

Keystone Pediatric Dentistry

SALLY Z. LAUTERJUNG, D.D.S., Inc.

3591 Reserve Commons Drive, Suite 200

Medina, OH 44256

Telephone: (330) 723-7566

MINOR/CHILD REGISTRATION

Please Print

PATIENT INFORMATION

Name of Minor/Child _____				
		(Last Name)	(First Name)	(Initial)
Sex	M <input type="checkbox"/>	F <input type="checkbox"/>	Age _____	Birthdate _____
Hobbies _____				
Home Address _____				
Street		City	State	ZIP
Mailing Address _____				
Street		City	State	ZIP
Person accompanying patient _____		Home Phone _____	Work Phone _____	
Cell Phone Number _____		E-Mail Address _____		
Whom may we thank for referring you _____				

PARENT GUARDIAN INFORMATION *(must be completed)*

Father's/Guardian's Name _____	Mother's/Guardian's Name _____
Address (if different from patient's) _____	Address (if different from patient's) _____
Home Phone _____ Work Phone _____ (If different from above)	Home Phone _____ Work Phone _____ (If different from above)
Employer _____	Employer _____
Soc. Sec. # _____ Birthdate _____	Soc. Sec. # _____ Birthdate _____
Dental insurance for minor/child? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental insurance for minor/child? <input type="checkbox"/> Yes <input type="checkbox"/> No
Plan Name _____	Plan Name _____
Phone No. _____	Phone No. _____
Address _____	Address _____
_____	_____
Group # _____	Group # _____
Policy # _____	Policy # _____

EMERGENCY CONTACT OTHER THAN PARENTS

In the event of an emergency, whom should we contact?		
Name _____	Relationship _____	Phone _____
Name _____	Relationship _____	Phone _____

DENTAL HISTORY

Date of last visit to a dentist _____	For what service _____				
	Yes	No	Yes	No	
Has child complained about dental problems?	<input type="checkbox"/>	<input type="checkbox"/>	Is flouride taken in any form?	<input type="checkbox"/>	<input type="checkbox"/>
Does parent assist child with brushing teeth daily?	<input type="checkbox"/>	<input type="checkbox"/>	Any injuries to mouth, teeth, head?	<input type="checkbox"/>	<input type="checkbox"/>
Does child use floss every day	<input type="checkbox"/>	<input type="checkbox"/>	Any unhappy dental experiences?	<input type="checkbox"/>	<input type="checkbox"/>
Any mouth habits - thumbsucking, mouth breathing, pacifier, sleeping with bottle, etc.? _____					

(Continued)

MEDICAL HISTORY

Minor/Child's Physician _____	City/State _____	Phone _____
Date of last physical examination _____	Results _____	
	YES NO	
Is minor/child under care of physician now? _____	<input type="checkbox"/> <input type="checkbox"/>	Medications _____
Receiving any medications or drugs? _____	<input type="checkbox"/> <input type="checkbox"/>	_____
Ever been hospitalized? _____	<input type="checkbox"/> <input type="checkbox"/>	For what? _____
Date _____	<input type="checkbox"/> <input type="checkbox"/>	Where _____
Ever had surgery? _____	<input type="checkbox"/> <input type="checkbox"/>	For What? _____
Date _____	<input type="checkbox"/> <input type="checkbox"/>	Where _____
Is there excessive bleeding when cut? _____	<input type="checkbox"/> <input type="checkbox"/>	Allergies? _____
HAS MINOR/CHILD HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING? <i>(If so, please check!)</i>		
<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> Amoxicillin Allergy	<input type="checkbox"/> Cystic Fibrosis	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Anemia	<input type="checkbox"/> Developmentally Delayed	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Aperts Syndrome	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Latex Allergy
<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> Downs Syndrome	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Aspergers Syndrome	<input type="checkbox"/> Drug/Alcohol Abuse	<input type="checkbox"/> Measles
<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Mononucleosis
<input type="checkbox"/> Autism	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Mumps
<input type="checkbox"/> Bladder Problems	<input type="checkbox"/> Fainting	<input type="checkbox"/> Muscular Dystrophy
<input type="checkbox"/> Brain Shunt	<input type="checkbox"/> Hearing Problems	<input type="checkbox"/> Penicillin Allergy
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Radiation Treatment
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Rheumatic Fever
		<input type="checkbox"/> Seizures
		<input type="checkbox"/> Sinus Problems
		<input type="checkbox"/> Speech Delay
		<input type="checkbox"/> Stomach Problems
		<input type="checkbox"/> Stroke
		<input type="checkbox"/> Sulfa Allergy
		<input type="checkbox"/> Thyroid Disease
		<input type="checkbox"/> Tuberculosis
		<input type="checkbox"/> Ulcers
		<input type="checkbox"/> Zithromax Allergy
		<input type="checkbox"/> Others

AUTHORIZATIONS

The information that I have given is correct to the best of my knowledge. I understand 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 for my minor/child. I am responsible for all charges regardless of personal financial agreements between parents.

 Signature of Parent/Guardian

 Date

RELEASE AND ASSIGNMENT

I certify that my minor/child is covered by insurance with _____ and I assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

 Signature of Parent/Guardian

 Date

KEYSTONE PEDIATRIC DENTISTRY

Sally Z. Lauterjung DDS Inc.

MISSION STATEMENT

Keystone pediatric dentistry will provide comprehensive dental care to children and adolescents, including those with special medical conditions and/or handicaps. Special emphasis will be placed on patient and parental education and prevention of oral and dental disease.

The primary teeth form the basis of the adult dentition, therefore, we will strive to preserve its integrity, while at the same time foster a healthy and relaxed attitude towards dental care, enabling the youth of our area to grow up free of oral or dental disease.

It is our objective to provide preventative measures, good service and quality dental care that is easily accessible to the people of Medina and the surrounding areas. We will establish a reputable practice oriented towards children, to which local practitioners may refer special cases.

In an effort to assist both a new and existing patients we have established the following policies:

- **We ask for only one adult per child in the treatment room during appointments.**
- Accompanying children will be asked to stay in the waiting room with an adult.
- **PLEASE TURN OFF CELL PHONES WHILE IN OUR TREATMENT AREAS.**
- If you choose not to accompany your child in the treatment room for their appointment, we do need for you to stay in the building.
- In an effort to see your child promptly, we may need to re-schedule your appointment, if you are more than fifteen minutes late.
- Please help us keep our new waiting room and restroom clean. No food or drinks allowed.
- All efforts will be made to have your child seen by the Doctor of your choice. However, some situations may arise resulting in a change of schedule.

FOR YOUR CONVENIENCE, THERE ARE DIAPER CHANGING STATIONS IN THE 1ST FLOOR RESTROOMS.

(Continued)

All charges are due on the day of service.

As a service to our patients, we accept dental insurance and will gladly file insurance claims for you. You are responsible for all charges incurred, regardless of insurance payment. For us to have the ability to offer you this service, we must have your complete information. This includes an insurance card or claim form with the address, telephone number and group number. If the insurance is through an employer, we will need the complete employer information also. Social Security numbers are necessary for our software insurance fields.

For established patients, if we have been able to predetermine the insurance company's expected payment, we will accept payment for the predetermined patient portion due on the day of service and we will bill your insurance.

Please contact your insurance company regarding your coverage in our office prior to your appointment. Each insurance company has their own policies and coverage tables. We are not able to know each insurance company's terms.

We recommend your child have a prophylaxis and fluoride treatment every six months. We recommend radiographs periodically and when they are needed for further diagnosis. Prophylaxis will be charged as an adult procedure when the patient has all permanent teeth or has reached the age of 13.

If you are unable to keep a scheduled appointment, please give us 24 hours notice. There may be a \$50.00 charge for a missed appointment. Two consecutive missed appointments may be reason for termination from our practice.

Please be advised: Accounts that are unpaid over 90 days, without monthly payments applied, will be referred to a collection agency. All costs incurred for the collection of your past due debt, such as applicable finance charges, collection fees, attorney fees and court costs will be added to your account balance. This will automatically terminate the patient from our practice, allowing 30 days for emergency treatment. Our office staff will make every effort to see that your account remains current to prevent this action.

We utilize a program called Quick Pay. We maintain your credit/debit card account number on file to capture any co-pays, deductibles or balances not covered by insurance. We will not use the credit/debit card account number unless your account goes over 90 days past due. This saves our practice and you from additional expenses related to collection fees. Those who decline to utilize the Quick Pay program must pay for all charges at the time of service. If there is dental insurance, we will give you a copy of the claim for you to submit to your insurance company with authorization to pay the insured directly.

Credit/debit card # _____ Type of card: _____

Expiration Date: _____ Three digit security code: _____

Authorized Signature: _____

We also offer a dental/medical credit card program called CareCredit. You can apply on line at www.carecredit.com.

Finance charges will incur on accounts that are over 90 days.
I have read and understand the policies of Keystone Pediatric Dentistry, Sally Z. Lauterjung DDS Inc.

Parent/Guardian Signature

Date

THANK YOU FOR YOUR UNDERSTANDING

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.

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 April 15, 2003 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 on request.

You may request a copy of our Notice at anytime. 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 providers providing treatment to you.

Payment:

We may use/disclose your health information to obtain payment for services provided to you.

Health care operations:

We may use and disclose your health information in connection with our healthcare operations. Health care operations include quality assessment and improvement activities, reviewing the competence and qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, and certification, licensing or credentialing activities.

Your authorization:

In addition to our use of your health information for treatment, payment or health care 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 of 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 health care or with payment for your health care, 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 necessary for your well-being.

**KEYSTONE PEDIATRIC DENTISTRY * Sally Z. Lauterjung DDS Inc.
3591 Reserve Commons Drive, Suite 200 *Medina, Ohio 44256 * 330-723-7566**

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PATIENT OR PERSONAL REPRESENTATIVE GIVING CONSENT

Patient's Name: _____
Address _____
Telephone _____ E-mail _____

TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Cheryl Ehrenfeld
Contact Telephone: 330-723-7566 Fax 330-723-3054
Contact E-Mail: cherie@keystonepd.com
Contact Address: 3591 Reserve Commons Drive, Suite 200, Medina, Oh 44256

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect action we took in reliance on this Consent before we received your revocation, and that we may decline to treat the patient or to continue treating patient if you revoke this Consent.

Signature

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry our treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

KEYSTONE PEDIATRIC DENTISTRY
Sally Z. Lauterjung DDS Inc.
3591 Reserve Commons Drive, Suite 200,
Medina, OH 44256
330-723-7566

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you're concerned that we may have violated your privacy rights, or you disagree with the 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 methods, or at alternative locations, you may complain to us using the contact information listed at the end of the 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 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: Cheryl Ehrenfeld
Contact telephone: 330-723-7567
Contact fax number: 330-723-3054
E-mail: *cherie@keystonepd.com*
Contact address: 3591 Reserve Commons Drive, Suite 200,
Medina, OH 44256