Scott L. Worley, DDS LLC
Board Certified in Pediatric Dentistry
4600 Lake Street · Lake Charles, LA 70605 · Ph.:(337) 474-0240 · 1 (800) 851-8243

Child's Information

Date ____/____/____

Child's Name_____ Nickname:_____

Date of Birth ____/____/____ ☐ Male ☐ Female Social Security# _____

Address _____ Home Ph _____

City _____ State _____ Zip _____

Physician _____ Emergency Contact _____ Phone# _____

Parent's Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Father's Information ☐ Parent/Guardian ☐ Step-Father

Name _____ Address Same as Child's ☐ Yes ☐ No
Last First Middle

Address _____ E-Mail _____

City _____ State _____ Zip _____ Date of Birth ____/____/____

Home Ph:_____ Cell Ph:_____ Social Security# _____

_____

Employer _____ Wrk Ph _____ DL# _____

Mother's Information ☐ Parent/Guardian ☐ Step-Mother

Name _____ Address Same as Child's ☐ Yes ☐ No
Last First Middle

Address _____ E-Mail _____

City _____ State _____ Zip _____ Date of Birth ____/____/____

Home Ph:_____ Cell Ph:_____ Social Security# _____

Employer _____ Wrk Ph _____ DL# _____

Dental Insurance Information

Primary _____ Secondary _____

Insured's Name _____ Insured's Name _____

Contract/ID# _____ Contract/ID# _____

Group# _____ Group# _____

Policy# _____ Policy# _____

Social Security# _____ Social Security# _____

Please check any information that is pertinent to your child

Medical History

	Yes	No
Is your child in good health?	☐	☐
Does your child have regular medical exams?	☐	☐
Is your child up to date with immunizations?	☐	☐
Is your child taking any medications?	☐	☐
If so, please list _____		
_____		
Has your child been hospitalized since birth?	☐	☐
Has your child had any unfavorable reactions to any medicines? If so, please list _____	☐	☐
_____		
Please discuss any serious medical conditions your child has had _____		
_____		
Child's Physician _____		
Ph._____		

☐ ADD/ADHD (Circle One)
☐ Allergies to any Drugs
☐ Allergies to Latex Products
☐ Asthma
☐ Hearing Disorder
☐ Nervous Disorder
☐ Bleeding Disorder
☐ Brain Disorder
☐ Vision Disorder
☐ Speech Disorder
☐ Kidney/Liver Condition
☐ Heart Condition
☐ Mental Condition
☐ Autism
☐ Retardation
☐ Congenital Birth Defects
☐ Hepatitis
☐ Diabetes
☐ Convulsions/Epilepsy
☐ Rheumatic/Scarlet Fever
☐ Cerebral Palsy
☐ Sickle Cell Anemia
☐ Spina Bifida
☐ Transfusions
☐ Tuberculosis
☐ Cancer
☐ Leukemia
☐ HIV+
☐ Other _____

Dental History

Is this your child's first dental visit?	☐	☐
If not, how long since last visit _____		
Previous Dentist Name _____		
Were any X-Rays Taken _____		
Is your child presently on a fluoride supplement?	☐	☐
Does your child have any of the following habits?	☐	☐
Lip Sucking/Biting Nail Biting		
Nursing/Bottle Habits Thumb/Finger Sucking		
Has your child had any injuries to the teeth, face, or mouth?	☐	☐
Age the bottle was discontinued _____		
What is your water source?		
☐ Private Well ☐ Public System		

Reason for Today's Appointment

Check Up & Cleaning ☐ Exam Only ☐ Evaluate Crowding ☐ Toothache ☐ 2nd Opinion ☐
Other _____

PERMISSION:

Since _____ is a minor, it becomes necessary that signed permission be obtained from the parent or guardian before any and/or all dental services can be performed by Dr. Scott L Worley. Authorization is hereby granted to Dr. Scott L Worley and shall remain in force and in effect canceled by either party.

Signed _____ Relationship _____ Date _____

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Patient Name: _____

I, being the parent or guardian of the named minor patient, hereby do authorize and request Dr. Worley's staff to submit claims and receive payments to and from my insurance company.

I also agree to be responsible for any bill incurred on this child for dental treatment, finance charges, and/or collection fees from an outside firm should this account become delinquent.

Date: _____

Parent/Guardian: _____

Relationship: _____

Witness: _____

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NO-SHOW POLICY

Due to the rising demand for appointments in our office, we have enacted a new NO SHOW policy. Please call to cancel or reschedule an appointment 24 hours in advance. We recognize that scheduling conflicts so occur, so please call us as soon as possible if this arises.

1. There will be no penalty for the first cancellation or no show within 24 hours of your appointment.

2. We will inactivate you for the 2nd no show as a patient of record.

Our front office attempts to contact all patients 2-3 days before their appointment. Unfortunately, missed or failed appointments contribute to inefficient scheduling, lost time and higher fees. If there is any change in address or phone number that may complicate contact with you, please inform our office as soon as possible. We are not responsible for missed appointments due to the inability to reach you.

Please understand that these policies are meant to keep our practice running smoothly and efficiently. They also help keep your treatment as affordable as possible and at a higher level of quality. If you have any questions about this policy, please feel free to contact us.

Sincerely Yours,

Dr. Scott Worley, DDS
The Dental Depot

I acknowledge receipt of the No-Show Policy

X_____
Parent/Legal Guardian Signature Date

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GENERAL INFORMATION AND CONSENT

We are pleased to receive your child as a patient in our office and feel honored by the confidence you have placed in us. We sincerely desire to make his or her visits as pleasant as possible. We feel that we can better establish patient-doctor relationships if our parents and patients are familiar with the service and procedures of this office.

INITIAL VISIT: Each child receives a thorough examination on their first appointment. It usually includes a prophylaxis (cleaning of teeth), topical fluoride, and dental x-rays, if they are needed. Oral hygiene instructions will be given to the patient and reviewed with the parent along with dietary recommendations. We employ all procedures available to reduce radiation risk including thyroid and gonadal lead apron, collimated x-ray machine. All x-rays are digital, providing fast results. We feel that it is extremely important for a child to have to have a full mouth x-ray (panorex), starting around the age of 5 or 6 to check any problems such as extra permanent teeth, congenitally missing teeth, cysts or eruption problems.

PARENTS MAY ACCOMPANY THEIR CHILD: We have an open door policy in our practice. We want our parents to participate in their child's dental education and feel that it is important that they support our recommendation. We feel that we can prevent most of your child's dental problems with a team effort.

NITROUS OXIDE (LAUGHING GAS): Frequently, we will employ the "Mickey Mouse Nose" (nitrous oxide), to help reduce anxiety and fear of dental procedures. It is tremendously effective when treating children and is very safe.

PREMEDICATION: It is sometimes necessary to premedicate young child with sedatives in order to successfully perform certain dental procedures. If we recommend premedication, the medications and anticipated side effects will be carefully explained before the procedure. As determined, children who are premedicated will have their vital signs monitored throughout the procedure.

HOSPITALIZATION: Some young or handicapped children requiring extensive treatment would benefit by having their work done under general anesthesia in a hospital setting. If we feel that this is a necessary way to treat your child, we will thoroughly discuss hospitalization with you.

PREVENTIVE DENTISTRY: Since some areas of Southwest Louisiana do not provide fluoride city water, preventive dentistry is extremely important. The American Academy of Pediatric Dentistry recommends that children who live in a non-fluoridated area routinely take fluoride supplements until the age of ten. Fluoride helps strengthen the teeth as they develop. Also, home fluoride rinse is recommended to strengthen the teeth that are presently in their child's mouth. We highly recommend sealants for the permanent molars and some secondary molars after they have fully erupted.

ORTHODONTICS: At each six-month hygiene appointment your child will be checked for proper eruption of teeth and/or any malocclusion that may be developing. We will inform you of any treatment that we feel necessary for your child.

CHILDREN'S TIME: Although we schedule appointment times for the treatment of your child, our office operates on children's time. This means that occasionally some of our patients who are not particularly interested in getting their dental work done may take extra time so that they are more comfortable and less apprehensive. This will invariably play havoc with our schedule and cause some delays. So let me apologize now if we are running behind. We are guilty of letting our patients manipulate the schedule somewhat when we are trying to give then the best possible dental experience. We also see many emergencies since children may have accidents at home, school or play.

APPOINTMENT POLICY: As a growing pediatric dental practice, our schedule is sometimes booked several months in advance. While we understand some appointments can't be kept, we would like the courtesy of a phone call notifying us, so that we may give that appointment time to another child.

We intend to render dental services as we would our own. If at any time you have questions concerning your child's dental health, please feel free to ask us.

PLEASE LET US KNOW IF YOU OBJECT TO THE USE OF FLUORIDE AND/OR XRAYS.

SCOTT L WORLEY DDS LLC

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/25/2016, 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at 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. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

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 if 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.

Our Privacy Official: Daphne Lanclos

Telephone: 337-474-0240 Fax: 337-474-1901

Address: Scott L Worley DDS LLC, 4600 Lake St., Lake Charles, LA 70605
E-mail: daphne@thedentaldepot.com

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General Information and Consent

I have read and understand the contents of this form

Parent's Signature _____ Child's Name _____

Print Name _____ Date _____

Acknowledgement of Receipt of Notice of Privacy Practices

* You May Refuse to Sign This Acknowledgment*

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

Print Name: _____

Signature: _____

Date: _____

Child/Children's Name (s): _____

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)