West Coast
pediatric dentistry

Specializing in infants, children, teens & patients with special needs

Welcome to Our Practice!

Our dental team is happy to welcome your child to our pediatric dental practice. We are pleased you have chosen us to help care for your child's oral health. We want you to know our dental team is committed to providing your child with the highest quality of dental treatment, and we do so in a gentle, efficient and knowledgeable manner.

The forms below help us know you and your child better so we can provide the very best treatment. Some forms are simply required by the government so we ask that you help us comply. Please print the forms below, fill them out completely and bring them with you to the first appointment. If the forms are not completed before your appointment, you will be asked to reschedule.

For children 3 years and older, we suggest you allow your child to accompany our staff through the dental experience. We can usually establish a closer rapport with your child when you are not present. Our purpose is to gain your child's confidence and overcome apprehension, and we are highly experienced in helping children overcome anxiety. Separation anxiety is not uncommon in children, so please try not to be concerned if your child exhibits some negative behavior. This is normal and will soon diminish. Studies and experience have shown that most children over the age of 3 years react more positively when permitted to experience the dental visit on their own and in an environment designed for children.

For children under the age of 3 years and those with special needs, we encourage you to accompany your child into the treatment room. We will need you for communication and reassurance.

Your child's first appointment will consist of a complete oral examination, x-rays, cleaning and a fluoride treatment, if your child is due. If your child had x-rays taken by a previous dentist, please be sure to have them sent to our office or bring them along. This will prevent duplication of x-rays and additional fees for you. We will not do any treatment at the first visit.

If you have questions regarding any treatment, fee or service, please discuss them with us promptly. We will make every effort to promote a mutually satisfying relationship. We look forward to see you and your child.

Welcome!

We are pleased to welcome you and your child to West Coast Pediatric Dentistry.
Please take a few minutes to fill out this form as completely as you can.
If you have any questions we'll be glad to help you. We look forward
to working with you in maintaining your child's dental health.

TELL US ABOUT YOUR CHILD

Child's Name: ____ Preferred Name:__________________ □ Male □ Female

Child's Birthdate: _______________ Child's Age: _____ Hobbies:___________________ School: ____________________

Child's Address: ____ Phone: ____________________

Social Security # ___________________________ Siblings in the practice ____

Whom may we thank for referring you? ____

PARENT / LEGAL GUARDIAN INFORMATION

Mother's / Guardian's Name: ____ Date of Birth: ________________

Address (if different from patient's): ____

Home Phone: ______________________ Work Phone: ______________________ Cell Phone: ______________________

Email: _____________________________Social Security #: ______________________ Employer: _____________________

Father's / Guardian's Name: ____ Date of Birth: ________________

Address (if different from patient's): ____

Home Phone: ______________________ Work Phone: ______________________ Cell Phone: ______________________

Email: _____________________________Social Security #: ______________________ Employer: _____________________

INSURANCE INFORMATION

Primary Dental Insurance: ________________________________ Group #: _________________ Policy #: ______________

Insurance Company Address:____ Phone: _______________

Subscriber's Name: ____ Relationship to Patient: _________________________

Date of Birth: ____________ Social Security #: _________________________ Employer: _____________________________

Secondary Dental Insurance: _______________________________ Group #: ________________ Policy #: ______________

Insurance Company Address:____ Phone: _______________

Subscriber's Name: ____ Relationship to Patient: _________________________

Date of Birth: ____________ Social Security #: _________________________ Employer: _____________________________

Medical History

Child's Name: ___________________________________ Physician's Name: __________________________________

Physician' s Address:____ Phone: ____________________

Has your child ever had any of the following?	Yes	No	Comments
Asthma, Cystic Fibrosis, Respiratory Disease, Tuberculosis			
Heart disease, Heart Murmur			
Anemia, Hemophilia, other Blood Disorders			
Sickle Cell Disease or Trait			
Diabetes, Thyroid, Glandular or other Endocrine Disease			
Liver Disease, Hepatitis or Jaundice			
Bladder Problems, Kidney Disease			
Skin, Bone, Muscle or Joint Disorder			
Cerebral Palsy or Neurological Disease			
Sexually Transmitted Disease or HIV			
Mental, Emotional or Developmental Delays			
Autism, ADHD, Genetic Disorder			
Syndrome			
Cancer			
Seizures, Epilepsy, Convulsions			
Speech disorder			
Hearing disorder			
Sight or eye disorder			
Has your child ever been seriously ill?			
Has your child had any significant injury?			
Has your child ever had surgery?			
Current medications your child is taking			Please list
Allergic to any medicines?			Please list
Allergic to foods, environmental pollutants, animals?			Please list

Is there any problem, disease or medical condition that we should know about in order to care for your child?

□ No □ Yes: ____

Dental History

Date of last visit to a dentist:____________ For what service?: __________________ Were x-rays taken? __________

Please have x-rays emailed to kidsdentistry@comcast.net or sent to our office to prevent duplication & unnecessary fees

Has your child had any of the following?	Yes	No	Comments
A dental problem, toothache or swelling			
Injury to the face or teeth			
An unhappy dental experience			
Mouth habit – thumb / finger sucking, pacifier			
Sleep with a bottle, sippy cup or at-will breastfeeding			
Does your water have fluoride?			
What is your child's favorite snack			Please list
Do you expect your child to be cooperative?			

Future Appointments

As a courtesy we remind you the day before each appointment. How do you prefer to be contacted?
□ Home phone □Work phone □ Cell phone □ Email

We encourage you to make your child's 6-month check up appointment in advance to reserve your spot. A postcard reminder will be sent 2 weeks prior to the appointment date.

If your child transferred from another office please allow us to be your child's dental home. This not only includes dental treatment but the check-ups as well. This allows us to develop an ongoing positive relationship with your child that encourages the optimal delivery of care.

Consent for Dental Treatment

I request and authorize Dr. Connie Verhagen and her staff to examine, clean my child's teeth and provide comprehensive dental treatment including fluoride, fillings, crowns, pulp treatment, extractions and nitrous oxide, if required. I further request and authorize the taking of dental x-rays as may be considered necessary for Dr. Verhagen to diagnose and/or treat my child's dental condition. I understand that dental treatment for children includes efforts to guide their behavior by guiding them to understand the treatment in terms appropriate for their age. Dr. Verhagen will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone. I understand that I will be responsible for any charges incurred on my child for dental treatment.

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(parent / legal guardian signature) relationship to patient date

In case someone other than you (parent / legal guardian) accompanies your child to future dental appointments, this person may give consent by proxy to possible treatment plan changes. (If unsigned, the patient will be rescheduled until a parent / legal guardian can accompany the patient to the appointment.)

___

(parent / legal guardian signature) relationship to patient date

Assignment of Dental Benefits

I certify that my dependent is covered by insurance and assign directly to Dr. Connie Verhagen or West Coast Pediatric Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid by insurance. I authorize my signature on all insurance submissions. I further authorize Dr. Connie Verhagen or West Coast Pediatric Dentistry to use my child's protected health information and may disclose such information to insurers, governmental agencies and their agents for the purpose of obtaining payment for services and determining insurance benefits or benefits payable for related services.

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(parent / legal guardian signature) relationship to patient date

AT THIS OFFICE WE FOLLOW THE GUIDELINES OF THE AMERICAN ACADEMY OF PEDIATRIC DENTISTRY IN REGARD TO FREQUENCY OF X-RAYS, CLEANINGS, FLUORIDE TREATMENT AND RESTORATIVE CARE. AS A SPECIALIST, I CONSIDER THESE GUIDELINES TO BE THE STANDARD OF CARE (BEST TREATMENT FOR YOUR CHILD). THESE GUIDELINES ARE NOT DICTATED BY DENTAL INSURANCE AND IT IS YOUR RESPONSIBILITY TO UNDERSTAND WHETHER YOUR PARTICULAR INSURANCE PLAN WILL REIMBURSE YOU FOR THESE SERVICES. PLEASE SPEAK WITH YOUR INSURANCE COMPANY OR EMPLOYER WITH QUESTIONS REGARDING LIMITATIONS AND FREQUENCIES.

Financial Agreement

Payment: Payment is expected in full for each appointment as services are rendered. Payment options are:

- Cash
- Check
- Credit Card (Visa, MasterCard, Discover)
- Care Credit (Interest-free special financing on approved credit)

No appointment will be made until the balance is paid in full.

Dental Insurance: Insurance is a contract between you and your insurance company. There is no direct relationship between our office and your insurance company. Your insurance benefits are determined by the type and design of the plan chosen by you and/or your employer; we are not a party to this contract. We have no control over the terms of your contract, the method of reimbursement, or the determination of your benefits. Some and perhaps all of their services can be defined by your insurance company as “not covered”, “denied” or “over UCR”. We will file your primary and secondary insurance claims as a courtesy to you. We do not guarantee payment and are not responsible for providing you with the plan limitations, exclusions and provisions determined by your insurance company. You agree to pay any portion of the charges not covered by your insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. We will file a pre-determination for recommended treatment when you request it.

Emergency / After Hours Appointment: If your child is seen for an emergency visit after our regular business hours an emergency visit fee is charged in addition to any treatment on that visit.

Returned Checks: There is a fee of $35.00 for any checks returned by the bank for insufficient funds.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show the previous balance, any new charges to your account, and any payments or credits applied to your account during the month. Professional fees are the responsibility of the parent or guardian authorizing treatment; we cannot send statements to other persons.

Past Due Accounts: If your account becomes seriously past due, we will take necessary steps to collect this debt. This may include sending your account to a collection agency or small-claims court.

Divorce: In case of divorce or separation, the responsible party prior to the divorce or separation remains responsible for the account. If the divorce decree requires the other parent to pay all or part of the treatment cost, it is the authorizing parent’s responsibility to collect from the other parent.

Questions: If you have unusual circumstances and would like to make special arrangements to pay your account we encourage you to contact us. We are not unreasonable and would like to work with you. Lack of any payment or communication can be interpreted as refusal of payment.

WEST COAST PEDIATRIC DENTISTRY, P.C.

NOTICE OF PRIVACY PRACTICES

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 04/14/03, 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 treatment to you.

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 $0.50 for each page, $18.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. 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. Connie Verhagen

Telephone: 231-780-3200 Fax: 231-733-2841

Address: 755 Seminole Road
Muskegon, MI 49441

PATIENT ACKNOWLEDGMENT AND CONSENT FORM

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA’s requirements, we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

PLEASE SIGN THIS FORM BELOW THE “ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF OUR PRIVACY PRACTICES”.

Existing Michigan Law requires (in addition to our attempt to obtain your written acknowledgment, discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with:

1. A defense to a claim challenging our professional competence;
2. A review entity’s functions;
3. A claim for payment of fees;
4. A third party payer’s examination of our records;
5. A court order as part of a criminal investigation;
6. An identification of a dead body;
7. A licensure investigation; or
8. A child abuse/neglect investigation.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

West Coast Pediatric Dentistry
Connie Verhagen, DDS, MS

Acknowledgement of Receipt of Notice of Privacy Practice

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Patient Name:____

Parent / Legal guardian Signature: ____

Date: ______________________

List all children seen by our practice: ____

Please list any other person (or persons) that we may disclose diagnosis, treatment recommendations and / or billing matters: ____

I consent to this office disclosing my child's (ren's) information as deemed necessary in connection to treatment or referral to another specialist.

Parent / Legal Guardian Signature:____

Date: __________________________________

_____ Parent / Legal guardian refused to sign

_____ The following circumstances prohibited the parent / legal guardian from signing this acknowledgement: ____

_____ An emergency situation prevented the parent / legal guardian from signing this acknowledgement