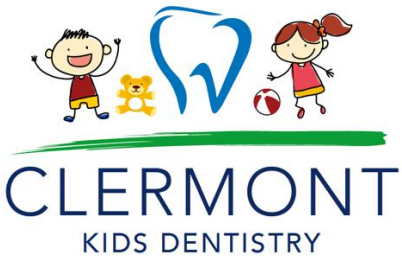


ARE YOU THIS CHILD'S LEGAL GUARDIAN?
◯ Yes ◯ No
If no, please explain: _____
HOW DID YOU HEAR ABOUT US?
◯ Insurance Listing_____
◯ Existing Patient (who) _____
◯ Online_____
◯ Community Resource_____
PEDIATRICIAN: _____
MEDICAL HISTORY: Is your child
Taking medications? _____
Under on-going care? _____
Hospitalized in the past? _____
CHECK ANY OF THE FOLLOWING FOR WHICH YOUR CHILD HAS BEEN TREATED IN THE PAST (5) YEARS:
◯ Allergies_____
◯ Anemia / Blood Disorder
◯ Asthma
◯ Autism
◯ Behavioral Issues, ADHD, Bipolar...etc.
◯ Cancer / Tumors
◯ Developmentally Delayed
◯ Diabetes: Type_____
◯ Endocrine
◯ Headaches
◯ Hearing Impairment
◯ Heart Defects, Disease or Murmur
◯ Hepatitis
◯ HIV or AIDS
◯ Hydrocephalus
◯ Kidneys
◯ Learning Disability (ies)_____
◯ Lung Disease
◯ Liver Disease
◯ Seizure / Fainting / Dizziness
◯ Speech Disorder / Therapy
◯ Thyroid
◯ Vision Impairment
◯ MY CHILD HAS NO MEDICAL CONDITIONS

EMAIL_____
Patient First Name: _____

Middle Initial____ Last Name_____
Nickname_____
Birth date_____ M/F_____
Guardian Name_____
DOB: _____ Soc. Sec #:_____
Guardian Name_____
DOB: _____ Soc. Sec #:_____
◯ Married ◯ Divorced ◯ Other_____
Home #:_____Cell#:_____
FULL Address (where child lives)_____
_____
_____
Guardian Employer: _____
Guardian Employer: _____

Dental Insurance_____
Group#:_____
Subscriber First Name_____
Middle Initial: _____Last Name_____
ID #:_____
Secondary Dental Insurance: _____
Subscriber First Name: _____
Middle Initial: _____ Last Name: _____
DOB: _____Soc. Sec#:_____
ID #:_____

*__CANCELLATION RESPONSIBILITY__ Clermont Kids Dentistry is an access to care clinic, and your time is reserved specifically for you. Should you need to cancel your appointment, please notify our office at least 24 hours prior, otherwise you may be charged our minimum exam fee ($67).

*** FINANCIAL RESPONSIBILITY** Clermont Kids Dentistry accepts most dental insurance plans. For your convenience, we send a dental claim to your insurance plan electronically the day your child receives treatment. Your insurance company is obligated to pay the claim within 60 days from the date of submission. At that point, we consider the outstanding balance billable to you, the consumer. You will be sent a statement showing the unpaid claims and/or your financial responsibility after all claims have been processed by your insurance provider.

CLERMONT
KIDS DENTISTRY

Parent Guidelines and Practice Terminology

Dear Parents,
In order to improve the chances of your child having a positive experience in our office, we are selective in our use of words. We try to avoid words that scare the child due to previous experiences. Please support us by NOT USING negative words that are often used for dental care. These include:

DON'T USE	Friendly vocabulary
Drill	Whistle
Drill on tooth	Clean a tooth
Needle or Shot	Sleepy juice
Cavity	Sugar bug
Yank tooth	Wiggle a tooth out
Tooth cleaning	Tickle teeth
Examination	Count teeth
Explorer	Toothpick
Rubber dam	Raincoat
Gas	Magic air

This will help you understand your child's description of the dental experience. Our intention is not to "FOOL" the child. It is to create an experience that is positive. We appreciate your cooperation in helping us build a good dental attitude for your child!

Parents are ALWAYS welcomed to the back office! An introduction and orientation to our Clermont Kids Dentistry team will take place on your first visit. Please use this time to, "Get to know us inside and out!" Our goal is to help each child navigate new or unfamiliar situations on their own. By supporting this guideline you are helping your child develop the self-confidence we all desire our children to have. We suggest the following guidelines to improve a positive outcome.

1) Allow us to prepare your child. A team member will be by their side during their adventure here!
2) Be supportive of the practice's terminology. It really does work!
3) Please be a team player when in treatment area. We love to interact with your child!

These are very important ways that can actively help in the success of your child's visit. We are confident that all will go well and hope the guidelines will help prepare you with confidence for the upcoming appointment.

Date_____Signature_____

Print Name_____

CLERMONT
KIDS DENTISTRY

STATEMENT OF PRIVACY PRACTICES

At Clermont Kids Dentistry, we are committed to protect the privacy rights of our patients and the confidential information entrusted to us. Our employees are dedicated and trained to ensure that your health information is never compromised. We reserve the right to amend our privacy policies and practices to stay current with industry standards, but will always inform you of changes that might affect your rights.

PROTECTING YOUR PERSONAL HEALTHCARE INFORMATION
We use and disclose the information we collect from you only as allowed by the Healthcare Insurance Portability and Accountability Act and the state of Florida. This includes issues relating to your treatment, payment, and our dental care operations. Your personal health information will never be otherwise given to anyone - even other family members - without your consent. You, of course, may give written authorization for Clermont Kids Dentistry to disclose your information to anyone you choose, for any purpose.

Our office and electronic systems are secure from unauthorized access and our employees are trained and qualified to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

COLLECTING PROTECTED HEALTH INFORMATION
We will only request personal information needed to provide our standard of quality dental care, implement payment activities, conduct normal dental practice operations, and comply with the law. This may include your name, address, telephone number(s), social security number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION
As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and government officials under certain circumstances. We will not use your information for marketing purposes without your written consent. We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, electronic mail, and postcards.

PATIENT RIGHTS
You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge you for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

Thank you for entrusting Clermont Kids Dentistry with the safety and health of your child. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

CLERMONT
KIDS DENTISTRY

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Statement of Privacy Practices for Clermont Kids Dentistry. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services or in the performance of the office's health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility. Clermont Kids Dentistry reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If the privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health information to the persons indicated below.
ANY MEMBER OF MY IMMEDIATE FAMILY [ ] YES [ ] NO
SPOUSE ONLY [ ] YES [ ] NO
OTHER (PLEASE SPECIFY) [ ] YES [ ] NO

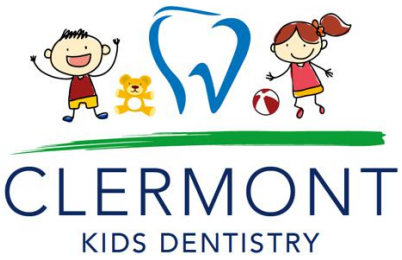
Name of Patient _____ Signature of Guardian/Patient _____
Date _____ Relationship to Patient _____

OFFICE USE ONLY Record of Acknowledgement Not Obtained Provided Prior to Treatment [ ] YES [ ] NO
Date Provided: / /

Reason For Denial:
[ ] Needed more time to review Statement of Privacy Practices
[ ] Wanted to consult with another person before signing
[ ] Unable to sign
[ ] Reason not given
[ ] Other (Explain):

Authorization For Use Or Disclosure Of Patient Photographic and/or Video Images

Authorization: I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by the practice listed below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations. Purpose: The photographic/video images, and/or testimonial will be used for: Social Media and/or Advertising Revocability: I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice via registered mail. Revocation affects disclosure moving forward and is not retroactive. This authorization expires 98 years from date signed. No Treatment Conditions: I understand that the practice cannot condition treatment on whether or not I sign this authorization.
Name of Patient _____ Signature of Guardian/Patient _____
Date _____ Relationship to Patient _____



Clermont Kids Dentistry Financial and Cancellation Policy

1. Payment is due at the time of service

a. If you sign consent for another adult to accompany your child or for your child to bring themselves to an appointment, please be sure to send payment with them or contact our office regarding payment prior to your child's appointment.

2. Dental Insurance

a. Insurance often does not cover the full cost of the treatment. We will estimate your insurance coverage and bill your insurance for the treatment on your behalf.
b. Any copays or coinsurance are due at time of service and will be collected at your child's appointment.
c. Should your insurance payment differ from the estimate received, the remaining balance is due within 30 days of receiving a statement.
d. Future appointments will not be scheduled for patients with an outstanding balance on their account until the account is settled.
e. Accounts not settled after 90 days will be referred to a collection agency.

3. Financial Arrangements

a. Care Credit
i. We offer Care Credit as a payment option, to better assist you. To inquire about the details, you may take a brochure or discuss with a front desk staff member.
b. Any questions regarding possible financial arrangements may be directed to our Office Manager.

4. Broken Appointments

a. A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least **24 hours' notice to avoid a $67.00 broken/cancellation appointment fee.**

I understand that I am responsible for any charges that are reasonably denied by my insurance company. By signing below, I consent to my child's treatment and my financial obligation to Clermont Kids Dentistry

_____ _____

Parent Signature (Guardian) Date