Harmony
pediatric dentistry & orthodontics

PATIENT REGISTRATION

Patient's Name: _____ Date of Birth: _____

Address: _____

City: _____ State:_____ Zip Code: _____

Parent/Legal Guardian Name: _____ Relationship: _____

Parent's Cell Phone Number: _____ Email Address: _____

Occupation: _____

Parent/Legal Guardian Name: _____ Relationship: _____

Parent's Cell Phone Number: _____ Email Address: _____

Occupation: _____

Alternative Caregiver Name: _____ Relationship: _____

Cell Phone Number: _____ Email Address: _____

Responsible Party (person responsible for payment on account): _____

Who will be accompanying child to appointments: _____ Relationship: _____

Who is your/your child's dentist? _____ Orthodontist? _____

Whom can we thank for referring you to our practice? _____

Primary Insurance Information:

Subscriber Name: _____ Subscriber Date of Birth: _____

Employer: _____ Insurance Carrier: _____

Insurance Phone Number: _____ Group Number: _____

Subscriber ID Number or Social Security Number: _____

**Metlife subscribers must provide social security number*

Secondary Insurance Information:

Subscriber Name: _____ Subscriber Date of Birth: _____

Employer: _____ Insurance Carrier: _____

Insurance Phone Number: _____ Group Number: _____

Subscriber ID Number or Social Security Number: _____

Signature of Parent/Legal Guardian: _____ Date: _____

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Pediatric Medical History

Child's Legal Name: _____ Preferred Name: _____ Date of Birth: _____

Birth Sex: _____ Current gender identity: _____ Pronouns: _____ Race/Ethnicity: _____

Primary Physician: _____ Phone number: _____ Last visit: _____

Current/Former Dentist: _____ Phone number: _____ Last visit: _____

Were x-rays taken of the teeth or jaws? YES NO Date of most recent dental x-rays: _____

Is your child being treated by a physician at this time? Reason: _____	YES	NO
Is your child taking any medication, vitamins, or supplements?.....	YES	NO
List names: _____		
Has your child ever been hospitalized, had surgery or a significant injury in an emergency department?.....	YES	NO
List date & describe: _____		
Has your child ever had a reaction to or problem with anesthetic? Describe: _____	YES	NO
Have you been told your child need antibiotics or other another medicine before dental treatment?.....	YES	NO
Reason: _____		
Has your child ever had a reaction or allergy to an antibiotic, sedative, or other medication?	YES	NO
List: _____		
Is your child allergic to latex or anything else such as metals, acrylic, or dye? List:_____	YES	NO
Is your child up to date on immunizations against childhood disease?.....	YES	NO

Please mark YES if your child has a history of the following conditions. For each YES, provide details in the box at the bottom of this list. Mark NO after each line if none of those conditions applies to your child.

Complications before/at birth, prematurity, inherited conditions, or birth defects (such as cleft lip/palate)...	YES	NO
Problems with physical growth or development	YES	NO
Sinusitis, chronic adenoid/tonsil infections	YES	NO
Sleep apnea, snoring, or mouth breathing.....	YES	NO
Congenital heart defect/disease, heart murmur, rheumatic heart disease	YES	NO
Irregular heartbeat or high blood pressure	YES	NO
Asthma, reactive airway disease, wheezing, or breathing problems	YES	NO
Cystic fibrosis	YES	NO
Frequent colds or coughs, or bronchitis; pneumonia	YES	NO
Jaundice, hepatitis, or liver problems	YES	NO
Gastroesophageal/acid reflux disease (GERD), stomach ulcer, or intestinal problems	YES	NO
Lactose intolerance, food allergies, nutritional deficiencies, or dietary restrictions	YES	NO
Current/history of eating disorder	YES	NO
Bladder or kidney problems; bedwetting	YES	NO
Fine/gross motor deficits, arthritis, limited use of arms or legs, muscle/bone/joint problems, or scoliosis.....	YES	NO
Rash/hives, eczema, or skin problems	YES	NO
Impaired vision, visual processing, hearing, or speech	YES	NO
Developmental disorders, learning problems/delays, or intellectual disability	YES	NO
Cerebral palsy, brain injury, concussion, epilepsy, or convulsions/seizures	YES	NO
Autism/ASD or sensory integration disorder	YES	NO
Recurrent or frequent headaches/migraines, fainting, or dizziness	YES	NO
Hydrocephaly or placement of a shunt (ventriculoperitoneal, ventriculoarterial, ventriculovenous)	YES	NO
Attention deficit/hyperactivity disorder (ADD/ADHD)	YES	NO
Behavioral, emotional, communication, or psychiatric problems/treatment	YES	NO
Diabetes, hyperglycemia, or hypoglycemia	YES	NO

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Precocious puberty or hormonal problems	YES	NO
Thyroid or pituitary problems.....	YES	NO
Anemia, sickle cell disease/trait, or blood disorder	YES	NO
Hemophilia, bruising easily, or excessive bleeding	YES	NO
Transfusions or receiving blood products	YES	NO
Cancer, tumor, other malignancy; chemotherapy, radiation therapy, or bone marrow, or organ transplant..	YES	NO
Cytomegalovirus (CMV), (HIV)/AIDS, methicillin resistant, staphylococcus aureus (MRSA), mononucleosis, scarlet fever, sexually transmitted disease (STD), or tuberculosis (TB)	YES	NO

PROVIDE DETAILS HERE: _____

_____

_____

Is there any other significant medical history pertaining to this child or their family that the dentist should know? NO

If YES, describe _____

What is your primary concern about your child's oral health? _____

How would you describe your child's oral health? Excellent Good Fair poor

Is there a family history of cavities? _____ If yes, indicate all that apply: Mother Father Brother Sister

Does your child have a history of any of the following? For each YES response, please describe:

Inherited dental characteristics	YES	NO	_____
Mouth sores or fever blisters	YES	NO	_____
Bad breath	YES	NO	_____
Bleeding gums	YES	NO	_____
Cavities/decayed teeth	YES	NO	_____
Toothache	YES	NO	_____
Injury to teeth, mouth, or jaws	YES	NO	_____
Clenching/grinding their teeth	YES	NO	_____
Jaw joint problems (popping, etc)	YES	NO	_____
Excessive gagging	YES	NO	_____

Sucking habit after one year of age YES NO Which? Finger Thumb Pacifier Other

How often does your child brush their teeth? _____ times per _____ Does someone help? YES NO

How often does your child floss their teeth? Never Occasionally Daily Does someone help? YES NO

Please check all sources of fluoride your child receives:

Drinking water toothpaste Over-the-counter rinse Prescription rinse/gel Fluoride treatment at dentist
Prescription drops/tablet/vitamins Fluoride varnish by pediatrician or other practitioner Other:_____

Is your child on a special or restricted diet? YES NO Describe: _____

Is your child a picky eater? YES NO Describe: _____

Does your child participate in any sports or similar activities? YES NO if YES, _____

Does your child wear a mouthguard during these activities? YES NO

Has your child ever had orthodontic treatment? YES NO When? _____

Has your child ever had a difficult dental appointment? YES NO Describe: _____

Is there anything else we should know before treating your child? _____

_____

_____	_____	_____	_____
Signature of parent/guardian	Relationship	Date	Signature of Staff reviewing

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.

Harmony Pediatric Dentistry and Orthodontics, hereafter referred to as "Practice," is committed to preserving the privacy and confidentiality of your health information. This Notice of Privacy Practices (NPP) describes how we may use and disclose your protected health information, hereafter referred to as "PHI," to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. 45 CFR§ 164.520. This Notice has been revised to conform to HIPAA's Final Rule referred to as the "Omnibus Rule" published 01/25/13. This notice replaces previous versions of the Notice and is effective 10/15/2020. You may access or obtain a copy according to the following options: 1) our website at www.harmonybethesda.com 2) contact the office and request a copy to be sent to you by mail or email, 3) request a copy at the time of your next appointment.

1. USES & DISCLOSURES OF PHI. How We Use Your Information: Your PHI may be used and disclosed by our Practice's provider, administrative and or clinical staff and others outside of our Practice who are involved in your care and treatment for the purpose of providing healthcare services to you.

A) Treatment: We will use and disclose your PHI to provide, coordinate or manage your care and any related services. We may disclose PHI to other providers who may be treating you such as a specialist.

B) Payment: We will use your PHI to obtain payment for the services provided by this Practice. For example, if we are working with your insurance plan, we may verify eligibility or coverage for benefit determination. We may use or disclose your information so that a bill may be sent to you that may include services provided.

C) Healthcare Operations: The Practice may use or disclose, as needed, your PHI to support its business activities such as quality performance reviews regarding our services or the performance of our staff.

i) Business Associates: We may share your PHI with third party business associates such as answering services, transcriptionists, billing services, consultants, trainers, and legal counsel. We obtain a written agreement with business associates to assure the protection and privacy of your PHI.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object: We may use or disclose your PHI in the following situations without your authorization or providing you the opportunity to agree or object as follows:

D) Required or Permitted by Law: We may use or disclose your PHI as required by law. This may include public health activities such as controlling a communicable disease or compliance with health oversight agencies authorized by law. We may disclose PHI to a public health authority authorized to receive reports of child abuse or neglect. We may disclose your PHI if we believe you have been a victim of abuse, neglect or domestic violence to a governmental agency authorized to receive such information in compliance with state and federal law. We may disclose your PHI to the Food and Drug Administration for the quality, safety, or effectiveness of FDA-regulated products or activities. We may disclose your PHI in the course of a legal proceeding in response

to a subpoena, discovery request or other lawful process. We may also disclose PHI to law enforcement providing applicable legal requirements are satisfied. We may disclose PHI to a coroner or medical examiner for identification purposes. We may disclose PHI to researchers when the information does not directly identify you as the source of the information and such research has been approved by an institutional review board to ensure the privacy of the PHI. We may disclose PHI as authorized to comply with workers' compensation laws. We may use and disclose your PHI if you are an inmate of a correctional facility, and this information is necessary for your care.

Authorization for Other Uses and Disclosures of PHI: Use and disclosure of your PHI not addressed in this Notice of Privacy Practices will be made only with your written authorization. You may revoke this authorization in writing at any time. If you revoke this authorization, we will no longer use or disclose your PHI; however, we are unable to retrieve previous disclosures made with your prior authorization.

Other Permitted and Required Uses and Disclosures that Require Your Permission or Objection:

E) Students: We may share PHI with students working in our Practice to fulfill their educational requirements. If you do not wish a student to observe or participate in your care, please notify your provider.

F) Appointment Reminders: We may contact you as a reminder of your appointment. Only limited information is provided on an answering machine or an individual other than you are answering the call. We may issue a post card or letter notifying you that it is time to make an appointment. You may provide a preferred means of contact such as a mobile telephone number or email address. Reasonable requests will be accommodated.

G) Family, Close Friends, Personal Representatives & Care Givers: Our staff may disclose to person involved in your care your PHI relevant to that person's involvement in your care or payment of the services providing you identify these individual(s) and authorize the release of information. If you are unable to agree or object to such disclosure, we may disclosure such information as necessary if we determine that it is in your best interest based on our professional judgment. If a young adult aged eighteen (18)

requests that his or her information not be released to a parent or guardian, we must comply with this request in compliance with state law. For minor children living in divided households, both parents (mother and father) have access to the PHI unless their parental rights have been terminated. Payment of services is addressed in your Final Divorce Decree; however, we obtain payment from the parent who brings the child in for treatment. We will provide you a statement to send to the other parent for your reimbursement.

H) Disaster Relief: If applicable, we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your care.

2. **YOUR RIGHTS.** The following is a statement of your rights regarding PHI we gather about you:

A) Copy of this Notice: You have the right to a copy of this notice including a paper copy.

B) Inspect and Copy PHI: You have the right to inspect and obtain a copy of PHI about you maintained by our Practice to include patient and billing records. You must submit a written request and indicate whether you prefer a paper or electronic copy. According to state and federal law, we may charge you a reasonable fee to copy your records. Our Practice does not transmit unsecure PHI via email. However, if you prefer this information emailed to you with encryption or security measures, we will comply with your request and will verify your email address. We suggest sending our Practice an email and we will reply with the attachment. (Note: Under federal law, you may not inspect or copy psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding. Please contact the Privacy Officer for more details).

C) Amendment: You have the right to have your provider amend your PHI about you in a designated record set. Please consult with the Privacy Officer. We may deny this request and you may respond with a statement. We may include a rebuttal statement in your record. Reasons we may deny amending such information, but not limited to these reasons, is if we did not create the information, or if the individual who created the information is no longer available to make the amendment or it is not part of the information maintained at our Practice.

D) Restrictions: You have the right to request a restriction of your PHI. If you paid out-of-pocket for a service or item, you have the right to request that information not be disclosed to a health plan for purposes of payment or health care operations, and we are required to honor that request. You may request in writing to our Privacy Officer not to use or disclose any part of your PHI for the purposes of treatment, payment or health care operations such as to family members or friends involved in your care or for notification purposes as described in this Notice of Privacy Practices. However, your provider is not required to agree to this restriction. You may discuss restrictions with the Privacy Officer.

E) Confidential Communications: You have the right to request to receive confidential communications from our Practice by

alternative means or at an alternative location. For example, you may prefer our Practice to use your mobile telephone or email rather than a residential line. Please make this request in writing to the Privacy Officer. Our staff will not ask personal questions regarding your request.

F) Disclosures: You have the right to request an accounting of disclosures of your PHI including those made through a Business Associate as set forth in CFR 45 § 164.528. The HITECH Act removed the accounting of disclosures exception to PHI to carry out treatment, payment, and healthcare operations if such disclosures are made through the EHR. To request an accounting, submit your request in writing to the Privacy Officer.

G) Breach Notification: According to the HITECH Act, you have the right to be notified following a breach of unsecured PHI that affects you. "Unsecured" is information that is not secured using technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the PHI unusable, unreadable, and undecipherable to unauthorized users. Breach notification applies to our Business Associates who are obligated to notify our Practice if a breach of unsecured PHI occurs that affects you.

H) Fundraising: If PHI is used for fundraising which is considered "health care operations," basic requirements must be satisfied to include notice to you and a process for you to opt-out. If the individual consents, only specific parts of PHI may be used for fundraising. Note: Your PHI will not be used in this manner.

3. COMPLAINTS. You have the right to file a complaint if you believe your privacy rights or that of other individuals' have been violated. You may contact our Privacy Officer and your issue will be addressed. You may also file a complaint with the Secretary of Health and Human Services at: U.S. Department of Health & Human Services, Office of Civil Rights, 200 Independence Avenue, SW, Washington, D.C. 20201. Your complaint must be filed in writing, either on paper or electronically, by mail, fax, or e-mail; name the covered entity or business associate involved and describe the acts or omissions you believe violated the requirements of the Privacy, Security, or Breach Notification Rules; and be filed within 180 days of when you knew that the act occurred. Visit the Office of Civil Rights website at www.hhs.gov/ocr/hipaa/ for more information.

If you have any questions, would like additional information, or want to report a problem regarding the handling of your PHI, you may contact the Privacy Officer at:

Harmony Pediatric Dentistry and Orthodontics
4818 Del Ray Ave
Bethesda, MD 20814
301-664-4220
smile@harmonybethesda.com

You will not be penalized for filing a complaint.

Your Privacy Is Important to Us

Acknowledgement of Receipt of Notice of Privacy Policies

I have received a copy of the Notice of Privacy Practices of Harmony Pediatric Dentistry and Orthodontics. I hereby authorize, as indicated by my signature below, Harmony Pediatric Dentistry and Orthodontics to use and to disclose my/my child's protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

_____ _____
Print Patient's Name Print Name of Parent/Guardian

Signature _____ Date _____

Please check your preferred means of communication:

□ You may contact me at my home telephone number _____

□ You may contact me on my mobile telephone number _____

□ You may send me an unencrypted email/text message at: _____

□ Other _____

Please list authorized persons with whom we may discuss your child's Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. _____ Date Added / Removed:_____

2. _____ Date Added / Removed: _____

3. _____ Date Added / Removed: _____

*** * * 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:

□ Individual refused to sign
□ Communication barriers prohibited obtaining the acknowledgement
□ An emergency prevented us from obtaining the acknowledgement
□ Other (Please Specify) _____ Staff Person Initials _____

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FINANCIAL POLICY

Patient Agreement and Financial Policy

I hereby agree to be responsible for the costs of care provided by Harmony Pediatric Dentistry and Orthodontics and/or the dental team for my dependent(s), whether or not I have a dental insurance benefit available**. I also understand that it is my responsibility to be aware of any limitations, and benefits of my insurance policy. I understand that Harmony Pediatric Dentistry and Orthodontics is ONLY in network with Cigna DPPO plans**. Payment in full to this office is my responsibility and I am aware that if I have an insurance plan other than Cigna, all benefits will be reimbursed directly to me.

I understand that there will be a $35 charge to all accounts in which a check payment is returned.

I understand that because appointments are not double-booked, I must provide notice of cancellation at least 48 hours prior to my child's scheduled appointment time**. At times a cancellation fee of may be assessed, or I may be required to put down a deposit in order to schedule my child's treatment.**

We make every effort to schedule appointments that are most convenient for you and that fit your personal schedule. Because we do not schedule several patients at the same time, all appointments are reserved exclusively for you and your child. In return, we ask that you make every effort not to change your reserved dental appointment.

I understand that for any treatment, payment in full is due at the time of service. I understand that failure to pay amounts due to this office will result in discontinuation of my child's treatment and my account being placed with a collection agency. In the event that my account is further referred to an attorney, I agree to pay all collection and attorney fees.

Date: _____ Signature: _____
Signature of patient/parent/legal guardian

I understand that the cost of orthodontic records (intraoral scan and cephalometric radiograph) is included in the fee for orthodontic treatment (braces or Invisalign). If I choose not to have treatment completed at Harmony Pediatric Dentistry and Orthodontics within 90 days, I will be responsible for payment of the orthodontic records in the amount of $385.

Date: _____ Signature: _____
Signature of patient/parent/legal guardian

Minor/Child Consent

I, being the parent or legal guardian of _____, do here, by request and authorize the dental team to perform necessary services for my child, including but not limited to radiographs (x-rays) and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered. I also understand that the parent or guardian who brings my child in for treatment or signs the orthodontic contract will be responsible for payment. A receipt will be provided so I may seek reimbursement.

Date: _____ Signature: _____
Signature of patient/parent/legal guardian