Patient Information Form

Patient's Full Name _____ *Called* _____

Street Address _____

City _____ State _____ Zip _____ School the child attends _____

Birth Date _____ Sex: ☐ M ☐ F How did you hear about us? _____

Orthodontist _____ Siblings Treated Here (if any) _____

Parent/Legal Guardian Information

Mother's Full Name _____ D.O.B. _____

Street Address (*if different from patient*) _____

City _____ State _____ Zip _____ Home # _____

Employer _____ Work # _____ **Cell#** _____

Father's Full Name _____ D.O.B. _____

Street Address (*if different from patient*) _____

City _____ State _____ Zip _____ Home # _____

Employer _____ Work # _____ Cell# _____

Email Addresses: _____

Primary Dental Insurance Information

Subscriber Name _____ Relation To Patient _____

Employer _____ Insurance Co. _____

Insurance Address _____

Insurance Ph# _____ Group # _____ I.D.# _____

Secondary Dental Insurance Information

Subscriber Name _____ Relation To Patient _____

Employer _____ Insurance Co. _____

Insurance Address _____

Insurance Ph# _____ Group# _____ I.D.# _____

Emergency Contact _____ Phone# _____

Consent

I hereby authorize payment directly to the attending dentist for the group insurance benefits otherwise payable to me. I authorize the dentist to release any information acquired in the course of treatment or examination. I understand that responsibility for payment for dental services provided in the office for my dependents is mine, due and payable at the time services are rendered. I further understand that a 1.5% finance charge or a $5.00 billing fee (whichever is greater) will be added to any balance over 60 days. In the event of default, I understand there will be a 30% collection cost and reasonable attorney fees required to effect collection of the note.

Signature of Parent or Legal Guardian _____

Please Print Name _____ **Date** _____

Volunteer Pediatric Dentistry

1516 Coleman Road Suite 201
Knoxville, TN 37909

209 East Emory Road Suite 101
Powell, TN 37849

865-558-8857 (Phone)
865-558-0291 (Fax)

Contact Person: Michael Koch

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient name_____

Patient number _____

Patient address _____

Patient phone number _____

Pediatrician's Name and Phone Number:_____

I authorize the professional office of Volunteer Pediatric Dentistry and my dentist to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1. Release of Health Records necessary for the proper treatment of dental procedures being performed.
2. Information can be released to other physicians/personnel necessary for the treatment of dental procedures.
3. Expiration date of this is two (2) years from the date of this document.

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated_____ Patient signature_____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient _____Print Name_____

AUTHORIZATION FOR RELEASE OF INORMATION

Name of Patient _____ Date of Birth _____

VOLUNTEER PEDIATRIC DENTISTRY is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information Check each person/entity that you approve to receive information	**Description of information to be released** Check each that can be given to person/ entity on the left in the same section
___ CELL PHONE ___ VOICE MAIL	____APPTS, BILLING INFORMATION & INSURANCE
___ CHILDS'S SCHOOL	____ EXCUSES/ K-12 RELEASE INFO
___ PARENT (MOTHER)	____ FAMILY BILLING INFORMATION ____ TREATMENT PLAN ____ MEDICAL
___ PARENT (FATHER)	____ FAMILY BILLING INFORMATION ____ TREATMENT PLAN ____ MEDICAL
___ LEGAL GUARDIAN OR OTHER (ex Grandparent) Name: _____	____ FAMILY BILLING INFORMATION ____ TREATMENT PLAN ____ MEDICAL

Rights of the Patient

I understand that 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 as described in this document by sending a written notification to Volunteer Pediatric Dentistry.

I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____ Date: _____

Signature of Parent, Legal Guardian, or Personal Representative

Description of Personal Representative's Authority (attach necessary documentation)

Effective date of notice: 10/2017

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

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I acknowledge that I received a copy of Volunteer Pediatric Dentistry's Notice of Privacy Practices.

Patient name: _____

Printed Name of Guardian: _____

Signature of Guardian: _____ Date _____