any subsequent visit over $200.00. Please keep in mind that your insurance coverage is a contract between you and your carrier. As a service to you, we will assist you in processing your dental claims; however, you are ultimately responsible for any balances not paid by your dental insurance.

- We see patients on an appointment basis. Urgent conditions and emergencies are given special consideration. Because we have a reserved appointment time for you, it is very important that you keep your appointment. If you must reschedule or cancel an appointment, we require two business days notice. We recognize that emergencies or unforeseen circumstances may arise that make it difficult for you to keep your scheduled appointment. If you cancel or fail to keep your appointment and do not notify us, it may delay treatment based on availability of appointment times. Multiple missed appointments may result in our asking you to see dental treatment elsewhere.

- We make every effort to be on time for our patients and we ask that you extend the same courtesy to us. If you arrive late to your appointment, it may impact our ability to treat you. We may be required to reschedule the appointment, delaying necessary treatment. Should an emergency occur which delays our seeing your promptly, we will do our best to notify you. We ask you for your understanding in this matter.

Thank you for your adherence to these policies.

_____ _____

Patient Signature (Parent/Guardian Signature) Date

TIMBERLANE
DENTAL GROUP

New Patient Information
Pediatric/Orthodontic

Patient's Name_____

Nickname _____ Date of Birth _____ Child's Soc. Sec. # _____

Parent/Guardian _____ Date of Birth _____ Email_____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Parent/Guardian _____ Date of Birth _____ Email_____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

I hereby authorize payment of the dental insurance benefits otherwise payable to me directly to Timberlane Dental Group. I understand that I am financially responsible for all charges whether or not paid by the insurance. I authorize Timberlane Dental Group to release all information necessary to secure payment. It is my responsibility to pay any deductibles, co-payments and any other fees not paid by insurance. I understand payment is expected at the time of service.

Patient's Signature_____ Date_____
(If patient is a minor, a parent or guardian must sign.)

Please Print Name _____ Date of Birth _____ Soc. Sec. # _____

DENTAL INSURANCE INFORMATION

Primary Dental Insurance

Patient's Relationship to the Insured (Circle) Self / Spouse / Child / Other

Name of Dental Insurance_____ Address_____

Please Check Which is Applicable: Group Insurance Medicaid Effective Date_____

Name of Policy Holder_____ Group #_____ Member ID #_____

Date of Birth (Policy Holder)_____ Soc. Security # (Policy Holder)_____

Employer Name_____

Secondary Dental Insurance

Patient's Relationship to the Insured (Circle) Self / Spouse / Child / Other

Name of Dental Insurance_____ Address_____

Please Check Which is Applicable: Group Insurance Medicaid Effective Date_____

Name of Policy Holder_____ Group #_____ Member ID #_____

Date of Birth (Policy Holder)_____ Soc. Security # (Policy Holder)_____

Employer Name_____

Medical Insurance (required for treatment of dental injuries sustained in an accident)

Patient's Relationship to the Insured (Circle) Self / Spouse / Child / Other

Name of Medical Insurance_____ Address_____

Please Check Which is Applicable: Group Insurance Medicaid Effective Date_____

Name of Policy Holder_____ Group #_____ Member ID #_____

Date of Birth (Policy Holder)_____ Soc. Security # (Policy Holder)_____

Employer Name_____

NOTICE OF PRIVACY PRACTICES

TIMBERLANE DENTAL GROUP

Dental Care for Smiles of Every Age

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 October 20, 2016, 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.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize 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 $ .50 per page up to a maximum of $5.00 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.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains soley to a health care item or service for you, or a person on your behalf (other than the health plan), has paid our practice in full.

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.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

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 Officer: Cindy Allen

Telephone: (802) 264-6906 Fax: (802) 862-8942

E-mail: cdallen@timberlanedental.com

Address: 60 Timberlane, South Burlington, VT 05403

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

TIMBERLANE
DENTAL GROUP

****You May Refuse to Sign This Acknowledgement****

I,_____, have received a copy of this office's Notice of Privacy Practices.

_____
(Please Print Name)

Patient's Name:_____
(Minor/Dependent) please print

_____
(Signature)

Parent/Guardian Signature Required

_____
(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
- ❑ Declined to return the form sent via U.S. Mail
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (please specify)

_____

_____

_____