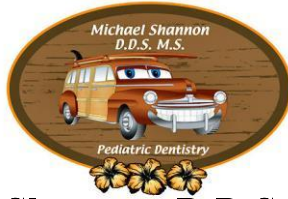

Michael A. Shannon, D.D.S., M.S., Inc.
Pediatric Dentistry

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PATIENT INFORMATION

Name ____ Nickname _________________ Sex: Male / Female
First Middle Last

DOB _____/ ____/ ____ Age _____ Weight _____lbs. Name of School __________________________ Grade _____

Child's Home Address ____________________________________ City _________________ Zip ___________

PARENTS/GUARDIANS INFORMATION

Name ______________________ Relationship to Child______________ SSN _____-___-_____ DOB _____/ ____/ ____

Check here if address is same as child's: ☐

Address_____________________________ City____________________________ Zip___________

Best Phone #(____) _____-_______ Alternate Phone #(____) _____-_______ E-Mail____________________________

Occupation _________________Work Phone #(____) _____-_______ Marital Status: Married / Divorced / Widowed / Single

Name ______________________ Relationship to Child______________ SSN ____-___-_____ DOB _____/ ____/ ____

Check here if address is same as child's: ☐

Address_____________________________ City____________________________ Zip___________

Best Phone #(____) _____-_______ Alternate Phone #(____) _____-_______ E-Mail________________________________

Occupation _________________Work Phone #(____) _____-_______ Marital Status: Married / Divorced / Widowed / Single

MEDICAL HISTORY

Please answer the following questions as thoroughly as possible and circle the appropriate responses.

Describe your child's overall physical health: Excellent / Good / Fair / Poor

1. Is your child currently under the care of a physician? Y / N
   If yes, please describe ____
2. Has your child had any serious illness or injury? Y / N
   If yes, please describe (include age) ____
3. Have your child's tonsils or adenoids been removed? Y / N
4. Is your child current on all vaccinations? Y / N
5. Has your child ever had any of the following:

Abnormal Bleeding	Y / N	Congenital Birth Defect	Y / N	Heart Murmur	Y / N	Rheumatic Fever	Y /N
AIDS/HIV	Y / N	Congenital Heart Defect	Y / N	Hemophilia	Y / N	Scarlet Fever	Y / N
Allergies	Y / N	Diabetes	Y / N	Hepatitis	Y / N	Seizures	Y / N
Anemia	Y / N	Endocrine Disorders	Y / N	Hives	Y / N	Sickle Cell Anemia	Y / N
Asthma	Y / N	Epilepsy	Y / N	Kidney Problems	Y / N	Sinus Problems	Y / N
Bleeding Disorders	Y / N	Frequent Infections	Y / N	Liver/GI Problems	Y / N	Shortness of Breath	Y / N
Blood Pressure	Y / N	Hearing Impaired	Y / N	Lupus	Y / N	Significant Injuries	Y / N
Blood Transfusions	Y / N	Behavioral Disabilities	Y / N	Measles	Y / N	Tonsillitis	Y / N
Breathing Problems	Y / N	Learning Disabilities	Y / N	Mitral Valve Prolapse	Y / N	Tuberculosis	Y / N
Bone Disorders	Y / N	Mental Disabilities	Y / N	Mononucleosis	Y / N	Thyroid Problems	Y / N
Cancer/Tumors	Y / N	Physical Disabilities	Y / N	Recurrent Headaches	Y / N	Vision Problems	Y / N
Chicken Pox	Y / N	Growth Problems	Y / N	Heart Problems	Y / N		

Does your child have any disease, condition or problem not listed above? ________________________________

Name of child's pediatrician ________________________ City ______________________ Phone #(___) ______ - _________

Please list **ALL medications** your child is currently taking ____

Please list **ALL allergies** your child has, including to medication _____________________________________

DENTAL HISTORY

Please answer the following questions as thoroughly as possible and circle the appropriate responses.

1. Who may we thank for referring you?____
2. Is this your child's first dental visit? Y/N

Previous Dentist: ________________________Date of Last Dental Exam: ____/____/____ Date of Last Cleaning: ____/____/____

3. What is your reason for bringing your child to the dentist today? ____
4. Has your child experienced any problems with previous dental work? Y / N

   If yes, please explain ____

5. Is your child nervous or frightened about dental visits? Yes / Somewhat / No
6. Have there been any injuries to your child's teeth, jaw or chin? Y / N

   If so, please explain ____

7. Does your child take fluoride supplements or drink fluoridated water? Y / N
8. Has your child ever been seen by an orthodontist? Y / N

   If yes, name: _____________________________ Date: _________________ Location: ________________________

9. Does your child brush his/her teeth daily? Y / N Do they require parental help? Y/N
10. Does your child floss his/her teeth daily? Y / N Do they require parental help? Y/N
11. Does your child have any of the following:

Sleep Apnea	Y / N	Clenching/Grinding	Y / N	Speech Problems	Y / N
Thumb/Finger/Lip Sucking	Y / N	Chewing on Objects	Y / N	Mouth-breathing	Y / N
Nursing Bottle Habits	Y / N	Tongue Thrust	Y / N	TMJ/TMD Pain	Y / N
Pacifier Sucking Habits	Y / N	Snoring	Y / N	Nail Biting/Lip Sucking	Y / N

DENTAL PPO INSURANCE INFORMATION

Name of Primary Insurance Company ____________________________ Insurance Co. Phone # (____) _____ -_______

Insurance Co. Address ____________________________ City _______________________ State_____ Zip________

Policy Holder's Name ________________________________Group # _______________ID #__________________________

Relationship _______________ D.O.B. _____ / _____ / _____ SSN _____ / ____ / _____

Policy Holder's Address ____ City ___________________ Zip ____________

Occupation ________________________________ Policy Holder's Employer ____

Employment Address _______________________ City _____________ Zip _________ Phone # (____) _____-_______

Name of Secondary Insurance Company __________________________ Insurance Co. Phone # (____) _____ -_______

Insurance Co. Address ____________________________ City _______________________ State_____ Zip________

Policy Holder's Name ________________________________ Group # _______________ID #__________________

Relationship _______________ D.O.B. _____ / _____ / _____ SSN _____ / ____ / _____

Policy Holder's Address ____ City ___________________ Zip ____________

Occupation ________________________________ Policy Holder's Employer ____

Employment Address _______________________ City _____________ Zip _________ Phone # (_____) _____-_______

Cancellation Policy: We make every effort to accommodate the busy schedules of our patients and their families. If you are unable to attend your appointment for any reason, we require that you notify our office **AT LEAST 24 HOURS** in advance. If you do not notify us 24 hours in advance, you will be charged a $50 fee. (Initials) ______

To the best of my knowledge the information I have provided on this form is correct, and I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize Michael A. Shannon, D.D.S., M.S., Inc. Pediatric Dentistry to release any information including the diagnosis and the records of any treatment or exam rendered to my child during the period of such dental care to third party payers and/or other health practitioners. I have received a copy of this office's Notice of Privacy Practices (HIPAA). I consent to their use and disclosure of my children(s) Protected Health Information to carry out treatment, payment activities, and healthcare operations

Responsible Party Signature:____ Date:_________________

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Insurance Benefits Explanation

Your treatment plan will include a breakdown of all applicable fees, and we will inform you of all estimated costs before treatment is administered. Charges are payable at the time of treatment.

Please ask a member of our staff, and we will review our payment options to accommodate your financial needs. We also offer financing through Care Credit.

Additionally, we will submit all insurance claims for you. If we are not a provider within a certain insurance plan, we are still happy to submit your claim as an out-of-network doctor. We will fully attempt to help you receive full insurance benefits; however, you are personally responsible for your account, and we encourage you to contact us if your policy has not paid within 30 days.

We are PPO providers for:

We do accept all other PPO Plans as an out of network provider.

Please understand that we file dental insurance as a courtesy to our patients. We do not have a contract with your insurance company, only you do. **Although we are happy to assist you, please know that it is your responsibility to understand your policy**. We will assist you in estimating your portion of the cost of treatment, but we at no time guarantee what your insurance will or will not pay with each claim. Please keep in mind the following:

Fact 1 - BENEFITS ARE NOT DETERMINED BY OUR OFFICE

Insurance policies are contracts between the insurance company and you, or your employer. Our financial arrangements for dental services are made with you, not with your insurance company.

Fact 2 - NO INSURANCE PAYS 100% OF ALL PROCEDURES

Dental insurance is intended to be an aid in paying for dental care. Most dental plans pay between 50% - 80% of the total fee. This percentage is determined by how much you or your employer has paid for the coverage, or the type of contract set up with the insurance company. At times, you may be notified by your insurance company that its reimbursement rates are lower than our actual fees. Often, insurance companies will state that your reimbursement has been lowered because a dentist's fees exceed the "usual and customary rates" (UCR). This is misleading. There are hundreds of insurance companies that offer dental insurance, and each company sets its own schedule for what they consider allowable. These allowable rates vary greatly.

"Estimate of Benefits" (EOB) reports you may receive may imply that your dentist is charging higher fees for your area or "overcharging" rather than saying that they are "underpaying" or stating that your plan's benefits are lower than usual and customary.

Fact 3 - DEDUCTIBLES & CO-PAYMENTS MUST BE CONSIDERED

When estimating dental benefits you must consider deductibles and percentages. Most dental plans have an annual deductible for restorative procedures. For example, assume the fee for a certain service is $150. Assuming that the insurance company allows $150 as its "usual and customary" fee, we can figure out what benefits will be paid. First an annual deductible, on average $50, is subtracted, leaving $100. The plan then pays 80% of $100, or $80. Beginning with a fee of $150, the insurance company will pay an estimated $80, leaving $70 to be paid by the patient. Of course, if the UCR is less than our fee, the insurance benefit will also be less. We will collect your co-payment and any deductibles at your time of service.

Responsible Party Signature:____ Date:______________

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INFORMED CONSENT FOR TREATMENT

I hereby authorize Dr. Michael Shannon and his staff to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my child's dental needs. I also authorize Dr. Shannon to perform all recommended and mutually agreed upon treatment, and to use the appropriate medication and therapy in connection with such treatment.

Informed consent indicates your awareness of, and agreement to, the various procedures performed at Michael Shannon Pediatric Dentistry. You understand that you have the right to ask any questions and we have the obligation to provide you with appropriate answers. It is our intent to provide the best possible dentistry for your child. We will always use warmth, friendliness, persuasion, humor and kindness. There are several other common behavior management techniques that are used by the dentist to protect the safety of your child, to eliminate disruptive behavior and to prevent the child from causing injury to themselves or others due to uncontrolled movements. The following are the techniques commonly used in our practice to sooth and calm an uncooperative patient:
Tell-Show-Do: The dentist and assistant explain to the child what will be done. We use simple terminology and repetition followed by a demonstration with instruments of what is to be done. The procedure will then be attempted on the child's mouth. Praise is used to reinforce cooperative behaviors.
Positive Reinforcement: These are techniques we use to reward the child for displaying desirable and cooperative behavior. Rewards may include praise, compliments, high-fives, prizes, or stickers.
I hereby acknowledge that I have read and that I understand the consent form. I hereby give authorization and consent to utilize the above techniques listed in conjunction with the treatment listed on my child's treatment plan.

Patient's Name:____

Responsible Party Name:______________________________ Relationship to Patient: ________________

Responsible Party Signature:____ Date:____________

Acknowledgement of receipt of Dental Materials Fact Sheet (DMFS) Available online or at the front desk:

Responsible Party Signature:____ Date:____________

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Financial Responsibility

It is our policy to discuss our fees and financial arrangements open and honestly with you. **Regardless of whether you have dental insurance or not, you are responsible for the full financial cost of dental treatment**.

If you have dental insurance all deductibles, co-payments, and portions of your bill that insurance does not cover are due at the time of service performed unless financial arrangements have been previously made with our office. For your convenience, we gladly accept personal checks, and most major credit cards. We also offer dental financing through Care Credit

If you have dental insurance, every effort will be made to estimate the portion of the total cost that may be covered by your dental insurance plan, however this is only an estimate. The day services are provided you will be responsible for your estimated portion as discussed on your financial arrangement plans. Our office will process an insurance claim for payment of dental treatment directly to us.

If we process your insurance claim, we will wait up to 30 days for payment from your insurance company. If we have not received payment, we will then bill you and have you contact your insurance company for payment of their portion to you. If we process your insurance claim and payment is denied or is less than our estimate of your coverage, you will be billed the remainder. Delinquent accounts will be charged a late fee of 1.5% per month. If you receive any communication from your insurance company about fees and / or dental services performed, please contact our office immediately.

When benefits are assigned directly to this office, if the insurance company sends a check to you in error, we will hold you responsible for immediate and complete reimbursement. If the insurance company has not paid the entire benefit available, we will hold you directly responsible for payment of the outstanding amount.

At any point during treatment, if the insurance company becomes uncooperative, we reserve the right to refuse to work with that insurance company and will look to you for payment of the remaining balance and you will have to settle with your insurance company.

If you do not have dental insurance, payment of all services are due at the time of service.

The mouth, gums, and teeth are constantly changing due to the progressive nature of dental disease. The actual costs of dental treatment may differ from the estimate due to our treatment of this progressive dental disease. In the event the actual costs of dental treatment differ from the estimated costs, you will be responsible for any additional cost. Every effort will be made to notify you if this occurs.

I certify that my child ____________________________ is covered by ____________________________Insurance Co. and I assign all insurance benefits directly to Dr. Shannon and Michael A. Shannon D.D.S., M.S., Inc. I understand that I am responsible for payment of all services rendered and am also responsible for paying co-payments and deductibles that my insurance does not cover. I hereby authorize Dr. Shannon to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

I assume financial responsibility for the above named child. I understand that payment is due on the day services are rendered. I authorize Michael A. Shannon, D.D.S., M.S., Inc. Pediatric Dentistry to collect payment from the insurance company. I understand that the insurance company may pay only a portion of my bill and that ultimately I am responsible for the full payment.

Thank you for selecting our office. We hope that should you have any questions regarding finances, financial arrangements, or dental insurance, you will feel free to talk to us at any time.

Patient's Name:____

Responsible Party Name:____ Relationship to Patient: ________________________

Responsible Party Signature:____ Date:_________________

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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.

We respect our legal obligation to keep heath information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPTIONS
The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). “Health care operations” mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we will ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION
In some limited situations, the law allows or requires us to use or disclose your health information with your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of foreign service;
- disclosures of de-identified information;
- disclosures relating to worker’s compensation programs;
- disclosures of a “limited data set” for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to “business associates” who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS
We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will notify you of appointment reminders via mail on a post card; e-mail; and/or text message. We may also leave you a reminder message on your home answering machine or with someone who answers your phone if you are not available.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.
If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person at the address, fax, or e-mail shown at the beginning of the Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION
The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax, or e-mail shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using e-mail to your personal e-mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send us a written request to the office contact person at the address, fax, or e-mail shown at the beginning of this Notice.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us, (or 60 days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax, or e-mail shown at the beginning of this Notice.
- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the correct information to persons who we know got the wrong information, and others that you specify. If do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax, or e-mail shown at the beginning of the Notice.
- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax, or e-mail shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax, or e-mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES
By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS
If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax, or e-mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION
If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

Acknowledgement of receipt of Michael Shannon DDS Notice of Privacy Practices:

Patient's Name:____

Responsible Party Name:__________________________ Relationship to Patient: ________________

Responsible Party Signature:______________________________ Date:____________