CHILD'S NAME ______________________________ SEX ________
ADDRESS ____
CITY ______________________ STATE ________ ZIP CODE ________
DATE OF BIRTH ______________________ AGE ____________
HOME PHONE (____)______________________

WHO IS ACCOMPANYING THE CHILD TODAY? Name ________________
Relationship ____
Do you have legal custody of this child? ________________
PARENTS MARITAL STATUS: single _____ married _____ widow ____ divorced ____
PARENT NOT LIVING WITH CHILD Name ________________________
Address ______________________ City ______________ State ________
Zip Code ___________Home phone _______________ Work phone ______________

MOTHER/GUARDIAN NAME ____________________________________
MOTHER/GUARDIAN EMPLOYER ________________________________
Employer address ______________________________ Phone ____________

FATHER/GUARDIAN NAME ____________________________________
FATHER/GUARDIAN EMPLOYER _________________________________
Employer address ______________________________ Phone ____________

WHO TO CONTACT IN CASE OF EMERGENCY IF OTHER THAN PARENT?
Name ______________________________Relationship ________________
Address ____________________________________ Phone ____________

DO YOU HAVE DENTAL INSURANCE? _________ IF YES, COMPLETE BELOW:
INSURED NAME ____________________________ RELATIONSHIP __________
INSURED S.S #__________________________ DATE OF BIRTH ____________
INSURANCE CARRIER ________________________ GROUP # ______________
INSURANCE CARRIER ADDRESS ________________________________
INSURANCE CARRIER PHONE __________________________________

SECONDARY INSURANCE ___________ IF YES, COMPLETE BELOW:
INSURED NAME ____________________________ RELATIONSHIP __________
INSURED S.S # __________________________ DATE OF BIRTH ____________
INSURANCE CARRIER ________________________ GROUP #______________
INSURANCE CARRIER ADDRESS ________________________________
INSURANCE CARRIER PHONE __________________________________

PERSON RESPONSIBLE FOR ACCOUNT ____________________________
RELATIONSHIP TO PATIENT ___________________________________

WHOM MAY WE THANK FOR REFERRING YOUR CHILD? ________________

PEDIATRIC DENTISTRY HISTORY

(to be completed by parent or guardian)

_______________ TODAY'S DATE

Child's Full Name _______________ Birth Date _______ Age ____ Sex ____

HISTORY

Is your child regularly seen by a medical doctor or clinic? Yes No

If yes, give name and address _______________

What is the date of the last complete medical exam? _______________

Has your child ever been hospitalized, had general anesthesia, or emergency room visits? Yes No

If yes, state the reasons _______________

Why do you want dental care for your child? _______________

MEDICAL HISTORY

Does your child have or ever had any of the following?

Check			
Yes	No	?	
			Frequent colds or ear infections
			Strep throat or tonsilitis
			Pneumonia or respiratory problems
			Tuberculosis
			Allergies
			Asthma
			Eye problems
			Stomach problems or frequent vomiting
			Liver disease, hepatitis or jaundice
			Diabetes
			Birth defect
			Learning disorder
			Regular injections or medications

If yes, list _______________

Check			
Yes	No	?	
			Heart murmur or disease
			Sickle cell anemia or trait
			Transfusions
			Bruises easily or bleeds a lot
			Scarlet fever or rheumatic fever
			Measles, mumps, or chicken pox
			Sexually transmitted disease
			Seizures or epilepsy
			Emotional or behavioral problems
			Pregnancy
			Drug or alcohol abuse
			Use of tobacco products
			Physical abuse

Other problems _______________

IMMUNIZATIONS

Has your child had the following immunizations?

Check			
Yes	No	?	
			DPT
			Oral polio
			Tetanus booster
			Measles

Check			
Yes	No	?	
			Mumps
			Tuberculosis (Tine Test)
			Was it positive?

FAMILY HISTORY

How many people are there in your household? _____ Adults _____ Children _____

Who takes care of your child during the day? _______________

Do any members of the household or other relatives have a history of:

Check			
Yes	No	?	
			Congenital heart disease
			High blood pressure
			Blood disease
			Severe allergies or asthma
			Mental retardation
			Seizures or convulsions
			Emotional problems
			Cleft lip or palate

Check			
Yes	No	?	
			Diabetes
			Urine or kidney problems
			Alcohol abuse
			Drug abuse
			Sexually transmitted diseases
			Tuberculosis
			Severe gum disease or decay
			Other diseases (List)

____

DEVELOPMENTAL HISTORY

For Younger Children

Check Yes	Check No		Check Yes	Check No	
____	____	Baby born premature	____	____	Rh or blood problem
____	____	Problems during pregnancy or delivery	____	____	Feeding problems
____	____	Problems immediately after birth	____	____	did baby go home w/ mother from hospital

For All Children

Check At what age did your child stand? _____ walk ____ talk ____

Yes	No		
____	____	Was your child breast fed?	When stopped? ________________
____	____	Was your child bottle fed?	When stopped? ________________
____	____	Did your child use a pacifier?	When stopped? ________________
____	____	Did your child suck a finger or thumb?	When stopped? ________________
____	____	Does your child attend any special classes or schools?	

What grade is your child in? _________________

For Older Children and Adolescents

Check Yes	Check No	
____	____	Has your child recently started to grow quickly?
____	____	Do you think your child has stopped growing?
____	____	Do you have any records of your child's height or weight changes?
____	____	Has your child shown any signs of reaching puberty? Ex.Girls-monthly period; boys – shaving or voice change

Dental History

Check Yes	Check No	
____	____	Is this your child's first visit to a dentist?
____	____	Has your child had toothaches in the past?
____	____	Does your child have pain now?
____	____	Does your child think anything is wrong with his/her teeth?
____	____	Has your child ever received trauma to teeth, mouth, or face?
____	____	Do you think your child will react negatively (be upset) to dental treatment?
____	____	Are you nervous about this treatment?
____	____	Does your child brush his/her own teeth?
____	____	Does your child use dental floss?
____	____	Do you usually help your child brush?
____	____	Do your child gums bleed when brushed?
____	____	Did you or your child ever get instructions in brushing?
____	____	Does your child use fluoride products: rinses, drops, tabs?

How old is your child's toothbrush? ____

Type of toothpaste ________________________________

How often are teeth brushed? ____

Signature of person completing form____

D. Bartholomew G. Kreiner ,D.D.S **511 S. Fountain Green Road**
BelAir Maryland 21015

Phone (410)-879-1730

Financial Responsibility and Patient Consent

I understand that I am responsible for payment of services rendered, co-payments and deductible that my dental insurance does not cover. Co –payments and deductibles are due at the time of service. If payment is not received within 30 days from date of service, you will be assessed a 1.5% late charge of your unpaid balance or a $ 5.00 billing fee whichever is greater, until balance is paid in full. Our contractual arrangements are with you are not your insurance company.
Any checks returned will be subject to a $40.00 returned check fee. If your account becomes assigned to a collection agency, I agree to pay the cost of collection agency fees, court costs, and attorney fees.

I authorize the dentist to release any information requested by any third party payor regarding charges incurred by the patient. I consent to all treatment, tests, and diagnostic procedures deemed necessary by the dentist. Absolutely no dental treatment will be started without my prior approval.

Any appointment cancelled less than 48 hours in advance will be charged a cancelled appointment fee of $64.00 which is not covered by insurance.

Any Scheduled appointment that the patient fails to appear with out notice will be charged a missed appointment fee of $64.00 which is not covered by insurance

I have read the above; I understand it and agree to the terms.

Patient Signiture____**Date**______________

Print Name____

D. Bartholomew G. Kreiner ,D.D.S **511 S. Fountain Green Road**
BelAir Maryland 21015

Phone (410)-879-1730

Financial Options

Dear Patient:

In an effort to provide you with payment arrangements, we have expanded our payment policy.

FULL PAYMENT ARRANGEMENTS ARE REQUESTED
AT THE TIME OF YOUR VISIT

We now offer the following payment options:

___________ Payment by cash

___________ Payment by Check

___________ Payment by Credit Card (Visa & MasterCard only)

___________ Guarantee any amount not covered by insurance with Visa or MasterCard

___________ Third Party Financing with Care Credit upon approval 12 month interest free if balance paid off in full within the 12 months for amounts starting at $1,000.00 or more.

Please make a choice, sign below and return to the office manager before treatment.

Our office is fully approved and accredited user of the Visa and MasterCard Health Care Program which will enable you to use your Visa and MasterCard to automatically cover amounts not paid by your insurance.

If none of the above applies, please see the office manager.

Print Name____

Patient Signiture____Date_______________

D. Bartholomew G. Kreiner ,D.D.S **511 S. Fountain Green Road**
BelAir Maryland 2101

D. Bartholomew G. Kreiner D.D.S

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: ______________________________

Address: ______________________________

Telephone: ______________________ E-mail: ______________________

Patient Number: ______________________ Social Security Number: ______________________

SECTION B: 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: Nancy

Telephone: **410-897-1730**

Fax: 410-638-6000

E-mail: belairmddental@gmail.com

Address: 511 South Fountain Green Road Bel Air, Maryland #21015

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 any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you 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 out treatment, payment activities and heath 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: ______________________________

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D. Bartholomew G, Kreiner D.D.S

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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This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

D. Bartholomew G, Kreiner D.D.S

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 04/14/2003, 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 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 Officer: Nancy
Telephone: 410-879-1730 Fax: 410-638-6000
E-mail: belairmddental@gmail.com
Address: 511 South Fountain Green Road Bel Air, Maryland #21015

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