iHeartSmiles
Pediatric Dentistry + Orthodontics
Dana M. Busciglio Díaz, DMD, MS
813-603-8800 | www.iHeartSmilesFH.com

PATIENT INFORMATION

Patient:_____Today's Date:_____
Preferred Name:_____Date of Birth:_____Age:_____ Sex: M F
School:_____Grade:_____
Home Address:_____City:_____Zip:_____
Preferred phone number for confirmation of appointments?_____
May we text message appointment confirmation? If so, which phone number?_____
Email address:_____
Who has legal custody of this patient?_____
Person responsible for payment of account:_____DOB:_____
How did you hear about our dental practice?_____
Reason for today's visit:_____
How do you think your child will respond to dental treatment?_____

Mother's Information:

Name:_____Date of Birth:_____
Occupation:_____Employer:_____
Driver's License #:_____Social Security Number:_____
Cell Phone:_(____)_____Home Phone :_(____)_____Work Phone:_(____)_____

Father's Information:

Name:_____Date of Birth:_____
Occupation:_____Employer:_____
Driver's License #:_____Social Security Number:_____
Cell Phone:_(____)_____Home Phone :_(____)_____Work Phone:_(____)_____

FINANCIAL & INSURANCE INFORMATION

Person Financially Responsible for Account:

Name:_____Relationship to Patient:_____
Billing Address:_____ City:_____ State:_____ Zip:_____
Cell Phone:_(____)_____Home Phone :_(____)_____Work Phone:_(____)_____

Insurance Information:

Dental Insurance Company:_____Phone #:_(____)_____
Insurance Company Address:_____
Name of Insured:_____SSN/ID#:_____DOB:_____
Group/Policy #:_____Employer:_____

Patient Name:_____ Date of Birth:_____

PATIENT MEDICAL & DENTAL HISTORY

Pediatrician:_____Phone #:_(_____)_____

Date of Last Dr. Appt:_____Reason:_____Are your child's immunizations up to date? Y N

Has your child ever been hospitalized? Y N If yes, please describe when & why:_____

_____

Has your child ever been treated in the emergency room? Y N If yes, please describe when & why:_____

_____

Has your child ever had to pre-medicate with antibiotics before dental appointment? Y N

List all current medication the patient is taking (prescription & over the counter), including the reason for taking the medication:_____

Does your child have allergies/adverse reactions/anaphylaxis to any food or medication…Such as: Penicillin, Red Dye, Peanuts, Latex, Lidocaine? Y N If yes to these or others, please list:

_____

Has your child ever been diagnosed with or treated for the following?

Y N Acid Reflux	Y N Breathing Problems	Y N Heart Condition/Disorder	Y N Rheumatic Fever
Y N ADHD/ADD Hyperactivity	Y N Cancer/Tumor/Malignancy	Y N Heart Murmur	Y N Seizure/Epilepsy
Y N Allergies	Y N Cerebral Palsy	Y N Hepatitis	Y N Sensory Issues
Y N Anemia	Y N Chemotherapy/Radiation	Y N HIV/AIDS	Y N Sickle Cell Disease
Y N Arthritis	Y N Cleft Lip/Palate	Y N Kidney Disease	Y N Sinus Problems
Y N Asthma	Y N Developmental Delay	Y N Latex Sensitivity/Allergy	Y N Sleep Apnea/Snoring
Y N Autism/Spectrum Disorder	Y N Down Syndrome	Y N Liver Disorder	Y N Speech Delays
Y N Birth Defects	Y N Diabetes	Y N Premature Birth	Y N Transplant
Y N Bladder Disease	Y N GI/Stomach Disease	Y N Profound Mental Impairment	Y N Tuberculosis
Y N Bleeding Problems	Y N Hearing Impairment	Y N Psychologic/Nervous Disorder	Y N Vision Problems
			Y N Other

What is your main concern about your child's teeth?_____

Do you assist your child in brushing his/her teeth? Y N

Does your child use dental floss? Y N

Was your child bottle fed? Y N Until what age? _____

Was your child breast fed? Y N Until what age? _____

Do you or your child have any concerns about the appearance of his/her teeth? Y N
Describe:_____

Does your child have a current or previous pacifier or thumb/finger sucking habit? Y N

Has your child ever had an accident or injury involving the teeth/jaws? Y N If so, when & where?

_____

Name of previous dentist office:_____

When was your child's last dental visit? _____

When were your child's last dental x-rays? _____

Is there something in particular that we should know about your child that may guide us in rendering care for them?_____

The information provided in this form is complete to the best of my knowledge. I will notify iHeartSmiles at future visits if any of the information changes. The person completing this form must print name and relationship to patient.

Print Name:_____Relationship:_____

Signature:_____Date:_____

Patient Name:_____ Date of Birth:_____

PARENT INFORMATION

Thank you for choosing our pediatric dental office for your child's care. It is our goal to make each child's visit a positive experience, treating your child as our own. Parents are welcome to come back to our treatment area. As experienced dental professionals, we recommend parents wait in our reception area as we guide your child through his or her appointment. Similar to a learning environment at school, children are more likely to socialize and interact without a parent present. Dr. Dana and her staff have excellent communication skills to help your child feel relaxed and we would like the best opportunity to explain, complete, and celebrate your child's successful appointment while having fun! With that being said, we understand that every child is unique, and we encourage your presence if your child is very young, has special needs, or you simply feel your child needs you present. Please let us know at check-in if you wish to come back, as we are happy to accommodate. We only ask that you act as a silent observer and other siblings remain in the reception play area. Should you decide to wait in the reception area but want to check on all the fun your child is having, please ask our front desk staff to bring you back for a "peek-a-boo" visit where you can observe your child without being in their direct line of sight. At the end of every visit we will always discuss your child's oral hygiene with you, and you will have the opportunity to ask as many questions as you would like.

APPOINTMENT POLICY

We reserve your appointment time specifically for you! If you need to reschedule, please give us at least a 24-hour notice so that we may give someone else the opportunity to use that time. A fee may be charged for late cancellations (less than a 24-hour notice) and/or missed appointments. This fee must be paid before a new appointment is scheduled.

CONSENT FOR TREATMENT

I, the undersigned parent/legal guardian, authorize Dr. Dana Busciglio Diaz and her staff to examine this child, clean his/her teeth, apply topical fluoride, perform necessary dental treatment, and obtain other records necessary for an accurate diagnosis for my child. I further request and authorize the taking of dental radiographs (x-rays) as may be considered necessary by Dr. Dana Busciglio Diaz to diagnose and/or treat my child's dental condition. I will allow photographs to be taken of my child and/or my child's teeth for diagnostic or educational purposes only. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr. Dana will provide an environment likely to help children learn to cooperate during treatment by using praise, distraction and story-telling techniques, & child-friendly demonstration of procedures and instruments.

Name of Guardian:_____ Signature:_____

Patient Name:_____ Date of Birth:_____

LETTER OF FINANCIAL RESPONSIBILITY

Payments for services are due at the time services are rendered. We accept cash, MasterCard, Visa, Discover, American Express, CareCredit, and Lending Club. If you have dental insurance, we would be happy to aid you in the processing of your claim. Your dental benefits help offset the investment of quality dental care for your child. It is our pleasure to assist you in maximizing your insurance benefits by completing your claim forms. If we are not in-network with your dental insurance, filing your dental claim is done as a courtesy and we will direct all reimbursement directly to you. We will be happy to discuss with you your child's treatment plan and answer any questions relating to your insurance. This is an agreement between Dana M. Busciglio Diaz, DMD, MS and the responsible party named on this form. In this agreement the words "you," "your," and "yours," refer to the responsible party. The word "account" means the account that has been established in your name to which charges are made and payment credited. The words "we," "us," and "our," refer to Dana M. Busciglio Diaz, DMD, MS. By executing this agreement, you are agreeing to pay for all services that are received.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, if any payments and/or credits were applied to your account during the month.

Payments: Unless our collection department approves other arrangements, the balance on your statement is due and payable when the statement is issued and is past due if not paid by the date listed on the statement.

Insurance co-payments: Any co-payment required by an insurance company must be paid at the time of service. Because this is an insurance requirement we cannot bill you for this.

Contracted Insurance: If we contract with your insurance company, we must follow our contract and their requirements. If you have a co-pay or deductible you must pay that at the time of service. It is the insurance company that makes the final determination of your eligibility. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

Non-contracted Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay it is the insurance company that makes the final determination of your eligibility**. Please keep in mind that although the insurance company states they will cover a specific service, this is not a guarantee of payment and the reimbursement rate may be less than what we charged depending on your insurance's usual and customary rates.** Some plans base the amount of benefit on a schedule of fees arbitrarily developed by insurance companies.

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

Waiver of Confidentiality: You understand if this account is submitted to a collection agency, or if you're past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Transferring of Records: You will need to request in writing if you would like to have copies of your records sent to another doctor or organization. You authorize us to include all relevant information, including your payment history.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we refer your account to a collection agency, you agree to pay all of the collection costs, which are incurred.

Your time is very important to us. When your appointment(s) are scheduled we make sure to set aside the necessary time just for your child. To keep our schedule efficient, our office requires at least 24-hour notice (business day) be given for cancellation or rescheduled appointments.

Patient's Name: _____Date: _____

Responsible Party/Relationship: _____

Signature of Responsible Party: _____

I authorize Dana M. Busciglio Pediatric Dentistry And Orthodontics, DMD, MS, PLLC, Dana M. Busciglio Diaz, DMD, MS, to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all the charges whether paid by insurance or not.

Payment is due in full at time of treatment, unless prior arrangements have been approved.

Patient Name:_____ Date of Birth:_____

AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

As part of your healthcare, this practice originates and maintains paper and/or electronic records describing your health history, symptoms, examinations, test results, diagnoses, treatment, any plans for future care or treatment and payment for the services or treatment we provided. We use this information to:

- Plan your care and treatment
- Communicate with other health professionals or entities who contribute to your healthcare
- Submit your diagnosis and treatment information for payment for the services or treatment provided to you

"ONLY AS PERMITTED OR REQUIRED BY FEDERAL OR STATE LAW", WE MAY USE YOUR PROTECTED HEALTHCARE INFORMATION TO DO THE FOLLOWING:

- To disclose, as may be necessary, your health information (including HIV+/AIDS status, drug/alcohol abuse/dependency notes and qualified mental health notes) to other healthcare providers and healthcare entities (such as: referrals to or consultation with, other healthcare professionals, laboratories, hospitals, etc.) or to others as may be required by law or court order concerning your treatment, payment and/or healthcare.
- To request from other healthcare entities and/or healthcare providers (i.e. doctors, dentists, hospitals, labs, imaging centers, etc.) specific healthcare information we may need for planning your care and treatment.
- To submit the necessary information to your insurance company(s) for coverage verification as well as the diagnosis and treatment information to your insurance company(s), other agencies and/or individuals) for payment of our services or treatment we provided to you.
- To discuss your health or payment information (only the minimum necessary in our judgment) with family members or other persons who are or may be involved with your healthcare treatment or payments.
- If you choose, please list by name and relationship the persons with whom we may share your healthcare or payment information:

  _____
- To leave appointment reminders or other minimum necessary information related to your healthcare or healthcare

  payments on an answering machine, mobile voice or text mail, email or with a household family member.

  [ ] Please check here if you do not want us to leave messages on your answering machine or with a household family member.

  [ ] Please check here if you do not want us to leave a voice/text message on your mobile device.

  [ ] **Please check here if you authorize us to send your healthcare information by email. Please understand that email may be an unsecured medium of transmission and is potentially accessible by others. In addition to checking the box, we reserve the right to require you to authorize in writing the transmission of your healthcare information to you by unsecured email.**
- You may request a copy of and you have the right to read our "Notice of Patient Privacy Practices " prior to signing this authorization. The NPP provides a more complete description of health information uses and disclosures.

I fully understand and agree to this authorization and acknowledge the above rights and disclosures.

Patient Name (please print): _____

Parent/Legal Guardian (please print):_____

Parent/Legal Guardian Signature:_____Date:_____

** If <u>other than patient</u> is signing, are you the parent, legal guardian, legal custodian or have a Healthcare Power of Attorney for the patient?* Yes [ ] No[ ]

RELATIONSHIP:_____

Patient Name:_____ Date of Birth:_____

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed this office's *Notice of Privacy Practices* explaining:

- How this office will use and disclose my protected health information.
- My privacy rights with regards to my protected health information.
- This office's obligations concerning the use and disclosure of my protected health information.

I understand that the *Notice of Privacy Practices* may be revised from time to time and that I am entitled to receive a copy of any revised *Notice of Privacy Practices* upon request.

I also understand that if I have any questions or complaints, I may contact:

iHeartSmiles
5601 Skytop Drive
Lithia, FL 33547
(813) 603-8800

You may also contact the Secretary of the U.S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Please contact our office for information on how to contact the U.S. Department of Health and Human Services.

Patient or Personal Representative

Signature:_____ Date:_____

Name:_____

Relationship to Patient:_____