WELCOME

1 About Your Child

Today's Date: ____/____/____ File #: _____

Child's Name: _____
LAST FIRST M.I.

Child's Nickname: _____ ❑ Boy ❑ Girl

Child's Birthdate: ____/____/____ Age: _____

School: _____ Grade: _____

Child's Home Phone #:(____) _____

Child's SS#: _____

Child's Address: _____
HOME ADDRESS

_____
CITY STATE ZIP

Referred By: _____
(If doctor, please give address & phone number.)

_____

2 Insurance Information

Primary Dental Insurance

Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: _____

Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ___/___/___

Insured's Employer: _____

Does either policy cover Orthodontics? ❑ Yes ❑ No

Secondary Dental Insurance

Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: _____

Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ___/___/___

Insured's Employer: _____

3 Child's Family Information

Who is accompanying this child today?

_____ _____
FULL NAME (IF OTHER THAN PARENT) RELATION TO CHILD

Do you have Legal Custody of this Child? ❑ Yes ❑ No

How many Brothers/Sisters? _____ Age(s): _____ _____ _____

Mother's Name: _____
❑ STEP MOTHER ❑ GUARDIAN

_____
(❑ **CHECK IF SAME AS CHILD'S)** HOME ADDRESS CITY STATE ZIP

(_____)_____ (_____)_____ _____
HOME PHONE # WORK PHONE # EXT.

_____ ____/____/____ _____
MOTHER'S SOCIAL SECURITY # DATE OF BIRTH MOTHER'S DRIVERS LIC. #

Employer: _____ How Long? _____

_____
EMPLOYER'S ADDRESS CITY STATE ZIP

Father's Name: _____
❑ STEP FATHER ❑ GUARDIAN

_____
(❑ **CHECK IF SAME AS CHILD'S)** HOME ADDRESS CITY STATE ZIP

(_____)_____ (_____)_____ _____
HOME PHONE # WORK PHONE # EXT.

_____ ____/____/____ _____
FATHER'S SOCIAL SECURITY # DATE OF BIRTH FATHER'S DRIVERS LIC. #

Employer: _____ How Long? _____

_____
EMPLOYER'S ADDRESS CITY STATE ZIP

4 Account Information

Person ultimately responsible for account

Name: _____ _____
RELATION TO CHILD

Billing Address: _____

_____
CITY STATE ZIP

_____ ____/____/____ _____
SOCIAL SECURITY # DATE OF BIRTH DRIVERS LIC. #

(_____)_____ _____ (_____)_____
WORK PHONE #: EXT. CELL PHONE #:

Payment method: ❑ Cash ❑ Check

_____ /_____
❑ Credit Card - Enter card # above (if accepted)

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).
Initials

Please Continue On Back

5 Child's Dental Information

Reason for today's visit: ❑ Exam ❑ Emergency ❑ Consultation

Is Child in pain? ❑ No ❑ Yes How Long?_____

Please indicate ☑ any of the following problems:

❑ Discomfort, clicking or popping in jaw.	❑ Lost/Broken Filling(s)	❑ Stained teeth
❑ Red, swollen or bleeding gums.	❑ Teeth grinding	❑ Locking Jaw
❑ Sensitive tooth, teeth or gums.	❑ Ringing in Ears	❑ Bad breath
❑ Blisters/Sores in or around the mouth.	❑ Broken/Chipped tooth	❑ Loose tooth

❑ Other(s):_____

Does child require pre-medication? ❑ Yes ❑ No ❑ Don't know

Previous Dentist:_____ (_____)_____

Last Dental exam: ____/____/____ Last Dental X-rays: ____/____/____

Times a day child brushes? _____ Times a week child flosses? _____

Is the child's water fluoridated? ❑ Yes ❑ No

How would you rate the child's smile? **Best** 1 2 3 4 5 6 7 8 9 10 **Worst**

6 Child's Medical History

Is Child taking any of the following medications? ❑ Pain killers (INCLUDING ASPIRIN) ❑ Ritalin ❑ Stimulants ❑ Blood Thinners ❑ Tranquilizers ❑ Insulin ❑ Muscle relaxers ❑ Others:_____

Child's Physician:_____ (_____)_____
DOCTOR'S NAME OR CLINIC NAME PHONE#

_____ Last Medical Exam: ____/____/____
ADDRESS CITY STATE ZIP

Does Child have or ever had any of the following diseases, medical conditions or procedures?

Y N Heart Murmur	**Y N** Tonsillitis	**Y N** High/Low Blood Pressure
Y N Rheumatic fever	**Y N** Respiratory Problems	**Y N** Hepatitis
Y N Artificial Heart Valves	**Y N** Asthma/Difficulty Breathing	**Y N** Artificial Bones/Joints/Implants
Y N Congenital Heart defect	**Y N** Blood Transfusion(s)	**Y N** Liver/Kidney/Organ Problems
Y N Scarlet Fever	**Y N** Leukemia/Anemia	**Y N** HIV+/AIDS/ARC
Y N Surgeries/Operations	**Y N** Diabetes/Hypoglycemia	**Y N** Tuberculosis TB
Y N Cancer/Tumors	**Y N** Hemophilia	**Y N** Psychiatric Problems
Y N Chemotherapy	**Y N** Abnormal Bleeding	**Y N** Hyper Active/ADD
Y N Jaw Problems TMJ/TMD	**Y N** Cleft Lip/Palate	**Y N** Fainting/Seizures/Epilepsy
Y N Hearing Problems	**Y N** Birth Defects	**Y N** Cerebral Palsy

Please list any other medical condition(s) child has or ever had:_____

_____

Is Child allergic to: ❑ Latex ❑ Penicillin/Amoxicillin ❑ Tetracycline ❑ Dental Anesthetics (Novocaine) ❑ Aspirin ❑ Food allergies ❑ Other(s):_____

Please rate the child's general health from 1-10: _____ Does child wear contact lenses? ❑Yes ❑No

Has this child ever taken the drug Ritalin? ❑ No ❑ Yes/How long?_____ Child's Blood type: _____

Does this child do any of the following? ❑ Thumb/Finger Sucking ❑ Tongue Thrusting/Sucking ❑ Heavy Snoring ❑ Mouth Breathing ❑ Lip Sucking/Biting

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature_____ Date ____/____/____
❑ Parent or Guardian ❑ Other:

UPDATE
(OFFICE USE)

Initials ____/____/____ Date
Comments

Initials ____/____/____ Date
Comments

Initials ____/____/____ Date
Comments

Breton Gardens Family Dentistry
Office and Financial Policy
(Effective 09-01-2010)

Please retain for your records.

At Breton Gardens Family Dentistry, we desire to provide the best possible dental care for you & your family. Our goal is to offer competent, compassionate and comprehensive dental care. We take that responsibility seriously, and are constantly seeking ways to optimize your dental care through continuing dental education and practice management seminars. We also feel it is a responsible business policy to clearly communicate our financial expectations of you. Most of this information has not changed from previous policies, however there are some differences. If you have any questions regarding these office and financial policies, please do not hesitate to speak with our financial coordinator. We consider it a privilege that you have chosen us at Breton Gardens Family Dentistry as dental care providers for you & your family.

New Patients

You are considered a new patient if you have never been to our office or there has been a lapse of two (2) or more years. At your first visit, you will receive a comprehensive exam, full series of x-rays, treatment plan and consultation with the doctor. You will be asked to bring any x-rays from your previous dentist to that first visit or they will be taken that day (we need them to complete your comprehensive exam). If your first visit is for emergency treatment, you will receive an exam of the troubled area, x-ray, and treatment plan. At this type of first visit we cannot guarantee additional treatment will be provided. We will do our best, but additional appointments or referrals may be needed.

All Patients

Please bring a list of **all** medications (prescription and over the counter) with dosage and how taken (drug name, 4mg, 2x/day). If you require pre-medication for dental work remember to take it or we will need to reschedule your appointment.

To provide you with the best standard of care, our office takes bitewing x-rays every year to check for cavities. Our office will also take a full series of x-rays every 5 years to evaluate bone levels, nerve and tooth health. This is in accordance with the ADA guidelines for standard of care for x-rays.

Children are a big part of our practice and we enjoy seeing them. For their safety, if they do not have an appointment, we ask that you bring someone to supervise them in the waiting area while you are being seen. Our office has too many hazardous areas to allow children to move freely throughout the office. We can no longer ask our receptionist to watch them.

We also ask that you turn off all cell phones while visiting our office. If you need to make a call, please do so out in the front lobby.

PAYMENT FOR SERVICES

All payments are expected at the time of service. We will also provide you with proper documentation to submit for insurance or employer reimbursements. **If you do not have insurance coverage full payment will be expected at the time of service.** Please bring any insurance cards or insurance information with

you to your appointment. **Without correct billing information you will be responsible for payment for treatment in full at time of service. If you have insurance coverage, it is our policy to collect all deductibles and co-pays at the time of service.** This policy has been set by your dental insurance and should be stated in your policy manuals. **The balance is ultimately your responsibility and is due 60 days from the date of service, regardless of what insurance does or does not pay.** If co-pay is not paid at the time of service, a $10.00 billing fee will be added to your account each month until paid in full. After 90 days, should any portion of the account balance need to be turned over to a collection agency, a $20.00 service fee will be added to the balance. If you have any questions regarding the co-payment amount, please contact your insurance plan or human resource department.

Concerning payment for children being seen as patients, payment must be made at time of service, regardless of who brings the child to the office. In situations with children of parents who have divorced, it is the responsibility of the parent who brings the child in for treatment.

METHODS OF PAYMENT

We accept the following methods of payment: cash, personal check, debit card, VISA, MasterCard, or Discover. Please note that a service fee of $20.00 will be assessed for all checks returned for insufficient funds. **If you wish to set up a payment plan, our office does work with Care Credit and Citi Health for zero and low interest loans.**

AUTHORIZATION FOR DENTAL CARE

If your child is a minor under 18 years of age, a parent or legal guardian must accompany him. If this is not possible, an adult who has obtained a written consent from you may accompany your child. The consent should give the adult permission to seek dental treatment for your child and must be signed and dated by a parent or guardian. The consent must be presented at the time of service. The parent or legal guardian must approve treatment and co-payment must accompany the patient at the time of service. We reserve the right to deny treatment if approval by the parent is not given.

MISSED APPOINTMENTS AND CANCELLATIONS

Missed appointments are costly to us, to you, and to other patients who could have used the time set aside for you. Cancellations are requested 24 hours in advance. This will allow us time to give the appointment to another patient who needs to be seen that day. We reserve the right to charge for missed or "no show" appointments.

Our "no show" policy states that **after 3 "no shows" you will be discharged from our practice.**

PATIENT NAME _____

PARENT/GUARDIAN _____ **(if patient is under 18)**

SIGNATURE _____ **DATE** _____

BRETON GARDENS
FAMILY DENTISTRY

David May and Heather Mallory-May, D.D.S.
4144 Breton Road SE, Kentwood, MI 49512, (616)455-0720

I have read and understand Drs. May, Mallory-May and Breton Gardens' Financial Policy.

I certify that the insurance information that I have given is correct. I will notify Breton Gardens Family Dentistry of any future changes in my dental insurance. I authorize the release of any dental information necessary in order to process a claim with my insurance company and authorize payment made directly to Drs. May, Mallory-May and Breton Gardens.

Please list all family members or other persons that Breton Gardens may discuss, the patient listed on this form, any general dental information including; treatment, payment and dental care appointments.

_____ _____

_____ _____

I authorize the release of information needed in case of a referral to a specialist. Yes _____ No _____

Please print the address (if other than your home) where you would like correspondence from our office.

_____

Do you prefer a postcard from our office to be enclosed in a sealed envelope marked confidential? Yes _____ No _____

Please print the telephone number (if other than your home number) where you would like to receive calls regarding your appointment.

_____*Please remember to update information if your number changes.*

note: a cell phone is not a secure and private line

Can confidential messages (ie: appointment reminders) be left on your answering machine or voicemail? Yes _____ No _____

PATIENT NAME _____

PARENT/GUARDIAN _____ (if patient is under 18)

SIGNATURE _____ DATE _____

OPTIONAL: Please complete the following information if you would like us to keep your credit card information on file to pay for charges at the time of service or for balances after insurance pays.

Card Number: _____ Type: VISA MASTERCARD DISCOVER

Name on card: _____ CVS# _____ Expiration Date: _____

Signature: _____ Today's Date: _____

REVISED 01/03/2008

MAY, MALLORY AND ASSOCIATES

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 April 1 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 your 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 heath information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities. Reviewing the competence of 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 us 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 authorization while it is 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 of 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 regarding 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 heath 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 or 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 on 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 your 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 your 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 f 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.

Restrictions: 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.