Greer Pediatric Dental Care
Dr. Mary Okuley

3115 F Brushy Creek Road
Greer , SC 29650
864-879-7977 | gpdcare.com

Welcome!

We are excited to have your child as a patient and we look forward to providing you with everything you need to make your visit to the dentist a positive experience for your family.

As a pediatric specialty practice, we care for the dental needs of children beginning with the eruption of their first tooth and continue to foster a relationship until young adulthood. We also care for those patients with special needs, regardless of age. Specialized care for children includes understanding not only your child's need for dental health, but also how a positive and caring environment can address all comfort needs. We strive to achieve optimum oral health through prevention and education first, and intervention, second. We want to make every experience a positive one so that a lifetime of good oral health may be obtained. Our practice philosophy is to treat and protect every child as if they were our own.

We thank you for choosing our practice for your family's dental healthcare needs. We look forward to taking care of your child/children's needs for many years to come. Should you have any questions or concerns, please feel free to contact us via email or phone.

Kindest Regards,

Dr. Mary Okuley and the Team at Greer Pediatric Dental Care.

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Patient Information

Child's Name _____ Name Called By: _____

Age _____ Birthday _____ Gender: M☐ F☐

Child's Home Address_____
STREET CITY STATE ZIP

Best Contact Phone Number _____

Name of School/Day Care_____

Brothers (Names and Ages) _____

Sisters (Names and Ages) _____

Whom may we thank for referring this patient? _____

Parent Information

Parent/Guardian Name_____ Relationship to Child_____

Address_____
STREET CITY STATE ZIP

Home Phone_____ Cell Phone_____ Work Phone_____

Email Address_____

Social Security Number_____ Date of Birth _____

Employer_____ Occupation _____

Employer's Address_____
STREET CITY STATE ZIP

Parent/Guardian Name_____ Relationship to Child _____

Address_____
STREET CITY STATE ZIP

Home Phone_____ Cell Phone_____ Work Phone_____

Email Address_____

Social Security Number _____-_____-_____ Date of Birth _____

Employer_____ Occupation _____

Employer's Address_____
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Emergency Contact/Friend not living with you_____

Emergency Home Phone#_____ Emergency Work Number_____

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Insurance Information

Insured's Name_____ Relationship to Patient_____

Insured's Employer _____ Insured's Date of Birth _____

Name of Insurance Company _____ Group Number_____

Insurance Company Address _____
STREET CITY STATE ZIP

I have received the following treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental plan benefit plan, unless Greer Pediatric Dental Care has a contractual agreement with my plan prohibiting all or portions of such charges. To the extent permitted by law, I authorize release of any information relating to claims filed.

Signature of Insured_____ Date_____

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Medical History

Family physician or pediatrician _____

Date of last medical examination _____

Has your child had any of the following? Please indicate with a checkmark:

☐ Allergies to Anesthesia	☐ Childhood Illnesses	☐ Kidney/Liver	☐ Rheumatic Fever
☐ Allergies to Medicine/Drugs	☐ Contagious Disease	☐ Learning Disability	☐ Scarlett Fever
☐ Allergies to_____	☐ Diabetes	☐ Malignancies	☐ Sinus Problems
_____	☐ Epilepsy/Seizures	☐ Measles	☐ Speech Disorder
☐ Anemia	☐ Hearing Disability	☐ Mumps	☐ Stroke
☐ Asthma	☐ Heart Problems	☐ Nervousness	☐ Typhoid Fever
☐ Autism	☐ Hepatitis	☐ Oral Herpes	☐ Tonsillitis
☐ Bleeding Disorder	☐ HIV virus	☐ Psychological Problems	☐ Tuberculosis

Does your child have any health problems that require active care of a physician?
☐ Yes ☐ No

Is your child presently taking any medications?
☐ Yes ☐ No
If yes, please list: _____

Has your child ever been hospitalized?
☐ Yes ☐ No
Reason: _____

Do you consider your child to be progressing normally?
☐ Yes ☐ No
If not, explain:_____

Dental History

Has your child complained about any dental problem?
☐ Yes ☐ No

Any injuries or surgeries to mouth, teeth, or head?
☐ Yes ☐ No
If yes, explain:_____

When did your child stop taking the bottle or sippy cup? _____

Do you assist your child with brushing?
☐ Yes ☐ No How often? _____

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Is dental floss used?

☐Yes ☐No How often? _____

Is your home supplied by well water?

☐Yes ☐No

Please check box if your child has any of the following habits

☐Thumb/Finger Sucking ☐Mouth Breathing ☐Pacifier ☐Nail Biting ☐Grinding
☐Other_____

Date of last dental visit `_____ With whom _____

Explain briefly why you brought your child for dental care:

_____

I hereby certify that all information is correct and true. Because the above-named child is a minor, it is necessary that a signed permission is obtained from a parent or legal guardian before any and/or all dental treatment can be commenced. I hereby grant such authorization, and shall accept responsibility for any and all fees incurred for such dental services. I understand that I am responsible for all charges whether or not covered by insurance.

Signature_____ Date _____

Relationship to Patient _____

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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 02/23/2010 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: Our facility employs an open system of delivering care. We will make every reasonable attempt to avoid accidental disclosure of your protected health information. Should you have any concerns, please advise us and we will attempt to accommodate you.

We may use or disclose, as needed, your protected health information in order to support our business activities.

For example, we may call you by name in the reception room when the doctor is ready to see you and she may have a copy of that day's schedule with your name on it in her operatory. We may use or disclose your protected health information, as needed, to contact you by phone or mail to confirm your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g. billing, etc.) for the practice.

Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary; to send you a newsletter or information regarding other services we might offer. We may also send you information about products or services we feel might be beneficial to you. You may contact our Privacy Officer to request that these materials not be sent to you.

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 reasons 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 notifi cation 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 of 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 by 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.

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 practically 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 $5.00 without x-rays and $10.00 if x-rays are requested. 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.

Contact Officer: Dr. Mary Okuley
Telephone: 864-879-7977
Email: dr.mary@gpdcare.com
Address: 3115 F Brushy Creek Road, Greer, SC 29650

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TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. I also consent to the medically appropriate disposal of any tissue or teeth which may be removed during operative procedures.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Dr. Mary Okuley
Telephone: 864-879-7977

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I,_____ ,(Parent/Legal Guardian) have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature: _____

Date: _____ Patient's Name: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Relationship to Patient: _____

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature:_____ Date:_____

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APPOINTMENT POLICY

We reserve time for each and every patient. Your child's scheduled appointment is specifically for him/her. Any change in this appointment affects many other patients. If a cancelation is unavoidable, please call the office in advance so that we may give that time to another patient.

I, _____, (Parent/Legal Guardian) understand that if I fail to give a 24- hour advance notice for a regular scheduled appointment or a 48- hour advance notice for a sedation appointment on more than 2 occasions, my child(ren) will be dismissed from Greer Pediatric Dental Care.

Signature: _____

Date: _____ Patient's Name: _____

PUBLICATIONS, PICTURE, AND INTERNET RELEASE FORM

As you are aware, there are potential dangers associated with the posting of personally identifiable information on a web site. Since global access to the Internet does not allow us to control who may access such information, these dangers have always existed. However, as your child's care provider, we want to celebrate your child and his/her good dental habits and behavior. The law requires that we ask your permission to post information about your child in the public domain.

Please check one of the following:

☐ I hereby grant permission for any photos/image and name to be published on the Greer Pediatric Dental Care internet site, media, newsletter, and/or promotional materials.

☐ I hereby grant permission for any photos/image (but not name) to be published on the Greer Pediatric Dental Care internet site, media, newsletter, and/or promotional materials.

☐ I do not grant permission for my child's photo/image or name to be published by Greer Pediatric Dental Care internet site, media, newsletter, and/or promotional materials.

☐ I also acknowledge that Greer Pediatric Dental Care may choose not to use my photo at this time, but may do so at its own discretion at a later date.

This release will supersede any previous releases on file.

Parent/Guardian name: (Please Print) _____

Signature: _____

Patient's name: _____ Date: _____