Montshire Pediatric Dentistry

Dr. Jonathan Norris

Patient Information

Child's Full Name:_____ **Date of Birth**_____

Child's Preferred Name: _____

Child's Address: _____

Physician's Name: _____

Mother/Guardian

Name: _____**Email:** _____

Mailing Address:_____

Home Phone:_____**Cell Phone:** _____

Father/Guardian

Name: _____**Email:** _____

Address: _____

Phone Number: _____ **Cell Phone:** _____

Emergency Contact: _____

Phone # _____**Relationship to patient**_____

Responsible Party

Name of person responsible for account: _____

Address: _____**Relationship to patient** _____

Driver's license #_____**DOB**_____**SS#**_____

Email address:_____

Employer: _____ Work Phone:_____

Dental Insurance Information

NH Medicaid_____ VT Medicaid_____

Private Dental Insurance

Policy Holders Name: _____SS#:_____DOB:_____

Relationship to Patient:_____

Employer Name: _____

Employer Address:_____

Insurance Company: _____Tel.#_____

Group#_____ Policy ID #_____

Do you have additional insurance? Yes or No If yes, complete the following:

Private Dental Insurance

Policy Holders Name: _____SS#:_____DOB:_____

Relationship to Patient: _____

Employer Name: _____

Employer Address: _____

Insurance Company: _____Tel.#_____

Group#_____ Policy ID #_____

I hereby authorize payment directly to Jonathan Norris, DDS of the group insurance benefits otherwise payable to me. I understand that I am responsible for all cost of dental treatment. I hereby authorize Jonathan Norris, DDS to administer such medications and perform such diagnostic, photographic and therapeutic procedures that may be necessary for proper dental care. I grant the right to the dentist to release my child's dental/medical histories and other information about my child's dental treatment to third party payers and/or health professionals. In the event that your account be turned over to our collection agency for non-payment, there will be a 30% increase added to your balance to defray the costs the collection agency charges us.

Signature of Parent or Guardian_____

Relationship to Patient _____ Date_____

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____ Patient Name: _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:

❑ First Name Only ❑ Proper Surname ❑ Other _____

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

❑ Cell Phone Confirmation
❑ Text Message to my Cell Phone
❑ Home Phone Confirmation
❑ Email Confirmation
❑ Work Phone Confirmation
❑ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

❑ Cell Phone Confirmation
❑ Text Message to my Cell Phone
❑ Home Phone Confirmation
❑ Email Confirmation
❑ Work Phone Confirmation
❑ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

❑ Phone Message
❑ Text Message
❑ Email
❑ **Any of the Above**
❑ **None of the Above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

_____ _____
Please ***print*** name of Patient Please ***sign*** Patient / Guardian of Patient

_____ _____
Legal Representative / Guardian Relationship of Legal Representative / Guardian

OFFICE USE ONLY

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

❑ It was emergency treatment
❑ I could not communicate with the patient
❑ The patient refused to sign
❑ The patient was unable to sign because
❑ Other (please describe) _____

Signature of Privacy Officer _____