Brian B. Lee, DMD
60 Great Rd., Acton, MA 01720
Phone: (978) 635-1000
Email: apdpatients@yahoo.com

Family Information

Mother

Name: _____

Address: _____

_____

SS #: _____ Date of Birth: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

E-mail: _____

Father

Name: _____

Address: _____

_____

SS #: _____ Date of Birth: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

E-mail: _____

About Your Child (Patient)

Name: _____

Nickname: _____

Date of Birth: _____ Gender: □ Male □ Female

School: _____ Grade: _____

In the Event of an Emergency

Who should we contact? _____

Relationship to Patient: _____

Phone Number: _____

Primary Insurance

Insurance Company: _____

Subscriber: _____

Subscriber #: _____

Group: _____

Group #: _____

Secondary Insurance

Insurance Company: _____

Subscriber: _____

Subscriber #: _____

Group: _____

Group #: _____

How were you referred to Acton Pediatric Dental?

☐ Insurance ☐ Internet ☐ Drive-By ☐ School ☐ Friend _____ ☐ Other _____

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Patient's Dental Information

1. Has the patient been to the dentist before? □ Yes □ No
   If yes, please fill out the following:
   - Name of previous dentist: _____ Phone #: _____

   - Date of last dental exam: _____ Date of last dental x-rays: _____

   - Has the patient experienced any difficulty with previous dental work? □ Yes □ No

     If yes, please explain: _____

2. What is the reason for today's visit? _____

3. Is the patient in any pain? □ Yes □ No If yes, for how long? _____

4. What type of water does the patient drink? (Check all that apply)
   □ Tap water □ Filtered Water □ Well Water □ Bottled Water

5. Does the patient take fluoride supplements? □ Yes □ No

6. Does the patient do any of the following?
   □ Finger/thumb/pacifier sucking □ Nail Biting □ Nursing/Bottle use □ Teeth Grinding

7. Does the patient participate in any sports? □ Yes □ No Please list: _____

Patient's Medical History

Physician: _____ Phone #: _____ Date of last physical exam: _____

Please describe the patient's current physical health: □ Good □ Fair □ Poor

Does the patient have a history of or conditions related to the following? (Check all that apply)

□ Anemia	□ Cancer	□ Epilepsy	□ HIV/AIDS	□ Rheumatic fever
□ Asthma	□ Cerebral Palsy	□ Food Allergies	□ Kidney	□ Surgeries or
□ Bladder	□ Chronic Sinusitis	□ Hearing	□ Latex Allergy	Hospital stays
□ Bleeding disorders	□ Diabetes	□ Heart	□ Liver	□ Tuberculosis
□ Behavioral disorders	□ Drug Allergies	□ Hepatitis	□ Penicillin Allergy	□ Other

- Does the patient require pre-medication/antibiotics prior to dental appointments? □ Yes □ No □ Don't Know

- Please list any medical conditions or allergies not mentioned above: _____

_____

- Please list all drugs/medications that the patient is currently taking and reason for taking them: _____

_____

I attest that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and that it's my responsibility to inform this office of any changes in my child's medical status.

Signature: _____ Date: _____

Print Name: _____ Relationship to Patient: _____

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Office Policies

Patient's Name: _____

Patient's Birthdate: _____

Consent for Services
I authorize and request the performance of dental services for my child/children. I give my consent to any advisable and necessary dental procedures, medications, or anesthetics administered by the dentist or by the supervised staff for diagnostic purposes or dental treatment.

Dental Insurance Subscribers
Co-insurance payments are due on the day of service. We verify eligibility with your dental insurance to the best of our ability prior to each appointment. We submit insurance claims and pre-estimates to your insurance after each visit. A treatment plan will be provided to you and we will inform you of your estimated payment prior to restorative appointments if possible. It is your responsibility to inform us of any changes in your dental plan and to know the details of your coverage.

Payment Options
We accept Visa, MasterCard, Discover, cash, check, and CareCredit as forms of payment. In-office monthly payment plans are also available for extensive treatment plans.

Fillings
Dr. Lee only does resin-based composite fillings in this office, as he believes there are many benefits to using the "white" composite rather than the "silver" amalgam filling. Your insurance may downgrade the resin to the fee allowed for an amalgam filling, in which case, you are responsible for the difference.

Cancelled, Rescheduled, or Missed Appointments
Kindly notify us 48 hours in advance if you need to cancel or reschedule an appointment. Cancelled, missed, or rescheduled appointments are subject to a charge of $50.00 per unit (30 minutes) without 48 hours notice. Three failed appointments (appointments that are missed or cancelled within 48 hours of the appointment time) will result in dismissal from the practice. If a patient is more than 15 minutes late for their appointment, the appointment may need to be rescheduled.

Financial Responsibility
I understand and acknowledge that I am financially responsible for the services provided for the above named, regardless of insurance coverage. If the account is not paid within 60 days of the date of service, I understand that I am responsible for all the fees, such as late charges, legal fees, collection agency fees and any other expenses incurred in collecting the balance.

By signing below, you acknowledge that you have read the above policies.

Signature: _____ Date: _____

Print Name: _____ Relationship to Patient: _____

Acton Pediatric Dental, P.C. 60 Great Road
Dr. Brian B. Lee Acton, MA 01720

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

Federal and state law requires us to maintain the privacy of your health information. That law also requires us 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 we describe in this notice while it is in effect. This notice takes effect April 14, 2003, 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 applicable law permits the changes. 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and health care operations. For example:
Treatment: We may use your health information for treatment or disclose it to a dentist, physician or other health care provider providing treatment to you.

Payment: We may use and disclose our health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to the federal Privacy Rules for its payment activities.

Health Care Operations: We may use and disclose your health information for our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. We may disclose your health information to another health care provider or organization that is subject to the federal privacy rules and that has a relationship with you to support some of their health care operations. We may disclose your information to help these organizations conduct quality assessment and improvement activities, review the competence or qualifications of health care professionals, or detect or prevent health care fraud and abuse.

On Your Authorization: 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 uses or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose our health information for any reason except those described in this notice.

To Your Family and Friends: We may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may 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. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

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

Disaster Relief: We may use or disclose your health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Public Benefit: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- as required by law;
- for public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;
- to report adult abuse, neglect, or domestic violence

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Acknowledgement of Receipt of HIPAA Privacy Practices Notice

SECTION A: The Patient

Name: _____

Date of Birth: _____

SECTION B: Acknowledgement of Receipt of Privacy Practices Notice

By signing below, I acknowledge that I have reviewed a copy of the Privacy Practices Notice from the above-named practice.

Signature: _____ Date: _____

Print Name: _____ Relationship to Patient:_____

SECTION C: (For Office Use Only) Good Faith Effort to obtain Acknowledgement

Describe your faith effort to obtain the individual's signature on this form:

_____
_____
_____

Describe the reason why the individual would not sign this form:

_____
_____
_____