CONWAY PEDIATRIC DENTAL GROUP &
NORTH LITTLE ROCK PEDIATRIC DETAL GROUP

Gerald W. Friend, D.D.S., M.S. **Mark E. Wilson, D.D.S., M.S.**
Jason S. Havard, D.D.S. **Clint D. Koen, D.D.S.**

THE FOLLOWING INFORMATION IS NECESSARY FOR ADEQUATE TREATMENT AND UNDERSTANDING OF YOUR CHILD. THANK YOU FOR COMPLETING IN FULL.

Please Print

Patient's Name_____Sex_____Race _____

Age_____ Date of Birth _____

Patient's Address _____

Street City State Zip

Ethnicity: ___Hispanic/Latino ___Nonhispanic/NonLatino ___Declined Preferred Language_____

Preferred Pharmacy & Number _____

Father/Guardian Name_____

Father/Guardian Address_____

Street City State Zip

Home Phone _____ Work Phone _____Cell Phone_____

Preferred Method of Contact _____

Date of Birth_____ Social Security Number_____

Place of Employment_____

Mother/Guardian Name_____

Mother/Guardian Address_____

Street City State Zip

Home Phone_____ Work Phone_____ Cell Phone_____

Preferred Method of Contact _____

Date of Birth_____ Social Security Number_____

Place of Employment_____

With whom does the patient live?_____

Other children in family who have received dental care in this office_____

Dental Insurance Co._____ Insurance ID Number _____

Family Dentist_____

Signature of Parent/Legal Guardian _____

Date _____ Relationship _____

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HEALTH HISTORY

Patient Name _____ Date of Birth _____Sex_____

Parents/Legal Guardian _____

Is your child in good health?_____

Does your child have regular medical examinations?_____

Is your child up to date with immunizations?_____

List all medications and dosages?_____

Has your child experienced any unfavorable reaction to medicine? (Such as penicillin, aspirin, xylocaine)__

Is your child allergic to any drug or food? If so what?_____

Is your child presently undergoing medical treatment?_____

Has your child ever been hospitalized? If so, date_____ Reason_____

Check any of the following that may pertain to your child:

____ Rheumatic Fever	____ Cerebral Palsy	____ Brain injury	____ Behavioral problems
____ Speech disorder	____ Heart Condition	____ Heart murmur	____ Liver
____ Kidney	____ Seizures Disorder	____ Mental disorder	____ Cancer
____ Emotional disorder	____ HIV+/AIDS	____ Vision disorder	____ Tobacco Use
____ Bleeding disorder	____ Asthma	____ Allergies	____ Cystic Fibrosis
____ Hepatitis	____ Diabetes	____ Developmental Delay	____ Autism
____Tuberculosis	____ Sickle cell anemia	____ Latex allergy	____ Other*

*If "other" is checked above, please list relevant medical condition _____

____ Premature birth ____ number of weeks early _____ weight at birth

Is your water supply fluoridated?_____

Has your child ever had trauma to the teeth?_____

Is this your child's first dental visit?_____

Is your child a thumb/finger sucker?_____

At what age was bottle and/or breast feeding discontinued?_____

Has your child ever had an unfavorable experience in a dental office?_____

Date of your child's last dental care_____

Purpose of this appointment_____

Thank you for your help. Other comments_____

Signature _____Date_____

Relationship _____

Conway Pediatric Dental Group & North Little Rock Pediatric Dental Group

Gerald W. Friend, D.D.S., M.S. Mark E. Wilson, D.D.S., M.S.
Jason S. Havard, D.D.S. Clint D. Koen, D.D.S.

GENERAL INFORMATION AND CONSENT

Thank you for choosing us to help you keep your children healthy. We are committed to helping you provide specialty dental care for your children. We desire to make your child's visit both productive and pleasant. The information requested on this form is designed to help us diagnose and treat dental decay (cavities).

INITIAL VISIT: Our goal is to provide a thorough dental/facial examination including radiographs (x-rays) and clinical photographs of the teeth. We will take radiographs on your child on this visit if he/she can cooperate with the assistant. Your child's teeth will be professionally cleaned and a prescription fluoride will be applied. Oral hygiene instruction will be given to the patient and reviewed with the parent along with dietary recommendations. We only take radiographs thereafter to check for cavities and observe growth, or for other justifiable needs. We employ all procedures available to reduce radiation risk including a thyroid lead apron and digital radiography.

If your child needs further treatment, a treatment plan will be discussed. Recommended dental procedures may include:

Sealants- help prevent dental caries.
Repairing diseased broken teeth with fillings or crowns
Treating infected teeth and/or gums
Pulpotomy- removal of diseased nerve tissue in the tooth
Extractions- removal of teeth

LOCAL ANESTHETIC: Injections are used to numb the teeth receiving treatment. Numbness usually lasts for 1 ½ to 3 hours. Allergic reactions are rare. Your child will be cautioned not to bite the numb lip and cheek. Please do not tell your child that they are going to get a "shot". We have our special way of informing them of this.

LAUGHING GAS: The use of laughing gas (nitrous oxide) is another safe way to provide dental treatment to mildly frightened, but helpful children. Laughing gas calms children, but does not put them to sleep or numb their teeth. It has few side effects and lasts only as long as the gas is being given through a nose mask. On rare occasions, the gas can cause an upset stomach and vomiting.

SEDATIONS: Sometimes drugs are used to relax a child who does not respond to other behavior management techniques or who is unable to comprehend or cooperate for the dental procedures. These drugs may be administered orally, by injection, or as a gas (nitrous oxide and oxygen). The child

does not become unconscious. Your child will not be sedated without you being further informed and obtaining your specific consent for such procedures.

GENERAL ANESTHESIA: The dentist performs the dental treatment with the child anesthetized in the hospital operating room. Your child will not be given general anesthesia without you being further informed and obtaining our specific consent for such a procedure.

Dr. Gerald Friend, Dr. Jason Havard, Dr. Mark Wilson and/or Dr. Client Koen or their associates, and will discuss the patient's dental condition/problem(s), the planned procedures and treatment, and the benefits to be reasonably expected from this treatment plan, compared with alternative approaches and/or no treatment.

CONSENT FOR DENTAL TREATMENT

I, being the parent or legal guardian of the below listed minor patient, hereby do authorize and request the performance of dental service by Dr. Gerald W. Friend, Dr. Mark E. Wilson, Dr. Jason S. Havard or Dr. Client D. Koen.

I understand that during the course of the patient's dental treatment, something unexpected may arise that may necessitate procedures in addition to or different from those listed on the patient's treatment plan and that I or my representative will be contacted prior to or at the initiation of treatment procedures not listed. I am aware that the practices of dentistry are not an exact science and acknowledge that no guarantees have been made to me concerning the results of the dental treatment that the patient receives in our office.

I understand that Dr. Gerald W. Friend, Dr. Mark E. Wilson, Dr. Jason S. Havard and Dr. Clint D. Koen and such assistants as he may designate to treat the below-mentioned patient will use restorative, oral surgery, and patient management techniques that are reasonable, necessary, and advisable.

I also authorize the administration of anesthetic and analgesics which may be deemed advisable by Dr. Gerald W. Friend, Dr. Mark E. Wilson, Dr. Jason S. Havard or Dr. Clint D. Koen.

I have read and understand this policy and have had any and all of my questions answered.

Patient Name_____Date_____

Parent/Legal Guardian_____Date_____

Relationship_____

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FINANCIAL POLICY

PLEASE READ CAREFULLY

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your responsibility.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE

At the time of your initial visit further treatment may be needed. If so, you will be scheduled for an appointment and you may request an estimate for the needed treatment. **ALL FEES QUOTED ARE ESTIMATES AND ARE SUBJECT TO CHANGE DEPENDING ON THE NATURE OF TREATMENT NEEDED.**

MISSED APPOINTMENTS

Unless canceled at least **24 hours in advance,** you may be subject to a failed appointment charge of $25.00. **Please help us serve you better by keeping your scheduled appointment.**

PATIENTS WITH INSURANCE

Insurance plans are accepted after proper verification and approval from our office staff on the day of service if possible. If we accept your insurance, our office will file any claims to your insurance company as a **COURTESY** to you. You will be responsible for any deductible and co-payment of total charges (unless estimated coverage is 100%) at the time of service. If your insurance plan has not paid the FULL BALANCE WITHIN 45 working days, and your claim does not require further verification from our office, you are required to pay the balance within 30 days after notification. If your insurance plan pays more than the balance due, we will refund you unless a credit on your account is requested. We do accept credit card payments with MasterCard, Visa, Discover, American Express, and Care Credit.

DUAL INSURANCE COVERAGE

Our office only files your PRIMARY INSURANCE. You will need to pay your estimated portion of your primary insurance at the time of service. You are responsible for filing your secondary insurance after you receive your explanation of benefits from your primary insurance company stating what they have paid. If your secondary insurance happens to pay our office instead of you we will send you a refund unless a credit to your account is requested.

AUTHORIZATIONS

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. Too the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X_____
Parent/Legal Guardian signature Date

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist(s) or dental entity.

Conway Pediatric Dental Group &
North Little Rock Pediatric Group
Gerald W. Friend D.D.S., M.S. Mark E. Wilson D.D.S., M.S.
Jason S. Havard, D.D.S Clint D. Koen, D.D.S.

X_____
Parent/Legal Guardian signature Date

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read and understand this policy. Any and all of my questions have been answered to my satisfaction.

Finally, we take great pride in the fact that you have chosen the Conway Pediatric Dental team for your child/children's dental care. We will all do our best to assure that your visit to our office will be the best treatment available anywhere.

X_____
Parent/Legal Guardian signature Date

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Patient Name _____

I have received and/or reviewed a copy of the Conway Pediatric Dental Group & North Little Rock Pediatric Dental Group Notice of Privacy Practices.

You may refuse to sign this acknowledgement.

Parent/Legal Guardian Signature _____Date_____

Please list below the names of individuals that you authorize to act as appointed healthcare representatives with whom the patient's dental care may be discussed.

Name_____Relationship_____

Name_____Relationship_____

Name_____Relationship_____

Name_____Relationship_____

Name_____Relationship_____

Name_____Relationship_____

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

Staff Signature_____Date_____

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction

At NLR/Conway Pediatric Dental Group, P.A., we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit NLR/Conway Pediatric Dental Group, P.A., a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve,

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of NLR/Conway Pediatric Dental Group, P.A., the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

NLR/Conway Pediatric Dental Group, P.A., is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us, or if you agree, we will email the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the practice's Privacy Officer, at 501-771-2990 or 501-730-0375.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the Office of Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office of Civil Rights. The address for the OCR is listed below:

Office for Civil Rights
U. S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.

For example: Information obtained by a member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your practitioner will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the practitioner will know how you are responding to treatment.

We will use your health information for payment.

For example: A bill may be sent to you or a thirt-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

We will use your information for regular health operations.

For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health

record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business Associates: There are some services provided in our organization through contacts with business associates. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Directory: Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgement, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral Directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ Procurement Organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similiar programs established by law.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law make provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

NOTICE OF PRIVACY POLICIES
FOR

North Little Rock / Conway Pediatric Dental Group

Mark E. Wilson, D.D.S., M. S.

Gerald W. Friend, D.D.S., M. S.

Jason S. Havard, D.D.S.

Clint D. Koen, D.D.S.