THE LIBBY GROUP
DENTAL HEALTH SPECIALISTS

Welcome to The Libby Group!
Our vision is to inspire collaborative health by providing you with the highest quality care.
Our goal is to create a comfortable experience each time you visit.

DENTAL HISTORY

Is this your child's first dental visit?
□ Yes □ No

Has your child ever had a bad dental experience?
□ Yes □ No

Does your child feel nervous about dental treatment?
□ Yes □ No

Does your child receive fluoride in vitamins, tablets, or water?
□ Yes □ No

HEALTH HISTORY

Is your child having any pain at this time? □ Yes □ No

Please list any medications/supplements your child is taking:

_____

_____

_____

When was your child's last routine medical exam? _____

Physician Name: _____

Please list any serious medical conditions, surgeries, and/or hospitalizations that your child has had:

_____

_____

_____

MEDICAL HISTORY

Y	N		Y	N		Y	N		Doctor Notes
□	□	ADHD / ADD	□	□	Diabetes: I II (circle)	□	□	Hepatitis A B C (circle)	_____
□	□	A.I.D.S / H.I.V	□	□	Down Syndrome	□	□	High Blood Pressure	
□	□	Asthma (Seasonal)	□	□	Epilepsy/Seizures	□	□	Low Blood Pressure	_____
□	□	Asthma (With Exercise)	□	□	Fainting/Dizzy Spells	□	□	Kidney Failure/Dysfunction	
□	□	Autism	□	□	Fever Blisters/Cold Sores	□	□	Liver Disease/Jaundice	_____
□	□	Anemia	□	□	Frequent Headaches	□	□	Mental Disability	
□	□	Bruise Easily	□	□	Hay Fever/Sinus Trouble	□	□	Rheumatic Fever	_____
□	□	Chemotherapy/Radiation	□	□	Heart Murmur	□	□	Psychiatric Treatment	
□	□	Congenital Heart Defect	□	□	Heart Surgery	□	□	Tuberculosis (TB)	_____
□	□	Cortisone Medication	□	□	Hemophilia/Bleed Easily	□	□	Thyroid Disease	

Have you ever been told that your child needs to be premedicated before dental treatment? □ Yes □ No

Is your child allergic or has reacted adversely to the following?

Y	N		Y	N	
□	□	Antibiotics	□	□	Aspirin
□	□	Codeine	□	□	Latex
□	□	Metals/Jewelry	□	□	Local/Dental Anesthetic

□ None

Is your child allergic to any medications or substances? If yes, please list:

_____

_____

_____

Patient Name _____ Parent/Guardian Signature _____ Date _____

PATIENT INFORMATION

Child's Name _____ DOB _____ Nickname _____

□ Male □ Female Who referred you? _____

Mother's Name _____ DOB _____ SSN _____

Cell Phone _____ Email _____

Father's Name _____ DOB _____ SSN _____

Cell Phone _____ Email _____

Address _____ City _____ State _____ Zip Code _____

Emergency Contact Name _____ Phone Number _____

INSURANCE BILLING

Would you like us to bill your dental insurance? □ Yes □ No

Insurance Company Name _____ Policy Holder Name _____

Member ID _____ Policy Holder DOB _____

HIPAA PRIVACY POLICY

I acknowledge that I have received a copy of the Notice of Privacy Practices for the office of The Libby Group. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health care information that might occur in my treatment, payment of services, or in the performance of the office's health care operations. This Notice of Privacy Practices also describes my rights and the responsibilities and duties of the office with respect to my protected health information. The Libby Group reserves the right to change the Privacy Practices that are described in the Notice of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Notice of Privacy Practices at the time of my first visit after the revisions become effective.

I authorize The Libby Group to share my child's information with the individual(s) listed below:

Name _____ Relationship _____

FINANCIAL GUIDELINES

As a courtesy, our team will gladly submit insurance claims on your behalf. We ask that you provide us with the most current dental insurance information and update us as often as changes occur. In addition, we ask that you review your plan and understand the details of coverage including: plan limitations, frequencies, waiting periods and maximums. Please also inform us if you have used benefits at another dental office within your plan year. We are happy to provide insurance and patient portion estimates to you. It is your responsibility to contact your insurance company if no payment has been made on a claim after 30 days from the date of service**. Regardless of insurance payment or non-payment, any balance incurred will ultimately be your responsibility.** We have a variety of payment options including Cash, Check, All Major Credit Cards, and Care Credit.

By signing this form, I acknowledge that I have read and agree to the above information. I understand that I am financially responsible for payment of any treatment provided, regardless of insurance payment or non-payment. I agree to keep my child's account balance in good standing by closing all balances greater than 45 days past any and all dates of service.

PATIENT CONSENT

I authorize The Libby Group to provide treatment for my child based on his/her oral health care needs. I agree to communicate any changes to my child's medical condition(s) at each visit. I understand that I will be informed of any treatment needed for my child and agree to services, regardless of insurance.

Parent/Guardian Signature _____ Date_____

Doctor Signature _____ Date_____

THE LIBBY GROUP
DENTAL HEALTH SPECIALISTS

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 Feb 1st, 2011, 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 you treatment.

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 the person's involvement in 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 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, we will charge you $25.00. 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:	Dr. Justin Libby
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