Carol Ann D. Nicrosi, DMD, MS

Kathryn J. Hoar, DMD

MEDICAL HISTORY

TODAY'S DATE: _____

CHILD'S NAME: _____ Age: _____ DOB: _____

CHILD'S PHYSICIAN: _____ Phone: _____

WHEN DID CHILD HAVE LAST MEDICAL EXAM? _____

Is your child in good health? YES☐ NO☐

Is your child up to date with immunizations? YES☐ NO☐

Is this your child's first dental visit? YES☐ NO☐

Is your child currently a thumb/finger sucker? ☐ Use a pacifier? ☐

If your child was bottle fed, at what age was the bottle discontinued? _____

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

☐ Rheumatic Fever
☐ Heart condition or murmur
☐ Sickle cell anemia
☐ Kidney disease
☐ Liver disorder
☐ Hepatitis
☐ Blood transfusion
☐ HIV positive
☐ Nervous disorder
☐ Lung problem
☐ Asthma
☐ Diabetes
☐ Acquired Immune Deficiency
☐ Prolonged bleeding
☐ Seizures or Epilepsy
☐ Cerebral palsy
☐ Muscular dystrophy
☐ Learning Disability
☐ Behavior or emotional disorder
☐ Hearing disorder
☐ Handicap/ Disabilities
☐ Tuberculosis
☐ Allergies (If yes, to what?) _____
☐ Other, please explain _____

Is your child presently taking medication? ☐YES ☐NO If yes, please tell what medication your child is taking and why _____

Has your child experienced any unfavorable reaction to medicine? YES☐ NO☐
(Such as penicillin, codeine, Tylenol, xylocaine)

Is your child presently undergoing medical treatment? YES☐ NO☐

Has your child ever been hospitalized since birth? YES☐ NO☐

If so, dates and reason: _____

Has your child had any injuries to teeth or mouth? YES☐ NO☐

Has your child ever had an unfavorable experience in a dental office? YES☐ NO☐

Does your child have a toothache? YES☐ NO☐

Name of your child's previous dentist: _____

Purpose of today's appointment: _____

Do we see other members of your family? (brothers or sisters) YES☐ NO☐

If so, please list: _____

Thank you for your help. If there is any information that you think might be of value to us in treating your child, please feel free to comment: _____

I understand that the information I have given is correct to the best of my knowledge, that 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 history. I authorize Dr. Nicrosi, Dr. Hoar, and the dental staff to perform the necessary dental services my child may need.

_____ **Child's Name**

_____ **Parent/Guardian**

_____ **Date**

Carol Ann D. Nicrosi, DMD, MS

Kathryn J. Hoar, DMD

MEDICAL RELEASE

I hereby give my permission for any and all dental care to be administered to my children (listed below):

Patient's Name	**Date of Birth**
	/ /
	/ /
	/ /
	/ /

Any of the following people may be designated to act on my behalf. I assume all financial responsibilities for any expenses incurred.

Designated Person's Name	**Relationship to Patient**

Parent/Legal Guardian Name: _____
(Please Print)

Signature: _____ _____
(Date)

AUTHORIZATION FOR RELEASE OF INFORMATION

To be completed if any parent/legal guardian desires to have medical information released to others.

I hereby authorize Carol Ann D. Nicrosi, DMD, MS, P.C. to use and/or disclose the protected health information of the aforementioned patients to:

- the adults listed above
- other physicians/dentists involved in the patients' care

I understand that the information used and/or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state laws. I understand that this Authorization is voluntary, and I have the right to refuse to sign this Authorization. I understand that upon my request I may see and copy the protected health information described on this Authorization. I understand that my protected health information may included information concerning communicable diseases and/or behavioral and mental health conditions. I understand that I may revoke this Authorization in writing at any time by sending written revocation to the Privacy Officer of Carol Ann D. Nicrosi, DMD, MS, P.C. I understand that any revocation will not affect any actions taken by Carol Ann D. Nicrosi, DMD, MS, P.C. prior to receipt of my revocation.

Parent/Legal Guardian Name: _____
(Please Print)

Signature: _____ _____
(Date)

Carol Ann D. Nicrosi, DMD, MS

Kathryn J. Hoar, DMD

CHILD'S REGISTRATION AND HISTORY

TODAY'S DATE _____

CHILD'S NAME _____ PREFERRED NAME_____
AGE _____MALE☐ ____FEMALE☐_____ CHILD'S DOB_____

FATHER'S INFORMATION
NAME_____
DOB_____
MAILING ADDRESS_____
_____
CITY_____
STATE_____ ZIP_____
SOCIAL SECURITY#_____
DRIVER'S LICENSE#_____
EMPLOYER_____
_____
HOME PHONE_____
WORK PHONE_____
CELL PHONE_____
NUMBER TO BEST REACH YOU_____
EMAIL_____

MOTHER'S INFORMATION
NAME_____
DOB_____
MAILING ADDRESS_____
_____
CITY_____
STATE_____ ZIP_____
SOCIAL SECURITY#_____
DRIVER'S LICENSE#_____
EMPLOYER_____
_____
HOME PHONE_____
WORK PHONE_____
CELL PHONE_____
NUMBER TO BEST REACH YOU_____
EMAIL_____

PERSON FINANCIALLY RESPONSIBLE (IF OTHER THAN PARENT)
NAME_____ RELATIONSHIP TO CHILD_____
SS# _____ STREET ADDRESS_____
DL#_____ CITY_____ZIP_____
HOME PHONE_____ CELL PHONE_____
EMAIL_____ WORK PHONE_____

PRIMARY DENTAL INSURANCE CONTRACT#_____
COMPANY_____ GROUP#_____
POLICY OWNER'S NAME_____

SECONDARY DENTAL INSURANCE CONTRACT#_____
COMPANY_____ GROUP#_____
POLICY OWNER'S NAME_____

WHOM MAY WE THANK FOR REFERRING YOU? _____

_____

Carol Ann D. Nicrosi, DMD, MS

Kathryn J. Hoar, DMD

OFFICE POLICY REGARDING FINANCIAL AGREEMENT AND APPOINTMENTS

- **Dental Insurance** is a contract between you and your insurance company. There is no direct relationship between our office and your insurance company. Your insurance benefits are determined by the type and design of plan chosen by you and/or your employer and we are not party to this contract. We have no control over the terms of your contract, the method of reimbursement, or the determination of your benefits. Some and perhaps all of the services can be defined by your insurance company as "not covered," "denied," or "over UCR." We will file your primary dental insurance claims as a courtesy to you. We do not guarantee payment and are not responsible for providing you with the plan limitations, exclusions, and provisions determined by your insurance company. You agree to pay any portion of the charges not covered by your insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. We will file a pre-determination for recommended treatment when it is requested by you. We are participating providers with BC/BS Alabama, Southland, Cigna, Guardian, MetLife and Delta Dental.
- If **your account** becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay the 33% collection fee.
- In the case of **divorce or separation**, the responsible party prior to the divorce or separation remains responsible for the account. 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.
- Please bring your insurance card to **every** appointment. Please advise us at check-in of any changes to your insurance.

Please note:
We will collect any portion not payable by insurance at the time of service. In cases where your business or a divorced parent covers the patient charges, we will be happy to file all necessary forms, or furnish you with a statement marked "PAID", in order that you may receive reimbursement.

I elect to pay cash_____, check_____, MasterCard_____, VISA_____, on all visits as treatment progresses.

The undersigned gives consent to agreed upon dental services and the use of appropriate methods thereto and in the case of collection to pay all collection and attorney's fees in behalf of:

_____	_____	_____
Child's Name	Signature of Parent/Guardian	Today's Date

- A combination of two broken appointments or late cancellations in a rolling year will mean that we can no longer see your child as a patient. You will receive a letter of dismissal.
- Please arrive on time for your appointment. If you are more than ten minutes late, your appointment may have to be rescheduled. The missed appointment will be counted as a broken appointment. There will be a broken appointment fee charged of $35.00.
- We kindly ask that parents remain on the premises while their child is receiving treatment. Please see the front desk prior to your child's appointment if you have any questions or concerns. We will be happy to reschedule the appointment for a more convenient time.

I understand and agree with the above policies regarding appointments.

_____	_____
Signature of Parent/Guardian	Date

Carol Ann D. Nicrosi, D.M.D., M.S., P.C

ACKNOWLEDGEMENT OF RECEIPT OF

HIPAA NOTICE OF PRIVACY PRACTICES
("Acknowledgement")

I acknowledge that I have received a copy of this Dental Practice's **HIPAA Notice of Privacy Practices**.

_____
Patient Name (Please Print)

_____ _____
Patient Signature Date

OR

_____
Signature of Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Other: _____

Please Note: It is your right to refuse to sign this Acknowledgement.

Dental Office Use Only

I tried to obtain written Acknowledgement by the individual noted above of receipt of our **Notice of Privacy Practices**, but it could not be obtained because:

__ An emergency prevented us from obtaining acknowledgement.

__ A communication barrier prevented us from obtaining acknowledgement.

__ The individual was unwilling to sign.

__ Other:_____

_____ _____
Staff Member Signature Date