Brent R. Humphrey DMD, P.A.
103 Spring Hall Drive
Goose Creek, SC 29445
(843)797-2000

Patient Information

1. Tell Us About Your Child

Child's Name _____
Last First M

Goes by: _____ ☐ Male ☐ Female

Siblings that we treat _____

Child's Birth Date ____/____/____ Child's Age _____

School _____ Grade _____

Child's Home # (____) _____

Child's Home Address _____

_____
City State County Zip

2. Mother's Information

Name _____
Last First MI

Mother Stepmother Guardian Birth Date ____/____/____

Employer _____

Home Address (if different from child) _____

_____
City State County Zip

Work # (____) _____

Home # (____) _____

Cell # (____) _____

(CIRCLE BEST PHONE NUMBER TO REACH YOU)

SS# _____ DL# _____

Email Address _____

3. Father's Information

Name _____
Last First MI

Father Stepfather Guardian Birth Date ____/____/____

Employer _____

Home Address (if different from child) _____

_____
City State County Zip

Work # (____) _____

Home # (____) _____

Cell # (____) _____

(CIRCLE BEST PHONE NUMBER TO REACH YOU)

SS# _____ DL# _____

Email Address _____

4. Who is Accompanying the Child Today?

Name _____

Relationship _____

Do you have legal custody of this child? ☐ Yes ☐ No

5. Primary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

_____

Insurance Co. Phone # (____) _____

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

Policy Owner's Name _____

Relationship to Child _____

Policy Owner's Birthdate ____/____/____

Policy Owner's Social Security # _____

Policy Owner's Employer _____

6. Secondary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

_____

Insurance Co. Phone # (____) _____

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

Policy Owner's Name _____

Relationship to Child _____

Policy Owner's Birthdate ____/____/____

Policy Owner's Social Security # _____

Policy Owner's Employer _____

7. Who may we thank for referring you to our office?

_____

8. Dental History

Is this your child's first visit to the dentist? Yes No

If not, how long since the last visit to the dentist? _____

Previous Dentist's Name _____

Were any x-rays taken at previous dental visits? Yes No

Have there been any injuries to the teeth, face or mouth?

Yes No If yes, please explain_____

_____

Why did you bring the child to the dentist today? _____

_____

_____

Does the child have any of the following habits?

Lip Sucking / Biting Yes No Nail Biting Yes No

Nursing / Bottle Habits Yes No Thumb / Finger Sucking Yes No

Clenching / Grinding Teeth Yes No

Has the child ever had a serious or difficult problem associated with previous dental work? Yes No

If yes, please explain _____

_____

Is the child's water fluoridated? Yes No

Is the child taking fluoride supplements? Yes No

Has the child ever had any pain or tenderness in his/her jaw/joint? (TMJ/TMD)? Yes No

Does the child brush his/her teeth daily? Yes No

Does he/she floss teeth daily? Yes No

9. Health History

Has the child ever had any of the following conditions?

Y N	Abnormal Bleeding	Y N	Disabilities/Special Needs
Y N	Allergies to any Drugs	Y N	Hearing Impairment
Y N	Any Hospital Stays	Y N	Heart Disease/Murmur/Defect
Y N	Any Operations	Y N	Hemophilia/Blood Disorders
Y N	Asthma	Y N	Hepatitis
Y N	Cancer	Y N	HIV +/ AIDS
Y N	Congenital Birth Defects	Y N	Kidney/Liver Conditions
Y N	Convulsions/Epilepsy	Y N	Rheumatic/Scarlet Fever
Y N	Pregnancy	Y N	Allergies to Latex Products
Y N	Tuberculosis (TB)	Y N	Diabetes
Y N	ADD / ADHD	Y N	Autism / Related Disorders
Y N	Blood Pressure Problems	Y N	Hives

Please discuss any serious medical conditions the child has/had

_____

_____

Please list all drugs the child is currently taking _____

_____

Please list all drugs the child is allergic to _____

_____

Is the child currently under the care of a physician? Yes No

Child's Physician _____

Physician's Phone (_____)_____

Overall description of the child's current health:

Good Fair Poor

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

10. I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest 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 my child may need. I also understand that the parent or guardian who accompanies the child is responsible for payment at the time of service.

_____ _____

Signature of Parent or Guardian Date Relationship to Patient

For Office Use Only

I verbally reviewed the medical / dental information above with the parent / guardian and the patient named herein. Initials _____ Date_____	Doctor's Comments _____ _____ _____ _____

Brent R. Humphrey DMD, P.A.
103 Spring Hall Drive
Goose Creek, SC 29445
(843)797-0045

Patient Appointment Agreement

Dr. Brent and his staff are committed to providing your children with the best possible care. Your clear understanding of our appointment policy is important to the success of our relationship with you and we are pleased to discuss our policies with you at any time.

KEEPING SCHEDULED APPOINTMENTS:

You may be surprised to know that missed appointments and last minute cancellations are the biggest problems in dental offices. So that we can provide your children with their needed treatment, we must ask the following from you:

> You make every effort to schedule appointments for times that you can keep. We require a minimum of 48 hours notice of cancellation. Missed appointments send the message that your child's appointment and our reserved time are not important to you, and we may discharge your family from our practice if this becomes a pattern.

MEDICAID COVERAGE RESPONSIBILITIES:

1. Please bring your child's card with you to each appointment.

2. Please notify us as soon as your child's Medicaid eligibility changes, especially if your child has an appointment scheduled. Your notification will allow us to verify coverage so that your child's appointment can proceed as scheduled.

With your support and cooperation, we look forward to taking care of your child's smile!

Your signature below indicates your acceptance of Dr. Brent's Patient Appointment Policies.

_____ _____

Parent or Guardian Date

Brent R. Humphrey, DMD, P.A.

FINANCIAL POLICY

Dr. Humphrey and his staff are committed to providing you and your family with the best possible care. Your clear understanding of our financial policy is important to the success of our relationship with you and we are pleased to discuss our professional fees with you at any time. We have prepared the following information to assist you in your planning and provide two copies, one for you to sign and return to our office, and one for your records.

For our patients with insurance:

We are happy to file the forms necessary to see that you receive the full benefit from your coverage; however, we cannot guarantee any estimated coverage. Because your insurance policy is an agreement between you and your insurer, we ask that our patients be directly responsible for all co-payments and pay the (EPR), estimated patient responsibility, at the time of service. We remind you that the criteria we use to establish our fees do not necessarily correspond with the criteria used by your insurer; for that reason, you may be responsible for amounts not covered by your policy. Although we will do everything possible to see that you receive your maximum benefit, please be aware that we will expect payment in full from you if we have not received insurance payment within 45 days of treatment.

For our self – pay patients:

Payment is expected at the time of service.

Payment options:

We accept payment by cash, check, Visa, MasterCard, or Discover. For those patients interested in exploring financing options for major procedures, we will gladly provide you with information about Care Credit.

The financial policy continues on the back side of this page.

Thank you for reviewing our Financial Policy. Please contact us with any questions.

MY SIGNATURE BELOW INDICATES MY ACCEPTANCE OF DR. BRENT HUMPHREY, DMD, P.A.'S FINANCIAL POLICIES.

_____ _____

Signature Date

Missed appointment fee: The second time a patient does not present on time for an appointment or cancels with less than 48 hours notice; it is our custom to assess a $50.00 fee. This fee must be paid before a new appointment is scheduled. Patients with three missed appointments may be asked to transfer their records to another office. Exceptions will be considered on an individual basis.

Divorce: After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Finance Charge: A finance charge will be imposed on each item of your account which has not been paid within sixty (60) days of the time the item was added to the account. The **FINANCE CHARGE** will be computed at the rate of one and one-half percent (1 ½ %) per month or an **ANNUAL PERCENTAGE RATE** OF eighteen percent (18%). The finance charge on your account is computed by applying the periodic rate (1½ %) to the "overdue balance" of your account. The "overdue balance" is calculated by taking the balance owed sixty (60) days ago and subtracting any payments or credits applied to the account during that time.

Past due accounts: If your account becomes past due, we will take necessary steps to collect the balance owed. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. Consideration of reinstatement to active patient status would require payment in full of the balance in question as well as all collection costs and agreement that future charges are paid in full at the time of service.

Returned checks: In the rare case of a check returned for insufficient funds, we will assess a processing fee of $30.00 on your account and will allow one week for receipt of cash or money order.

BRENT R. HUMPHREY DMD, P.A.

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 5/22/12, 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 $0.25 for each page, $20 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: Shannon Donofrio

Telephone: 843-797-2000 Fax: 843-797-8826

E-mail: FrontDesk@DrBrentKidsDentist.com

Address: 103 Springhall Drive Goose Creek, SC 29445

BRENT R. HUMPHREY DMD, P.A.

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)