



WELCOME

ROBERT H. ELLIS, JR. D.D.S., Board Certified, Diplomate American Board of Pediatric Dentistry
AMY ELLIS GREEN, D.M.D., Board Certified, Diplomate American Board of Pediatric Dentistry
ROBERT H. ELLIS, III, D.M.D., Board Certified, Diplomate American Board of Pediatric Dentistry
JOHN W. JENKINS, D.M.D., Board Certified, Diplomate American Board of Pediatric Dentistry
W. NETTLES GREEN, D.M.D., M.S., Orthodontist

Tell Us About Your Child

Today's Date _____
Child's Name _____
last first mi
Nickname _____ Male Female
Child's Birthdate ____/____/____ Child's Age _____
School _____ Grade _____
Hobbies _____
Child's Home # _____ SS# _____
Child's Home Address _____
City _____ State _____ Zip _____
County _____
Other family members seen by us _____

Who is responsible for making appointments?

Name: _____
List best phone # to reach you during the day (____) _____
Email address _____ (____) _____

Referral Information

Who may we thank for referring you? _____
If the referral is from a patient family please list the children's names:

Parents Information

Parent's Marital Status: Married Divorced Separated Widowed Remarried Single

Mother Step Mother Guardian Birthdate: ____/____/____ Home Phone #: (____) _____ Work Phone #: (____) _____

Name: _____ Social Security #: _____

Address: (if different from child's) _____
Street City State Zip

Occupation _____ Employer: _____

Father Step Father Guardian Birthdate: ____/____/____ Home Phone #: (____) _____ Work Phone #: (____) _____

Name: _____ Social Security #: _____

Address: (if different from child's) _____
Street City State Zip

Occupation _____ Employer: _____

Person Responsible for Account

Name: _____ Relationship: _____ Social Security# _____

Billing Address: (if different from child's) _____
Street City State Zip

Work Phone#: (____) _____ Home Phone# (____) _____ Employer: _____ Driver's License #: _____

Insurance Information Primary

Orthodontic Coverage Yes No

Insurance Co. Name: _____ Phone#: (____) _____ Group# (Plan, Local, or Policy): _____

Insurance Co. Address: _____
Street City State Zip

Policy Owner's Name: _____ Relationship to Patient: _____

Policy Owner's Birthdate: ____/____/____ Social Security#: _____ Policy Owner's Employer: _____

Employer's Address: _____
Street City State Zip

Medical History

Child's Physician: _____ Phone#: (____) _____ Date of last visit: _____

Address: _____

Street City State Zip

Is the child currently under the care of a physician? Yes No Please explain: _____

Please describe the child's current physical health: Good Fair Poor Are immunizations current? Yes No

Please list all drugs that the child is currently taking: _____

Please list all drugs that cause the child allergic reactions: _____

Anything you would like to discuss with the doctor in private? Y N Explain: _____

Has the child had/experienced any of the following:

- | | | |
|-------------------------------|---|---------------------------|
| Y N Abnormal Bleeding | Y N Convulsions | Y N Lupus |
| Y N Aids/HIV+ | Y N Developmental Delay | Y N Measles |
| Y N Anemia | Y N Diabetes | Y N Mitral Valve Prolapse |
| Y N Allergies | Y N Handicaps/Disabilities | Y N Mononucleosis |
| Y N Asthma | Y N Hearing Impairment | Y N Rheumatic Fever |
| Y N Autism/Related Disorders | Y N Heart Murmur | Y N Scarlet Fever |
| Y N Blood Disorders | Y N Premed required <input type="checkbox"/> Y <input type="checkbox"/> N | Y N Seizure Disorder |
| Y N Blood Pressure - High/Low | Y N Hemophilia | Y N Sickle Cell Anemia |
| Y N Blood Transfusion | Y N Hepatitis | Y N Skin Rash |
| Y N Cancer | Y N Hives | Y N Speech Delay |
| Y N Chicken Pox | Y N Kidney Problems | Y N Tonsillitis |
| Y N Congenital Heart Defect | Y N Liver Problems | Y N Tuberculosis (TB) |

Please list any serious medical problems not listed above or past hospitalizations the child has experienced:

What is the primary reason for today's visit? _____

Is the child currently in pain? Yes No

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

Has the child ever had any injuries to his/her teeth, mouth, head or jaws? Yes No If yes, describe _____

Has the child experienced problems with previous dental work? Yes No If yes, explain _____

Is the child's water fluoridated? Yes No Is the child taking fluoridated supplements? Yes No

Does the child brush his/her teeth daily? Yes No Does an adult assist with brushing? Yes No

Floss his/her teeth daily? Yes No Does an adult assist with flossing? Yes No

Previous/Present Dentist: _____ Last Visit Date: _____

(Please Circle)

Does/did the child have any of the following habits?

- | | | |
|------------------------|---|--------------------------------|
| Y N Lip Sucking/Biting | Y N Clenching/Grinding Teeth | Y N Tongue/Cheek Biting |
| Y N Nail Biting | Y N Used Pacifier until age _____ | Y N Speech Problems |
| Y N Chewing on Objects | Y N Nursing Bottle Habits until age _____ | Y N Tongue Thrust |
| Y N Mouth Breather | Y N Thumb/Finger Sucking until age _____ | Y N Breast Fed until age _____ |
| | Y N Still in Sippy Cup | |

Authorizations

I affirm that the information I have given is correct to the best of my knowledge. 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.

Signature of parent or guardian

Date

The parent or guardian who accompanies the child is responsible for payment at time of service.

Drs. Ellis, Green and Jenkins

8905 Two Notch Rd.

Columbia, SC 29223

803-788-9593

Financial Agreement and Office Policies

The dentists and staff of Drs. Ellis, Green and Jenkins are dedicated to providing your child with the best possible care and service. Understanding our financial agreement is an important part of your care and treatment.

- Your estimated patient responsibility (co-insurance and deductible) is due in full at the time of service.
- We accept cash, checks, money orders, Visa and MasterCard.
- Visa and MasterCard payments can be processed over the phone.

Insurance:

By providing your insurance information, you have agreed to be responsible for services provided. It is very important that you know the terms of your plan, including benefits, limitations, co-insurance, deductible, remaining max and out of pocket expense before each scheduled appointment.

We will file **all** of your dental claims regardless of your insurance plan and are in-network providers with United Concordia and Delta Dental Premier. If there is secondary coverage, that information must be provided before the scheduled appointment. If provided after the appointment, you will be responsible for filing the claim to your secondary insurance carrier.

We will collect your portion due (co-insurance) and deductible as estimated based on our system at the time services are rendered. Any pre-estimate or treatment plan provided to you is **not** a guarantee of payment. Payment is determined by your insurance company upon receipt of a claim. Payment is due in **full** at the time services are rendered **if** the patient is under a pre-existing clause or has reached the annual maximum.

For our self-pay patients, payment is due in full at the time of service.

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 are required to pay all of the collection costs which are incurred.

Separation / Divorce:

In the situation of a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for their treatment fees. 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. As always, the person bringing the child to the appointment will be expected to pay as required.

Returned Checks:

In the rare case of a returned check for insufficient funds, we will assess a processing fee of \$30.00 on your account. We allow one week for receipt of full payment by cash, credit card or money order. Unpaid returned checks will be forwarded to the Richland County Solicitor's Office.

**THE OFFICE POLICIES CONTINUE ON THE BACK SIDE OF THIS PAGE.
PLEASE SIGN ON NEXT PAGE.**

Drs. Ellis, Green and Jenkins
8905 Two Notch Rd.
Columbia, SC 29223
803-788-9593

Confirming of Appointments:

We will make every attempt to contact you to remind you of your child's appointment. However, your confirmation call is a courtesy to you; we encourage you to record the scheduled information on your calendar.

Missed / Canceled Appointments:

The second time a patient misses an appointment, or cancels with less than 24 hours notice; we may assess a fee. This fee must be paid before a new appointment is scheduled. Patients with multiple missed appointments will be asked to transfer their records to another office. Exceptions will be considered on an individual basis.

Scheduling:

We try, whenever possible, to accommodate your need for appointment times that fit your schedule. There are certain types of procedures and ages of children, however that we schedule at specific times in order to provide the best care possible.

For additional information, please visit our website: www.wecaredentalsc.com.

Thank you for reviewing our Financial Agreement and Office Policies. Please contact us with any questions.

I have read and understand the financial agreement of Drs. Ellis, Green and Jenkins and I agree to comply with its terms. I understand that I am financially responsible for all charges whether or not they are covered by insurance and agree such terms may be amended from time-to-time by the practice.

Print Your Name (Responsible Party)

Print Patient's Name

Signature

Date

DRS. ELLIS, GREEN and JENKINS

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 institutions or law enforcement officials having lawful custody of protected health information of inmates or patients 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 a copy, we will charge you \$35.00. 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 a satisfactory explanation of 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.

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 may also 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 Information:
8905 Two Notch Road, Columbia, SC 29223
803-788-9593 (Phone) 803-788-3123 (Fax)

Drs. Ellis, Green and Jenkins

NAME OF PRACTICE

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.

Patient's Name: _____

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.
- Communication barriers prohibited obtaining the acknowledgement.
- An emergency situation prevented us from obtaining the acknowledgement.
- Other (please specify).

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