

WELCOME

1

About Your Child

Today's Date: ____ / ____ / ____ File #: ____

Child's Name: _____
LAST FIRST M.I.

Child's Nickname: _____ ☐ Boy ☐ Girl

Child's Birthdate: ____ / ____ / ____ Age: ____

School: _____ Grade: ____

Child's Home Phone #: (____) _____

Child's SS#: _____

Child's Address: _____
HOME ADDRESS

CITY STATE ZIP

Referred By: _____
(If doctor, please give address & phone number.)

2

Insurance Information

Primary Dental Insurance

Co. Name: _____

Address: _____

CITY STATE ZIP

Phone #: _____

Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ____ / ____ / ____

Insured's Employer: _____

Does either policy cover Orthodontics? ☐ Yes ☐ No

Secondary Dental Insurance

Co. Name: _____

Address: _____

CITY STATE ZIP

Phone #: _____

Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ____ / ____ / ____

Insured's Employer: _____

3

Child's Family Information

Who is accompanying this child today?

FULL NAME (IF OTHER THAN PARENT) RELATION TO CHILD

Do you have Legal Custody of this Child? ☐ Yes ☐ No

How many Brothers/Sisters? _____ Age(s): _____

MOTHER'S NAME ☐ STEP MOTHER ☐ GUARDIAN EMAIL ADDRESS

(☐ CHECK IF SAME AS CHILD'S) HOME ADDRESS CITY STATE ZIP

(____) (____) (____)
HOME PHONE # WORK PHONE # EXT.

MOTHER'S SOCIAL SECURITY # DATE OF BIRTH MOTHER'S DRIVERS LIC. #

Employer: _____ How Long? _____

EMPLOYER'S ADDRESS CITY STATE ZIP

FATHER'S NAME ☐ STEP FATHER ☐ GUARDIAN EMAIL ADDRESS

(☐ CHECK IF SAME AS CHILD'S) HOME ADDRESS CITY STATE ZIP

(____) (____) (____)
HOME PHONE # WORK PHONE # EXT.

FATHER'S SOCIAL SECURITY # DATE OF BIRTH FATHER'S DRIVERS LIC. #

Employer: _____ How Long? _____

EMPLOYER'S ADDRESS CITY STATE ZIP

4

Account Information

Person ultimately responsible for account

Name: _____ RELATION TO CHILD

Billing Address: _____

CITY STATE ZIP

SOCIAL SECURITY # DATE OF BIRTH DRIVERS LIC. #

(____) (____) (____)
WORK PHONE #: EXT. CELL PHONE #:

Payment method: ☐ Cash ☐ Check

☐ Credit Card - Enter card # above (if accepted)

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

Please Continue On Back

5

Child's Dental Information

Reason for today's visit: ☐ Exam ☐ Emergency ☐ ConsultationIs Child in pain? ☐ No ☐ Yes How Long? _____Please indicate ☒ any of the following problems:

- ☐ Discomfort, clicking or popping in jaw. ☐ Lost/Broken Filling(s) ☐ Stained teeth
☐ Red, swollen or bleeding gums. ☐ Teeth grinding ☐ Locking Jaw
☐ Sensitive tooth, teeth or gums. ☐ Ringing in Ears ☐ Bad breath
☐ Blisters/Sores in or around the mouth. ☐ Broken/Chipped tooth ☐ Loose tooth
☐ Other(s): _____

Does child require pre-medication? ☐ Yes ☐ No ☐ Don't know

Previous Dentist: _____ (_____) _____

Last Dental exam: ____ / ____ / ____ Last Dental X-rays: ____ / ____ / ____

Times a day child brushes? _____ Times a week child flosses? _____

Is the child's water fluoridated? ☐ Yes ☐ No

How would you rate the child's smile? Best 1 2 3 4 5 6 7 8 9 10 Worst

6

Child's Medical History

 Is Child taking any of the following medications? ☐ Pain killers (INCLUDING ASPIRIN) ☐ Ritalin ☐ Stimulants
☐ Blood Thinners ☐ Tranquilizers ☐ Insulin ☐ Muscle relaxers ☐ Others: _____

 Child's Physician: _____ (_____) _____
 DOCTOR'S NAME OR CLINIC NAME PHONE#

Last Medical Exam: ____ / ____ / ____

ADDRESS CITY STATE ZIP

Does Child have or ever had any of the following diseases, medical conditions or procedures?

- | | | |
|------------------------------------|--|---|
| Y N Heart Murmur | Y N Tonsillitis | Y N High/Low Blood Pressure |
| Y N Rheumatic fever | Y N Respiratory Problems | Y N Hepatitis |
| Y N Artificial Heart Valves | Y N Asthma/Difficulty Breathing | Y N Artificial Bones/Joints/Implants |
| Y N Congenital Heart defect | Y N Blood Transfusion(s) | Y N Liver/Kidney/Organ Problems |
| Y N Scarlet Fever | Y N Leukemia/Anemia | Y N HIV+/AIDS/ARC |
| Y N Surgeries/Operations | Y N Diabetes/Hypoglycemia | Y N Tuberculosis TB |
| Y N Cancer/Tumors | Y N Hemophilia | Y N Psychiatric Problems |
| Y N Chemotherapy | Y N Abnormal Bleeding | Y N Hyper Active/ADD |
| Y N Jaw Problems TMJ/TMD | Y N Cleft Lip/Palate | Y N Fainting/Seizures/Epilepsy |
| Y N Hearing Problems | Y N Birth Defects | Y N Cerebral Palsy |

Please list any other medical condition(s) child has or ever had: _____

 Is Child allergic to: ☐ Latex ☐ Penicillin/Amoxicillin ☐ Tetracycline ☐ Dental Anesthetics (Novocaine)
☐ Aspirin ☐ Food allergies ☐ Other(s): _____
Please rate the child's general health from 1-10: ____ Does child wear contact lenses? ☐ Yes ☐ NoHas this child ever taken the drug Ritalin? ☐ No ☐ Yes/How long? ____ Child's Blood type: ____
 Does this child do any of the following? ☐ Thumb/Finger Sucking ☐ Tongue Thrusting/Sucking
☐ Heavy Snoring ☐ Mouth Breathing ☐ Lip Sucking/Biting

■ We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.

■ Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

■ I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

■ I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

I acknowledge that I have received a copy of the Summary of Privacy Notice.

Initials

Signature

Date

☐ Parent or Guardian ☐ Other:UPDATE
(OFFICE USE)

Initials / Date

Comments

Initials / Date

Comments

Initials / Date

Comments

Dr. Susan A. Hockaday DDS, PA
1433 Emerywood Drive
Charlotte, North Carolina 28210

Financial Agreement

We, the staff of Dr. Hockaday, thank you for choosing us as your dental provider. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with the highest level of care and to building a successful provider-patient relationship with you and your family. We believe the understanding of your financial responsibility is vital to that provider-patient relationship, and our goal is inform you of the provisional aspects of that financial policy but also to keep the lines of communication open regarding them. If at any time you have any questions or concerns regarding our fees, policies, or responsibilities please feel free to contact our office @ **704-553-2348**.

Please understand that payment for services is an important part of the provider-patient relationship. If you do not have insurance, proof of insurance, or participate in a plan that will not honor an assignment of insurance benefits, payment for services **will be due at time of service** unless a payment arrangement has been approved in advance by our staff.

We realize that temporary financial problems may affect timely payment on your account. If this should occur, please contact us for assistance in the management of your account. Our goal is to provide quality care and service. Please let us know immediately if you require any assistance or clarification from anyone within our business.

We make payment as convenient as possible by accepting (cash, money order, check, Mastercard, Visa, American Express, Discover, Care Credit, Flex Spending account). A \$50.00 **service fee** will be charged for all returned checks.

Interest

Interest will be charged if a balance remains after 90 days from the date of service. Interest will be charged at a rate of 18%.

Insurance

Please remember that your insurance policy is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy. We have found that patients who are involved with their claims process are more successful at receiving prompt and accurate payment services from their insurance carrier. We do expect patients to be interactive and responsible for communicating with your insurance carrier on any open claims.

It is your responsibility to provide all necessary insurance eligibility, identification, authorization and referral information and to notify our office of any information changes when they occur. Even a preauthorization of services does not guarantee payment from

our insurance carrier. We also require photo identification when accepting insurance information. It is the patient's responsibility to know if our office is participating or non-participating with their insurance plan. Failure to provide all required information may necessitate patient payment for all charges. When insurance is involved, we are contractually obligated to collect co-payments, co-insurance, and deductibles, as outlined by your insurance carrier.

Missed Appointments

We require notice of cancellations **24 hours in advance**. This allows us to offer the appointment to another patient. If you fail to keep your appointments without notifying us in advance: a **missed appointment fee of \$45 will apply**. Three (3) missed appointments may cause you to be discharged from the practice so that we can provide care to other patients. We reserve the right to reschedule your appt, if you are more than 15 minutes late.

Medical Records Fees

Patients are entitled under federal law to have access to their protected health information and we follow all rules, guidelines, and exceptions to ensure compliance to patient rights. However, providers also have the right to compensation for records and our fees are a reasonable cost-based fee for copies including the copying, supplies, labor and postage of the files, and or summaries.

Timeliness of Appointments

We try to see everyone in a timely manner, but if you have been waiting more than 10 minutes, please notify the front desk, so that we can best serve your needs and reschedule you if necessary.

I have read and understand the above financial policy. I agree to assign insurance benefits to Dr. Hockaday whenever applicable. I also agree, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections if such action becomes necessary.

Print Name

Signature of Authorized Representative

Date: _____

(Name of Practice)

**Acknowledgement of Receipt
Of Notice of Privacy Practices**

Patient Name & Address: _____

I have received a copy of the Notice of Privacy Practices for the above named practice.

Signature

Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ☐ An emergency existed & a signature was not possible at the time.
- ☐ The individual refused to sign.
- ☐ A copy was mailed with a request for a signature by return mail.
- ☐ Unable to communicate with the patient for the following reason:

☐ Other: _____

Prepared By _____

Signature _____

Date _____

Authorization for Release of Information – Compound Release

Name of Patient _____	Date of Birth _____
_____ is authorized to release protected health information about the above named patient in the following manner and/or to selected persons.	

Check each person/entity approved to receive information.	Check type of information that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Results of lab tests/x-rays ☐ Other _____
☐ Other person (s) (provide name and phone number)	☐ Financial ☐ Medical
☐ Email communication-Provide email address* _____ *For email communication to occur, please accept the disclosure below:	☐ Financial ☐ Medical ☐ Appointment reminders ☐ Breach notification
☐ Text communication – Provide number * _____ *For text communication to occur, accept the disclosure below:	☐ Appointment reminder ☐ Other: _____
☐ For email and/or text communication I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.	
☐ Photo of patient received by patient or legal guardian ☐ Photo taken by staff (Example: pre/post procedure) ☐ Other	☐ May be posted in office ☐ May be posted on website ☐ Other _____

Patient Rights: - I have the right to revoke this authorization at any time by contacting our office. - I may inspect or copy the protected health information to be disclosed as described in this document. - Revocation is not effective in cases where the information has already been disclosed but will be effective going forward. - 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 have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

 Signature of Patient or Personal Representative

Date _____

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

Revised Jan 2018

SUSAN A. HOCKADAY, DDS, PA
Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

**If you have any questions about this Notice please contact the Privacy Officer:
Dr. Susan Hockaday**

Effective Date: April 14, 2003

Revised: 9/16/2013

We are committed to protect the privacy of your personal health information (PHI).

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI.

We are required by law to maintain the privacy of your PHI. We will follow the terms outlined in this Notice.

We may change our Notice, at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised Notice by:

- Posting the new Notice in our office.
- If requested, making copies of the new Notice available in our office or by mail.
- Posting the revised Notice on our website: **www.hockadayandbaucomdds.com**

Uses and Disclosures of Protected Health Information

We may use or disclose (share) your PHI to provide health care treatment for you.

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you.

EXAMPLE: Your PHI may be provided to a physician to whom you have been referred for evaluation to ensure that the physician has the necessary information to diagnose or treat you. We may also share your PHI from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

We may also share your PHI with people outside of our practice that may provide medical care for you such as home health agencies.

We may use and disclose your PHI to obtain payment for services. We may provide your PHI to others in order to bill or collect payment for services. There may be services for which we share information with your health plan to determine if the service will be paid for.

PHI may be shared with the following:

- Billing companies
- Insurance companies, health plans
- Government agencies in order to assist with qualification of benefits
- Collection agencies

EXAMPLE: You are seen at our practice for a procedure. We will need to provide a listing of services such as x-rays to your insurance company so that we can get paid for the procedure. We may at times contact your health care plan to receive approval PRIOR to performing certain procedures to ensure the services will be paid for. This will require sharing of your PHI.

We may use or disclose, as-needed, your PHI in order to support the business activities of this practice which are called health care operations.

EXAMPLES:

- Training students, other health care providers, or ancillary staff such as billing personnel to help them learn or improve their skills.
- Quality improvement processes which look at delivery of health care and for improvement in processes which will provide safer, more effective care for you.
- Use of information to assist in resolving problems or complaints within the practice.

We may use and disclose your PHI in other situations without your permission:

- If required by law: The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. For example, we may be required to report gunshot wounds or suspected abuse or neglect.
- Public health activities: The disclosure will be made for the purpose of controlling disease, injury or disability and only to public health authorities permitted by law to collect or receive information. We may also notify individuals who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.
- Health oversight agencies: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
- Legal proceedings: To assist in any legal proceeding or in response to a court order, in certain conditions in response to a subpoena, or other lawful process.
- Police or other law enforcement purposes: The release of PHI will meet all applicable legal requirements for release.
- Coroners, funeral directors: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law
- Medical research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
- Special government purposes: Information may be shared for national security purposes, or if you are a member of the military, to the military under limited circumstances.

- Correctional institutions: Information may be shared if you are an inmate or under custody of law which is necessary for your health or the health and safety of other individuals.
- Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Other uses and disclosures of your health information.

Business Associates: Some services are provided through the use of contracted entities called "business associates". We will always release only the minimum amount of PHI necessary so that the business associate can perform the identified services. We require the business associate(s) to appropriately safeguard your information. Examples of business associates include billing companies or transcription services.

Health Information Exchange: We may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care.

Treatment alternatives: We may provide you notice of treatment options or other health related services that may improve your overall health.

Appointment reminders: We may contact you as a reminder about upcoming appointments or treatment. We may leave you a message to remind you of an appointment.

We may use or disclose your PHI in the following situations UNLESS you object.

- We may share your information with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. For example, we may discuss post procedure instructions with the person who drove you to the facility unless you tell us specifically not to share the information.
- We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.
- We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts.

The following uses and disclosures of PHI require your written authorization:

- Marketing
- Disclosures of for any purposes which require the sale of your information

All other uses and disclosures not recorded in this Notice will require a written authorization from you or your personal representative.

Written authorization simply explains how you want your information used and disclosed. Your written authorization may be revoked at any time, in writing. Except to the extent that your doctor or this practice has used or released information based on the direction provided in the authorization, no further use or disclosure will occur.

Your Privacy Rights

You have certain rights related to your protected health information. All requests to exercise your rights must be made in writing. You may contact Dr. Hockaday at office@drhockadaydds.com with your requests.

You have the right to see and obtain a copy of your protected health information.

This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. If requested we will provide you a copy of your records in an electronic format. There are some exceptions to records which may be copied and the request may be denied. We may charge you a reasonable cost based fee for a copy of the records.

You have the right to request a restriction of your protected health information.

You may request for this practice not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. We are not required to agree with these requests. If we agree to a restriction request we will honor the restriction request unless the information is needed to provide emergency treatment.

There is one exception: we must accept a restriction request to restrict disclosure of information to a health plan if you pay out of pocket in full for a service or product unless it is otherwise required by law.

You have the right to request for us to communicate in different ways or in different locations.

We will agree to reasonable requests. We may also request alternative address or other method of contact such as mailing information to a post office box. We will not ask for an explanation from you about the request.

You may have the right to request an amendment of your health information.

You may request an amendment of your health information if you feel that the information is not correct along with an explanation of the reason for the request. In certain cases, we may deny your request for an amendment at which time you will have an opportunity to disagree.

You have the right to a list of people or organizations who have received your health information from us.

This right applies to disclosures for purposes other than treatment, payment or healthcare operations. You have the right to obtain a listing of these disclosures that occurred after April 14, 2003. You may request them for the previous six years or a shorter timeframe. If you request more than one list within a 12 month period you may be charged a reasonable fee.

Additional Privacy Rights

- You have the right to obtain a paper copy of this notice from us, upon request. We will provide you a copy of this Notice the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible.
- You have a right to receive notification of any breach of your protected health information.

Complaints

If you think we have violated your rights or you have a complaint about our privacy practices you can contact:

Dr. Susan Hockaday
704-553-2348
Office@drhockadaydds.com

You may also complain to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

If you file a complaint we will not retaliate against you for filing a complaint.

This notice was published and becomes effective on April 13, 2003.

PATIENT CODE OF CONDUCT

We are committed to ensuring a safe and comfortable environment. By working together in mutual respect and cooperation, we can achieve the best possible outcomes for your care.

This Code of Conduct outlines the behaviors expected of all patients in our office and informs you of the potential consequences of noncompliance.

BEHAVIORAL EXPECTATIONS

- I will address any concerns with the doctor or staff members calmly and respectfully.
- I will refrain from any form of verbal or physical abuse, harassment, aggression, violence, or any behavior that causes disruption or intimidation.
- I will respect other patients' rights, safety and privacy.
- I will not take photos or share images from inside the office on social media, as this may violate another patient's privacy.
- I will not use AI-enabled devices (such as smart glasses, recording assistants, or other wearable/voice activated tools) within the office, as they may compromise patient privacy.
- I will not bring strong scents of smoke or marijuana odors into the office space, for the comfort and health of our staff and patients.

CONSEQUENCES OF NON-COMPLIANCE

If I fail to comply with this Code of Conduct, appropriate measures will be taken to ensure the safety and comfort of other patients and staff. This may include notifying law enforcement and, if necessary, my dismissal from the practice.

I agree to follow the above conditions during my visit to Dr. Susan Hockaday DDS, PA.

By signing below, I confirm that I understand and accept these terms.

Patient Name: _____

Date: _____

Signature: _____