Comprehensive Family DENTAL
HEALTH FOCUSED DENTISTRY & ORTHODONTICS

PATIENT INFORMATION

Welcome to our practice!
This confidential information will help us prepare for your visit.

PATIENT

NAME	NICKNAME
SS #	BIRTHDATE
INTERESTS/HOBBIES/SPORTS	
WHOM MAY WE THANK FOR REFERRING YOU?	
FAMILY MEMBERS SEEN AS PATIENTS HERE	

PRIMARY PARENT/GUARDIAN INFORMATION

PARENT OR LEGAL GUARDIAN #1	RELATIONSHIP TO PATIENT	SS #
DATE OF BIRTH	ADDRESS	EMAIL
HOME PHONE #	CELL PHONE #	WORK PHONE #
EMPLOYER NAME	OCCUPATION	EMPLOYER ADDRESS

DENTAL INSURANCE COMPANY NAME	DENTAL INSURANCE COMPANY ADDRESS	DENTAL INSURANCE COMPANY PHONE #	GROUP OR POLICY

SECONDARY PARENT/GUARDIAN INFORMATION

PARENT OR LEGAL GUARDIAN #2	RELATIONSHIP TO PATIENT	SS #
DATE OF BIRTH	ADDRESS	EMAIL
HOME PHONE #	CELL PHONE #	WORK PHONE #
EMPLOYER NAME	OCCUPATION	EMPLOYER ADDRESS

DENTAL INSURANCE COMPANY NAME	DENTAL INSURANCE COMPANY ADDRESS	DENTAL INSURANCE COMPANY PHONE #	GROUP OR POLICY

We may use an automated appointment reminder system that can send you convenient email, text messages, and/or postcards. We may also call and if necessary leave brief voicemail messages.

If you would prefer **NOT** to receive routine reminders from us via certain methods, please indicate below:

☐ NO TEXT MESSAGES ☐ NO EMAILS ☐ NO CELL PHONE ☐ NO HOME PHONE ☐ NO WORK PHONE ☐ NO POSTCARDS

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HEALTH HISTORY

Welcome to our practice!
This confidential information will help us prepare for your child's visit.

MY CHILD'S CURRENT MEDICAL HEALTH IS
◯ EXCELLENT ◯ GOOD ◯ FAIR ◯ POOR

My CHILD IS UNDER THE CARE OF A PHYSICIAN
◯ YES ◯ NO

PHYSICIAN NAME

PHYSICIAN PHONE #

PHYSICIAN ADDRESS

MY CHILD TAKES THE FOLLOWING MEDICATIONS (INCLUDE BOTH PRESCRIPTION & OVER THE COUNTER)

DOES YOUR OR HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING?

☐ ANEMIA	☐ COLD SORES	☐ FEVER BLISTERS	☐ HIV/AIDS	☐ SCARLET FEVER
☐ ARTHRITIS	☐ COLITIS	☐ GLAUCOMA	☐ HOSPITALIZED	☐ SEVERE OR FREQUENT HEADACHES
☐ ARTIFICIAL JOINT	☐ DIABETES	☐ HEART ATTACK	☐ KIDNEY PROBLEMS	☐ SHINGLES
☐ ARTIFICIAL VALVE	☐ DIFFICULTY BREATHING	☐ HEART MURMUR	☐ MITRAL VALVE PROLAPSE	☐ SINUS PROBLEMS
☐ ASTHMA	☐ DRUG/ALCOHOL DEPENDENCE	☐ HEART SURGERY	☐ PACEMAKER	☐ STROKE
☐ BLOOD TRANSFUSION	☐ EMPHYSEMA	☐ HEMOPHILIA/BLEEDING	☐ PSYCHIATRIC PROBLEMS	☐ TUBERCULOSIS
☐ CANCER	☐ EPILEPSY/SEIZURES	☐ HEPATITIS	☐ RADIATION TREATMENT	☐ ULCERS
☐ CHEMOTHERAPY	☐ FAINTING	☐ HIGH/LOW BLOOD PRESSURE	☐ RHEUMATIC FEVER	☐ _____

IS YOUR CHILD ALLERGIC TO OR HAD DIFFICULTY WITH ANY OF THE FOLLOWING SUBSTANCES

☐ ASPIRIN ☐ CODEINE ☐ DENTAL ANESTHETIC ☐ ERYTHROMYCIN ☐ LATEX ☐ PENICILLIN ☐ SULFA ☐ TETRACYCLINE

☐ OTHER (PLEASE LIST): _____

PLEASE SELECT ONE

◯ MY CHILD CURRENTLY HAS NO DENTAL PAIN, JAW PAIN, OR SENSITIVITY
◯ MY CHILD CURRENTLY HAS SOME DENTAL PAIN, JAW PAIN, OR SENSITIVITY

PLEASE SELECT ONE

◯ MY CHILD'S MOUTH IS VERY COMFORTABLE
◯ MY CHILD'S MOUTH IS MODERATELY COMFORTABLE
◯ MY CHILD'S MOUTH IS UNCOMFORTABLE

The information provided is accurate & complete to the best of my knowledge. I authorize the doctor to take X-rays, make study models, photographs, or other diagnostic materials deemed appropriate by the doctor to make a diagnosis of my child's dental health condition. I authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the services required for my child's dental health. I understand that the doctor will discuss treatment before it is initiated. I further authorize and consent that the doctor choose and employ such assistance as deemed fit.

I understand that the responsibility for payment for professional services provided in this office for my child is mine, due and payable at the time services are rendered unless written financial arrangements have been made and signed by me. In the event of default I promise to pay interest on the indebtedness, together with any collection costs and attorney fees as may be required to effect collection.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

DATE

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR CHILD'S HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your child's health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your child's health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice 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 your child for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your child's health information to a physician or other healthcare provider providing treatment to your child.

Payment: We may use and disclose your child's health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your child's 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 child's health information for treatment, payment or healthcare operations, you may give us written authorization to use your child's 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 child's health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your child's health information to you, as described in the Patient Rights section of this Notice. We may disclose your child's health information to a family member, friend or other person to the extent necessary to help with their healthcare or with payment for their 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, a personal representative or another person responsible for your child's care, of their location, their general condition, or death. If you are present, then prior to use or disclosure of your child's 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 child's healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your child's 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 child's health information for marketing communications without your written authorization.

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

Abuse or Neglect: We may disclose your child's health information to appropriate authorities if we reasonably believe that they 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 their 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 child's health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

THIS NOTICE OF PRIVACY PRACTICES CONTINUES ON NEXT PAGE

NOTICE OF PRIVACY PRACTICES

PATIENT RIGHTS

Access: You have the right to look at or get copies of your child's 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 child's 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, charges may apply for printing, postage, and time needed to complete the request. 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 child's 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 child's 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 child's 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 child's 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 child's privacy rights, or you disagree with a decision we made about access to your child's health information or in response to a request you made to amend or restrict the use or disclosure of their health information or to have us communicate with you by alternative means or at alternative locations, you may file your complaint 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 child's 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.

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Note: You may refuse to sign this acknowledgment.

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

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY	DATE

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ INDIVIDUAL REFUSED TO SIGN
- ☐ COMMUNICATION BARRIERS PROHIBITED OBTAINING THE ACKNOWLEDGMENT
- ☐ AN EMERGENCY SITUATION PREVENTED US FROM OBTAINING ACKNOWLEDGMENT
- ☐ OTHER (PLEASE SPECIFY): _____

SIGNATURE OF OFFICE REPRESENTATIVE	DATE

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ALL ABOUT YOU

Help us get to know your child by having them fill this out or filling it out with them

Name	Nickname	Age

Hobbies/Interests

Pets

School	Grade

Favorite Color	Favorite Food

Favorite Movie/Show	Favorite Character

Favorite Animal	Favorite Holiday

What do you want to be when you grow up?

How do you feel about the dentist?

What questions do you have for the doctor?