Randall J. Pagenkopf, DMD, P.A.
Pediatric and Adolescent Dentistry

My staff and I welcome you to our family of patients and thank you for selecting us to provide your children with their dental care.

As we being our “partnership,” we pledge to give your children the basis for a lifetime of excellent dental health in an environment designed with their comfort in mind. It is our goal to assure excellent oral health both in our office and at home. Our dental care techniques use the most current and progressive methods supported by accepted research. Our dental professionals love children and participate actively in dental education to remain current at the highest level.

In this welcome pack you will find our medical history and insurance information forms, as well as a copy of our financial police. We ask that you complete all applicable information and bring it with you to your first visit. If at any time you have questions about treatment, fee, service, or policies, we hope you will feel comfortable discussing them with us promptly and openly.

For a closer look at our practice and to print out a “MY VISIT TO THE DENTIST” coloring book keepsake, we invite you to visit our website at www.smilesbydrrandy.com.

We look forward to meeting you soon.

Dr. Randy and Staff

495 Wando Park Blvd., Suite 100 | Mt. Pleasant, SC 29464
Phone: (843) 971-6221 | Fax: (843) 971-3810 | www.smilesbydrrandy.com

Randall J. Pagenkopf, D.M.D.

Pediatric & Adolescent Dentistry

The following information is necessary for us to provide the best possible treatment for you child. Please respond completely to all questions.

Patient's full name ______________________ Prefers to be called ______________ Age _____

Sex _____ Race ______________ Date of birth __________ Place of birth ______________________

Patient's street address ______________________ City ______________ State _____ Zip ________

Home phone (________) ______________________

Father's name ______________________ Date of birth __________ Social Security # ______________

His street address ______________________ City ______________ State _____ Zip ________

Phone (______) ____________ Where employed? ______________________ Phone (______) ____________

Father's dental insurance ______________ Address ______________ Policy # ______________

Mother's name ______________________ Date of birth __________ Social Security # ______________

Her street address ______________________ City ______________ State _____ Zip ________

Phone (______) ____________ Where employed? ______________________ Phone (______) ____________

Mother's dental insurance ______________ Address ______________ Policy # ______________

Phone numbers for appointment confirmation/reminder ______________________________

With whom does patient live? ____

Medicaid? ☐ Yes ☐ No Children's Special Health Services ______________ Other ______________

Patient's physician ______________________ Family dentist ______________________

How did you learn about us? ☐ Doctor ☐ Parent ☐ Patient ☐ Phone book Referring person's name ______________

______________ Address ______________ City ______________ State _____ Zip ________

Health history

	Yes	No
Is your child in good health?	☐	☐
Does your child have regular medical exams?	☐	☐
Are your child's immunizations current?	☐	☐
Is your child presently taking medication?	☐	☐
Please list ______________________		
Any history of allergic reaction to medication?	☐	☐
Please list ______________________		
Is your child undergoing any medical treatment?	☐	☐
Please explain ______________________		
Has your child been hospitalized since birth?	☐	☐
Date __________ Reason ______________		
List any infectious diseases ______________		

Please check any that pertain to your child

☐ Hepatitis	☐ Asthma
☐ Lung problem	☐ Allergies
☐ Brain injury	☐ Mental disability
☐ Liver problem	☐ Mental disorder
☐ Kidney problem	☐ Emotional disorder
☐ Epilepsy	☐ Nervous disorder
☐ Diabetes	☐ Autism
☐ Cerebral palsy	☐ Speech disorder
☐ Bleeding disorder	☐ Hearing disorder
☐ Sickle cell anemia	☐ Vision disorder
☐ Tuberculosis	☐ Other ______________

Other information

	Yes	No
Is this your child's first dental visit?	☐	☐
If no, date of last dental care ______________		
Any unfavorable experiences in a dental office?	☐	☐
Does your child have a toothache?	☐	☐

	Yes	No
Is your child a finger sucker?	☐	☐
Does your child use a pacifier?	☐	☐
Was your child bottle fed? Until age ______	☐	☐
Was your child breast-fed? Until age ______	☐	☐

Purpose of today's appointment ____

What is your water source? ☐ Private well ☐ Public system Name of public system ______________

Thank you for your help. If there is any additional information that you think might be of value to us in treating your child, please feel free to comment: ____

I agree to diagnostic procedures and dental treatments as found necessary and desirable by Randall J. Pagenkopf, D.M.D. for the patient named above. I do also authorize and request the administration of such anesthesia /sedatives as may be deemed advisable by the above named doctor. I am aware that I will be informed of all services before any treatment is rendered to my child. I will accept responsibility for this account should named party fail or insurance benefit be denied. Date ______________ Signature ______________________

Email: ______________________

Welcome to our Practice!

We would love to get to know you better. We consider out patients out friends.
Please tell us a little about yourself and feel free to ask us questions, too.

1. My name is ______________________________

2. My friends call me ______________________________

3. I attend school at ______________________________

4. I'm in the __________ grade.

5. My favorite subject in school is ______________________________

6. I have a pet that is a _________ their name is ____________

7. My Favorite TV show is ______________________________

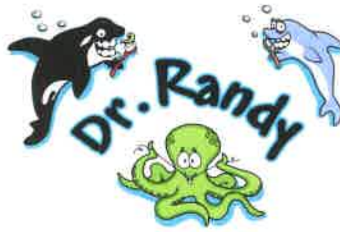
8. My favorite book is ______________________________

9. My favorite singer or band is ______________________________

10. My favorite food is ______________________________

11. My favorite sports are ______________________________

12. My hobbies are ______________________________



Randall J. Pagenkopf, DMD, P.A.
Pediatric and Adolescent Dentistry

Financial Agreement

Our office believes that an essential part of a good relationship is to establish and communicate a financial agreement to our parents.

- Payment is due at the time of your child's visit. We will gladly accept cash, check, Visa, Master Card, or Discover. We run checks electronically (same as a debit card) so we ask that you have a valid driver's license and telephone number on each check.

- If your child has dental insurance, we will file your primary claim and, if applicable, assist you with the filing to your secondary dental insurer. Dr. Randy is not in- network with any dental insurance so you will be responsible, at the time of service, for any estimated charge that is not covered by your dental plan.

- Payment will include any unmet annual deductible, coinsurance, or non- covered charges from your primary insurance carrier. If you do not have any insurance coverage or if your coverage is currently under a pre- existing condition clause, payment in full is expected at the time of your child's visit.

- Because Dr. randy is not in network with any dental contracts, there are a few dental insurances that are set up to reimburse the patient. If these companies are set up to reimburse you, the subscriber, you will pay for th eservices up front, we will file with your insurance, and your insurance company will reimburse you.

- If your child misses an appointment and you are not able to give the office 24 hours notice to change an appointment, you will be asked to pay a $50.00 rescheduling fee.

- There are instances when a family has some changes in the parental structure. If this is the case, the parent that brings the child to the appointment is responsible for payment at the time of service. If payment arrangements are to be made by another party, the payment must be received prior to or at the time of your child's appointment.

- In those rare cases when an account has been turned over to a collection agency or Small Claims Court, the account holder will be responsible for the balance on the account, as well as costs associated with collections, including any court fees.

Signature of Parent ____

Date ____

Randall J. Pagenkopf, DMD, 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.

* ______________________

(Please Print Name)

* ______________________

(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
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please Specify) ______________________________

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Reproduction and use of this form by dentists and their staff is permitted. Any other use, duplication or distribution of this form by any other party requires the prior written approval of the American dental association.

This form is educational only, does not constitute legal advice, and covers only federal not state law (August 14, 2002)

Randall J. Pagenkopf, D.M.D

Notice of Privacy Practices

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 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 on 07/30/2007 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 forms 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 Discovery 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 or 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 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 of 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 $0.10 for each page, $6.00 per hour for staff time to locate and copy you r 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 purpose 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 Communications: 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 this 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 Website 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 complain to the U.S. Department of Health and Human Services. We will provide you with the address to file a complaint with us or with the U.S. Department of Health and Human Services.

Office Manager: Chandi
Telephone: 843-971-6221
Fax: 843-971-3810
Email: smilesbydrrandy@gmail.com
Address: 495 Wando Park Blvd. Ste. 100
Mt. Pleasant, SC 29464