alexandria pediatric dentistry
anna brasher moreau, d.d.s., m.s.
board certified pediatric dentist

patient acquaintance information

Date: _____

Child's Name: _____ DOB: _____
Child's Pediatrician: _____ Child's School: _____

Sibling(s) Name: _____ DOB: _____
_____ DOB: _____
_____ DOB: _____

Mother's Information: ◯ Mother ◯ Stepmother ◯ Legal Guardian
Name: _____ DOB: _____
Address: _____
City/State/Zip: _____
Employer: _____ Position: _____
Home phone: _____ Social Security #: _____
Work phone: _____ DL#: _____
Cell Phone: _____ Email Address: _____

Father's Information: ◯ Father ◯ Stepfather ◯ Legal Guardian
Name: _____ DOB: _____
Address: _____
City/State/Zip: _____
Employer: _____ Position: _____
Home phone: _____ Social Security #: _____
Work phone: _____ DL#: _____
Cell Phone: _____ Email Address: _____

Child lives with ◯ Mother ◯ Father ◯ other _____

Parent's Dentist: _____ Whom may we thank for referring you?_____

Do you have dental insurance? ◯ Yes ◯ No
Insurance Company: _____ Phone: _____
Employer: _____ Member ID#: _____ Group#: _____
Benefit Coverage Period: _____
Employee/Subscriber Name: _____ DOB: _____SS#: _____
Is this child covered by Medicaid? ◯ Yes ◯ No
Does this child have secondary dental insurance? ◯ Yes ◯ No
Who is financially responsible for this account? Name _____ relationship_____

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1400 metro drive, suite a • alexandria, louisiana 71301

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patient health information

Child's name: _____ Sex:_____
Nickname: _____ Age: _____ Birth Date: _____
Does your child have a health problem? ◯ Yes ◯ No
If yes, please list: _____
Does your child take any medicine(s) regularly? ◯ Yes ◯ No

Name of Medication	Dosage	Reason

Is your child allergic to penicillin? ◯ Yes ◯ No
Other drugs? Please list: _____

_____

Has your child ever been hospitalized or had any surgical procedures? ◯ Yes ◯ No
When? _____
Reason? _____
Has your child had any history of the following or currently being treated for:

☐ ADD/ADHD ☐ Cardiac Issues/Heart Murmur ☐ Epilepsy/Seizures ☐ Lung disease
☐ Allergies ☐ Cleft lip or palate ☐ Handicaps/Disabilities ☐ Rheumatic/Scarlet Fever
☐ Anemia ☐ Diabetes ☐ Hearing Impairment ☐ Speech Problems
☐ Asthma ☐ Dyslexia ☐ HIV/AIDS ☐ Tuberculosis
☐ Bleeding ☐ Disorder ☐ Emotional Issues ☐ Kidney/Liver Issues

Has your child been tested for or diagnosed with any neurological disorders? ◯ Yes ◯ No
☐ Autism ☐ Asperger's Syndrome ☐ PDD ☐ Sensory Intergration Disorder
Other: (Please list) _____
Please explain briefly why you brought your child for dental care: _____

_____

Is this your child's first visit to the dentist? ◯ Yes ◯ No If no, how long since last dental visit?_____
Has your child had any unfavorable dental experience? ◯ Yes ◯ No
Does your child have a toothache now? ◯ Yes ◯ No
Does your child suck his thumb or finger(s)? ◯ Yes ◯ No
Does your child have a pacifier, nursing bottle or sipper cup habit? ◯ Yes ◯ No
Have there been any injuries to teeth, falls, blows, chips, etc.? ◯ Yes ◯ No

consent for treatment of a minor

The undersigned hereby authorizes Alexandria Pediatric Dentistry to perform the examination and, after explanation, provide necessary dental services deemed appropriate for the care of the above-named child. This consent shall remain in full force and effect until cancelled by either party. I understand that I am responsible for notifying this office of any accidents, major illnesses, or changes in medical history of the above named child.

Signed _____ **Date** _____ **Relationship to Child**_____
Who is accompanying this child today? _____ Relationship to Child_____
Do you have legal custody of this child? ◯ Yes ◯ No
Is the child is adopted? ◯ Yes ◯ No

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release of medical information

Patient Name _____

Date of birth _____

I, _____, give my consent for the release of any medical records concerning my child _____ to Alexandria Pediatric Dentistry.

Signature _____

Print Name _____

Date _____

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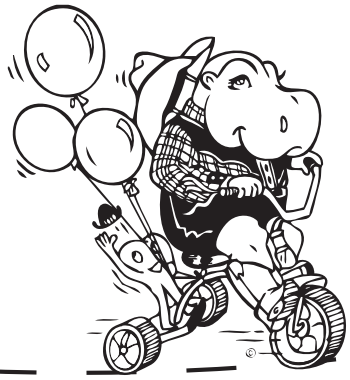

DISPOSITION OF CHILD'S DENTAL CARE

IN THE EVENT I AM UNABLE TO BE PRESENT AT MY CHILD'S APPOINTMENT, I ALLOW THE FOLLOWING

NAME _____

RELATIONSHIP _____

NAME _____

RELATIONSHIP _____

NAME _____

RELATIONSHIP _____

TO MAKE DECISIONS REGARDING MY CHILD'S DENTAL CARE

CHILD'S NAME _____

GUARDIAN'S SIGNATURE _____

DATE _____

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notice of privacy practices

this notice describes how health information about you may be used and disclosed and how you can get access to this information. please review it carefully. the privacy of your health information is important to us.

our legal duty:

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 1/1/2009, and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

uses and disclosures of health information:

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as email, voicemail messages, postcards, or letters).

patient rights

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, a fee may apply for staff time to copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

questions and complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer:

Telephone 318-445-5471 Fax 318-445-5901 Address 1400 Metro Dr. Suite A, Alexandria, LA 71301

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acknowledgement of receipt of notice of privacy practices

You May Refuse to Sign This Acknowledgement

I, _____ , have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

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:

- O Individual refused to sign
- O Communications barriers prohibited obtaining the acknowledgement
- O An emergency situation prevented us from obtaining acknowledgement
- O Other (please specify)

_____

_____

_____

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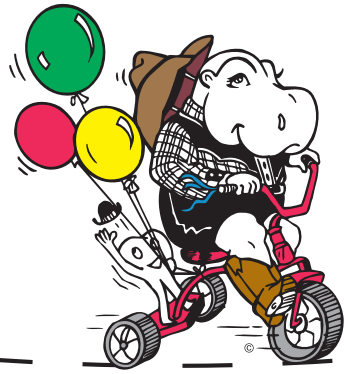

OFFICE PHILOSOPHY AND POLICIES

Parental Presence
We invite you to stay with your child during the initial examination. During future appointments we suggest you allow your child to accompany our staff through the dental experience. We can usually establish a closer rapport with your child when you are not present. Our purpose is to gain your child's confidence and help them overcome apprehension. We also believe children feel proud of their ability to navigate through a dental visit on their own. However, we do recognize and respect the unique needs of every patient. If you choose, one parent may accompany the child to the treatment room. For the safety and privacy of all patients, other children who are not being treated should remain in the waiting room with a supervising adult. We also request that you remain in our office for the duration of child's dental appointment.

Scheduling
Since appointed times are reserved exclusively for each patient, we request that you notify our office 24 hours in advance of your scheduled appointment if you are unable to keep your appointment. Another patient, who needs our care, could be scheduled if we have sufficient time to notify them. We realize that unexpected things can happen, but we ask for your assistance in this regard.

Financial Policy
We accept cash, check, MasterCard, Visa, Discover Card, American Express and Care Credit. We also accept a variety of dental insurances. Payment is due at the time dental treatment is provided. Any balance carried over 90 days will be turned over to our collection agency.

Insurance Policy
If we have received all of your insurance information on the day of the appointment, we will be happy to file your claim as a service to you. We recommend that you be familiar with your insurance benefits, as we will collect from you the estimated amount insurance is not expected to pay. We make every effort to provide you with an accurate insurance estimate, however, please understand this is just an estimate. The portion not estimated to be covered by your insurance is due at the time of service. Our office will allow 40 days for your insurance to pay on your claim. We file insurance electronically so your insurance company will receive each claim within days of the treatment. If your insurance does not pay within 40 days, or if the insurance payment differs from the amount estimated, a statement will be mailed to you and the balance is your responsibility.

Please realize that dental insurance is meant to be an aid in receiving dental care. No insurance pays 100% of all procedures. Many patients think that their insurance pays 90-100% of all dental fees. In reality, most plans only pay between 50-80% of the average total fee. Some pay more, some pay less. The percentage paid is usually determined by how much you or your employer has paid for coverage or the type of contract your employer has set up with the insurance company.

Our office does not accept payment from secondary insurance plans, with the exception of Medicaid. If you carry a secondary insurance we will be glad to provide you with a copy of your Superbill to assist you in filing your secondary claim.

I have read and understand the above policies _____ Date_____

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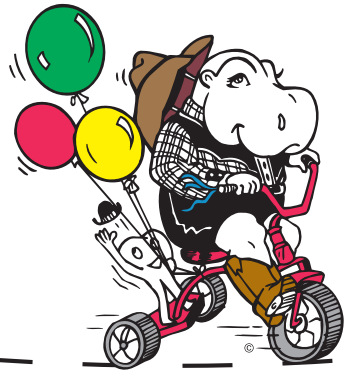

BIPPO'S LINGO

Our Word	Description
Tooth Pictures	Dental X-rays
Tooth Counter	Dental explorer which is an instrument used to examine teeth
Sunshine	Overhead light used to illuminate the dark mouth
Tooth Vitamins	Fluoride used to strengthen enamel and fight against cavities
Sugar Bugs	Dental caries, "cavities", dental decay
Mr. Thirsty	Suction used to drink up water and saliva
Tooth Chair or Mouth Rester	Instrument used to help hold the mouth open comfortably
Sleepy Jelly	Topical anesthetic, numbing medicine
Tooth Towel	Gauze used to dry or wipe teeth
Push	Anesthesia used to numb the mouth WE AVOID the words SHOT and NEEDLE
Tooth Ring	Small clamp that is used to secure a raincoat to a tooth requiring a restoration
Raincoat	A plastic rubber dam that isolates the tooth we are working on, keeping it dry and keeping debris out of the mouth
Tooth Washer	Highspeed dental handpiece that whistles really loud and washes the sugar bugs out of the tooth
Tooth Tickler or Mr. Bumpy	Slowspeed dental handpiece that bumps and tickles the decay away
Tooth Soap, Blue Jelly	Cleaning agent applied to a tooth before a sealant or white filling
Play Dough	Medicated paste that is placed inside a tooth needing nerve treatment
Princess Crown or Tooth Hat	Stainless Steel Crowns
Silver Star	Amalgam Filling
Wiggle	Extract WE AVOID the word PULL
Red Stuff	Blood
Bippo Nose	Nitrous Oxide Mask Placed over the Patient's Nose to deliver Nitrous Oxide
Giggle Wind	Nitrous Oxide or "Laughing Gas" used to help calm nervous patients and alleviate anxiety

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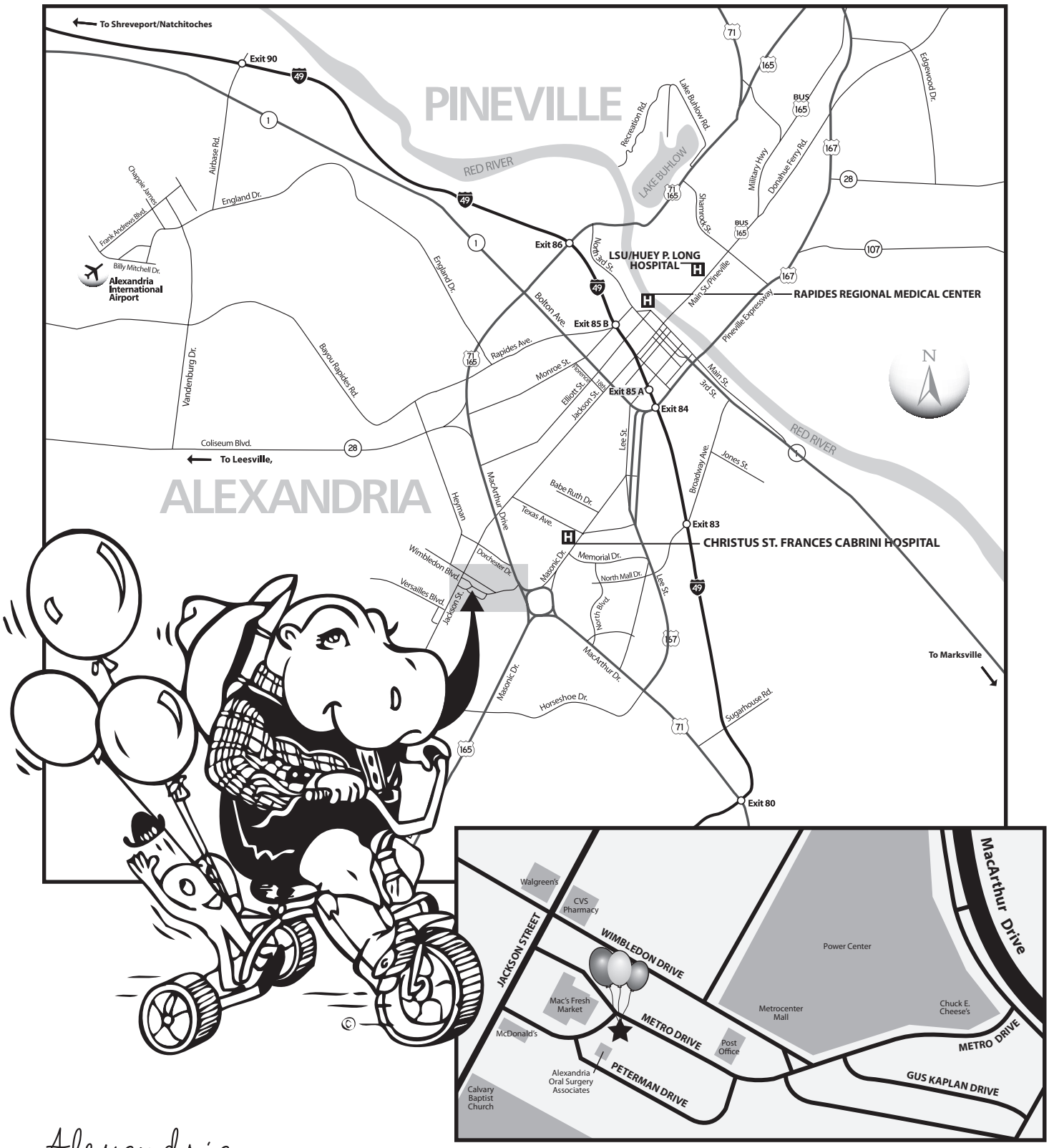

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