Paige Prather
Smiles

Authorization for Release of Information to Providers

Patient Name: _____ Date of Birth: _____

To provide patients with optimal care we try our best to work as a team with other providers and keep open lines of communication. Please list any other providers the patient is currently seeing including PCP, pediatrician, therapists, chiropractors, bodyworkers etc. This gives us permission to discuss care with them as needed and allows them to be supportive and provide optimal care as well.

I authorize PS Smiles to release my medical/dental and/or billing information to the following individual(s):

1. Name and phone number_____

   Specialty: _____

2. Name and phone number_____

   Specialty: _____

3. Name and phone number _____

   Specialty: _____

4. Name and phone number _____

   Specialty: _____

Patient Information

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient.

You have the right to revoke this consent in writing.

Signature: _____ Date: _____

PEDIATRIC PATIENT HISTORY

Patient Name: _____ **Gender**: Male Female

Date of Birth: _____/_____/_____ **Birth Weight:** _____ lbs _____ oz Current Weight: _____ lbs_____oz

Name of Mother: _____ **Name of Father**: _____

Delivery: □ Vaginal □ Cesarean **Was this child premature?** _____ How many weeks? _____

Were there problems with this child's delivery? _____ If so, please list**:** _____

Did this child have any unusual problems in the hospital such as trouble breathing, blue spells, yellow jaundice, trouble feeding, etc?

_____

Did this child need special treatment while in the hospital such as oxygen, transfusions, or lights? _____

Is this child breast feeding? Y N **Did/Does this child have any problems with breast feeding or formula feeding?** _____

_____

Current Milk Intake: Type: _____ Amount (oz/day): _____ **Does this child suck a finger, thumb or pacifier?** _____

Are you currently seeing a Lactation Consultant? Y N **If so, who?** _____

Please mark all of the following that this child has been treated for:

□ Heart Disease	□ Bleeding/Transfusions	□ Asthma/Trouble Breathing	□ Mental Delays
□ Liver/GI Disease	□ Anemia	□ Hepatitis	□ Physical Delays
□ Kidney Disease	□ Rheumatic Fever	□ Cleft Lip/Palate	□ Adverse Drug Reactions
□ Speech/Hearing	□ Seizures	□ Frequent Infections	□ Autism
□ Eyesight	□ Congenital Birth Defects	□ Endocrine/Growth	□ Other Problems:
□ Cancer/Tumors	□ Significant Injuries	□ Blood Dyscrasias	_____
□ Cerebral Palsy	□ Diabetes	□ AIDS	

Does this child have any of the following?

□ Lung Problems	□ Heart Problems	□ Kidney/Urinary Problems	□ Bone/Muscle Problems
□ Gastro-Intestinal Problems	□ Brain/Nervous System Problems	□ Skin Problems	□ Eye/Ear/Nose/Throat Problems

Has this child ever had a reaction to or problem with an anesthetic? Y N **Describe:** _____

Is this child up to date on immunizations against childhood diseases? Y N **Did this child receive Vitamin K at birth?** Y N

Recent Hospitalizations or Surgeries: _____

Please list all known drug allergies: _____

Do any immediate family members have a history of bleeding or clotting disorders? If so, who? _____

Please list any regular medications (over the counter or prescription) and include dose and frequency: _____

_____

Any other medical issues we should be aware of: _____

Name of Pediatrician: _____ **Phone:** _____**Date of last physical exam:** _____

To the best of my knowledge, this information is true and correct. I know if there are any changes in my child's health, it is my responsibility to inform my child's provider.

Print Patient Name: _____

Print Name of Parent/Guardian: _____ **Relation**: _____

Signature of Parent/Guardian:____ **Date**: ________________________________

Paige Prather Smiles

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Chart#: _____ FOR OFFICE USE ONLY

Patient Name: _____ * (Last) _____ * (First) ____ (MI)

_____ (Preferred Name)

Title: **Gender:** * _____ (Mr/Ms/Mrs/etc) ◯ Male ◯ Female

Family Status: * ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: *

SS#: ___-__-____

Prev. Visit:

Email Address:

Best time to call:

Phone: * (Home) (Mobile) (Work) (Ext)

(Fax) (Other)

Address: * (Address 1)

(Address 2)

(City) * (State) * ____-____ * (Zip Code)

In case of emergency, who is to be notified? (Please provide best contact phone number)

Please verify that the information you have provided is correct.

☐ **By checking this box, I understand that I will be given a medical claim form to submit indivdually to my medical insurance company to seek any reimbursement.**

Minor/Child Agreement:

☐ **I understand that any parent, who brings in a minor for treatment, is responsible for that patient's account balance. A Guardian must remain in the office for the entire duration of a minor's treatment. No patient, under the age of 18, will be treated without a documented guardian present in the office. I verify that I am the parent/guardian of the said patient and there are no court orders now in effect that prohibit me from signing this form. I do hereby authorize the dental staff of Dr. Paige Prather to perform any necessary dental services for the stated minor. Should a child be "dropped off" or left without an attending guardian, the dependent's appointment will be cancelled and charges will apply.**

Cancellation Policy

☐ * **Your appointment time is especially reserved for you. We value your time and we ask that you value the time of our doctor and other patients. Having an accurate schedule allows our team to provide each patient with maximum attention and allows us to keep more closely to your scheduled appointment time. We pride ourselves on little to no wait time. A $75 cancellation fee will be applied for any appointment 1 hr. or less in length canceled without 2 business days notice. Down payments are required to schedule any appointment over 1 hour in length. These down payments are nonrefundable if cancelled without 2 business days notice for any reason at a rate of $250/hr. of reserved time. Cancellation of a sedation appointment will differ from this basic policy and these terms will be reviewed at the time of booking the appointment. If you arrive more than 15 minutes late you will be asked to reschedule your appt. out of consideration for our other patients' time and a cancellation fee will apply. If you cancel more than 2 times without 2 business days notice within a period of 6 months, you will be moved to our Priority Scheduling list, meaning appointments cannot be scheduled more than one day in advance of the appointment time. We provide complimentary reminders of your appointment via text, email, and phone calls. Most of our patients greatly appreciate this service. You may choose the reminder method that works best for you or opt out of this service entirely. However, all cancellation policies still apply. If you have questions or concerns about this policy, please consult with a team member prior to scheduling an appointment.**

Financial Policy: Please read over thoroughly prior to receiving services.

☐ * **Payment is due, in full, at the time of service. We can accept Cash, Mastercard, Visa, Discover, American Express, Care Credit and insurance checks. We accept personal checks from patients with a record of 6 months with our practice. We charge a service fee of $30.00 for any check that is returned.**

☐ **As a courtesy for insured patients, a claim is provided to the patient prefilled with the codes so the patient can file for reimbursement from their insurance carrier. We collect in full upfront for all services provided. We do work with some third party financing companies should you need this option to prevent delay of needed treatment. Payment is usually remitted from your insurance carrier within 30 days of the service date. If at 30 days, your claim is still unpaid you may contact your insurance carrier directly to ensure timely payment of the claim. We can provide a replacement claim one time for up to 90 days and will assist in providing letter of necessity. At 90 days if the claim is still unpaid, you will need to pursue reimbursement on your own and can contact your carrier directly for help with this. If for any reason payment is not collected prior to services being rendered all outstanding balances are due and payable no later than 30 days after services are rendered. Failure to do so will result in monthly late fees and finance charges at a rate of 8% of the total amount owed. Should extensive measures be required to collect any past due balance you agree to be responsible for all fees associated with such collection including but not limited to attorneys fees. Insurance Policies have specified restrictions that limit a patient's treatment. If you choose to receive the services prescribed by Dr. Prather and they are not covered by your insurance, all costs associated with the non-covered services are your full financial responsibility. We always base treatment recommendation on what is best for you and your overall health, not on what insurance will cover. No guarantee or estimate can be given on your insurance coverage as this is an agreement and policy set up by your employer and your insurance carrier is liable to you only for these benefits.**

☐ * **HIPAA NOTICE: Notice of Privacy Practices: Effective Date of Notice: January 24, 2007. We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it. This Notice is available at any time, for your review or personal copy, in the reception area of our practice. By checking this box you are confirming knowledge of your rights to privacy as a patient and the receipt of this Notice.**

☐ * **By checking this box, I acknowledge that the information on this form is complete and correct. I understand that it is my responsibility to inform my doctor if I/my minor have any changes in contact/personal information. I realize that failure to do so can result in inability to reach me and or provide products and or notifications reguarding my treatment and health and that additional costs may be incured because of this.**

Please sign and date below:

Signature _____ _____

Date _____

Response Date: _____