Arthur O. Lyford, DMD, PLLC ~ 3 Market Pl, Unit D ~ Hollis, NH 03049
603-465-3800 ~ www.lyfordsmiles.com ~ lyfordsmiles@lyfordsmiles.com

Welcome

to our Practice! We strive to make each of your child's visits pleasant and comfortable.

Child's Name_____
Nickname_____
Birthdate _____Age ___
Soc. Sec #_____
Address_____
City, ST, Zip_____
School_____

Name_____
Relationship_____
Birthdate _____Age ____
Soc. Sec #_____
DL #_____
Address_____
City, ST, Zip_____
Home Phone_____
Cell Phone_____
Work Phone _____
e-Mail_____

Who is responsible for making appointment?

Mother ☐ Stepmother ☐ Guardian

Name _____
Home Phone_____
Work Phone_____
Cell Phone_____
Address_____
City, ST, Zip_____
Employer_____
Occupation_____
e-Mail_____
Soc. Sec #_____
DL #_____

Father ☐ Stepfather ☐ Guardian

Name_____
Home Phone_____
Work Phone_____
Cell Phone_____
Address_____
City, ST, Zip_____
Employer_____
Occupation_____
e-Mail_____
Soc. Sec #_____
DL #_____

Financial Guidelines

For your convenience we offer the following methods of payment in full at each appointment:
Cash - Personal Check - Visa - MC - Amex - Discover
Additionally, we will complete a complimentary benefits check as well as submit pre-authorizations to your insurance company. We submit all insurance at time of service electronically.
I understand that my dental insurance is an agreement between my insurance company and me, that I am responsible for the total fees at time of service regardless of my insurance.
I understand that responsibility for payment for services provided for myself or my dependent(s) is mine, due and payable at the time services are rendered.
Our office requires 48 hour notice for any canceled appointments to avoid a $125 cancellation fee.
There will be a $50 charge for all returned checks. A service charge of 1 ½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days. If you account is sent to collections you will be responsible for any and all costs involved in the collections process. This will include all court costs, attorneys fees, and correspondences.

Dental & Health History

Your child 's overall health as well as any medications which your child takes could have an important inter-relationship with the dental care your child receives. Please answer each of the following questions completely.

How often does your child brush?_____ How often does your child floss?_____

Is your child's water fluoridated? ☐ Yes ☐ No Does your child take fluoride supplements? ☐ Yes ☐ No

Does your child:

Suck thumb/finger?_____ ☐ Yes ☐ No Chew hard objects (pencils, etc.)? ☐ Yes ☐ No

Suck/Bite Lip?_____ ☐ Yes ☐ No Grind teeth?_____ ☐ Yes ☐ No

Bit/Chew Nails?_____ ☐ Yes ☐ No Clench jaws?_____ ☐ Yes ☐ No

Previous Dentist_____ Address_____

Date of last dental visit_____

Has your child had difficulty with previous dental visits? ☐ Yes ☐ No

_____

Child's Physician_____ Address_____

Phone #_____

Previous Hospitalizations/Surgeries/Serious Illness?

_____ When?_____

Is you child currently taking medications? ☐ Yes ☐ No (If yes, please list)

_____

Does your child have a history of allergies/sensitivities/adverse reactions to any drugs or medications (penicillin, Novocain, etc.?) ☐ Yes ☐ No (If yes, please describe)_____

_____

Does your child have a history of allergies to any other substance (latex, environmental, etc)?

Has you child ever had any of the following:

Asthma ☐ Yes ☐ No Handicaps/Disabilities ☐ Yes ☐ No Diabetes ☐ Yes ☐ No

Stomach, Liver or Kidney Problems ☐ Yes ☐ No Abnormal Bleeding ☐ Yes ☐ No

Hepatitis ☐ Yes ☐ No Congenital Heart Defect ☐ Yes ☐ No Cancer ☐ Yes ☐ No

HIV/AIDS ☐ Yes ☐ No Rheumatic Fever ☐ Yes ☐ No Convulsions/Epilepsy ☐ Yes ☐ No

Hemophilia ☐ Yes ☐ No Heart Murmur ☐ Yes ☐ No Tuberculosis ☐ Yes ☐ No

Please explain any medical problems your child has: _____

Authorization & Release

To the best of my knowledge, the questions on this form have been accurately answered. 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 also authorize the dental staff to perform the necessary dental services my child may need.

I also authorize the Dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such car to third party payers and/or other health practitioners.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____Date:_____

Parent Name & Signature

ARTHUR O. LYFORD, D.M.D., P.L.L.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Signature

_____
Date

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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

ARTHUR O. LYFORD, D.M.D., P.L.L.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 officials having lawful custody of protected health information of inmates or patients 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 also request access by sending us a letter to the address at the end of this Notice. We reserve the right to charge you a reasonable cost-based fee for expenses such as copies and staff time.

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 of 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.

~ The ART of Dentistry, Arthur O. Lyford, DMD, PLLC ~ 3 Market Pl ~ Hollis, NH ~ 603-465-3800