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Pediatric Dentist

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www.thepediatricdentalstudio.com

Tell Us About Your Child

Today's Date: _____ Child's Name: _____ Nickname: _____
Last *First* *MI*

Child's Birthdate: _____ Child's Age: _____ ☐ Male ☐ Female Is your child adopted? ☐ Yes ☐ No

School: _____ Grade: _____ Social Security #: _____

Child's Home Address: _____
Street *City* *State* *Zip*

Child's Home Phone: _____ Who may we thank for referring you? _____

What is the primary reason for today's visit? _____

Dental History

Is this your child's first dental visit? ☐ Yes ☐ No

Is your child currently in pain? ☐ Yes ☐ No Has your child experienced problems with previous dental work? ☐ Yes ☐ No

If so, explain: _____

Previous dentist: _____ Date of last visit: _____ Date of last x-ray: _____

Why did you leave your previous dentist? _____

What did you like most about any dentist you have seen? _____ Least? _____

Have there been any injuries to your child's teeth jaws, falls, blows, chips, etc. ☐ Yes ☐ No

Does your child take fluoride vitamins or drink fluoridated water? ☐ Yes ☐ No

Has your child been seen by an orthodontist? ☐ Yes ☐ No Who? _____

Does your child brush his / her teeth daily? ☐ Yes ☐ No Does he / she require parental help? ☐ Yes ☐ No

Does your child floss his / her teeth daily? ☐ Yes ☐ No Does he / she require parental help? ☐ Yes ☐ No

Name of parent's dentist: _____ City: _____ Phone: _____

Does / did your child have any of the following habits: *(check the boxes that apply)*

☐ Lip sucking and nail biting	☐ Chewing on objects	☐ Clenching / grinding teeth	☐ TMJ / TMD pain
☐ Thumb / finger sucking	☐ Nursing bottle habits	☐ Tongue / cheek biting	☐ Used pacifier
☐ Tongue thrust	☐ Mouth breather	☐ Sippy cup	☐ Breast fed

Medical History

Child's physician: _____ Phone: _____ Date of last visit: _____

Address: _____
Street *City* *State* *Zip*

Is your child currently under the care of a physician ☐ Yes ☐ No Please explain: _____

Does your child have social / personality / temperament concerns that we should be aware of? _____

Please describe your child's current physical health: ☐ Good ☐ Fair ☐ Poor **Are immunizations current?** ☐ Yes ☐ No

Please list all medication and dosage that your child is currently taking: _____

Please list all drugs and / or things that cause your child allergic reactions: _____

Anything you would like to discuss with the doctor in private? ☐ Yes ☐ No

Has your child had / experienced any of the following: *(check the boxes that apply)*

☐ Abnormal bleeding	☐ ADD / ADHD	☐ Diabetes	☐ Low blood pressure
☐ AIDS / HIV +	☐ Endocrine system disorders	☐ Lupus	☐ Epilepsy / Seizures
☐ Physical delays	☐ Anemia	☐ Frequent infections	☐ Any hospital stays
☐ Frequent headaches	☐ Any operations	☐ Asthma	☐ Mental delays
☐ Rheumatic fever	☐ Autism	☐ Blood disorder	☐ Blood transfusion
☐ Breathing / Lung problems	☐ Hepatitis	☐ Sight disorders	☐ Cancer / Tumors
☐ High blood pressure	☐ Celiac disease	☐ Social delays	☐ Cerebral palsy
☐ Kidney disease	☐ Speech / Hearing problems	☐ Congenital birth defect	☐ Liver disease
☐ Stomach / GI disease	☐ Heart condition / Murmur	☐ Tuberculosis (TB)	

Please discuss any serious medical problems your child experiences, now or in the past: _____

_____

Parent/Guardian's Information

Family's E-mail: _____ Parent's Marital Status ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Remarried ☐ Single

Father

Name: _____ Birthdate: _____ Check Appropriate: ☐ Step-Father ☐ Guardian

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer: _____ Occupation: _____ Social Security #: _____

Mother

Name: _____ Birthdate: _____ Check Appropriate: ☐ Step-Mother ☐ Guardian

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer: _____ Occupation: _____ Social Security #: _____

Name of parent who resides with the child: _____

Nearest relative: _____ Address: _____ Phone: _____

Insurance Information

Is your child covered by a dental insurance plan? ☐ Yes ☐ No

Primary Insurance

Insurance Co. Name: _____ Phone: _____ Group #: _____
Plan, Local, or Policy Number

Insurance Co. Address: _____ City _____ State _____ Zip _____
Street / PO Box

Insured's Name: _____ Relationship to Patient: _____

Insured's Address: _____ Home Phone: _____
If different from above

Insured's Birthdate: _____ Social Security #: _____ Insured's Employer: _____

Secondary Insurance

Insurance Co. Name: _____ Phone: _____ Group #: _____
Plan, Local, or Policy Number

Insurance Co. Address: _____ City _____ State _____ Zip _____
Street / PO Box

Insured's Name: _____ Relationship to Patient: _____

Insured's Address: _____ Home Phone: _____
If different from above

Insured's Birthdate: _____ Social Security #: _____ Insured's Employer: _____

Authorization and Release

To the best of my knowledge the information I have given on this form is correct, and 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 authorize the dentist to release any information including the diagnosis and the records of any treatment or exam rendered to my child during the period of such dental care to third party payers and / or their health practitioners.

I have received a copy of this office's Notice of Privacy Practices. I consent to their use and disclosure of my children(s) Protected Health Information to carry out treatment, payment activities and healthcare operations.

Signature _____ Date _____

Consent for Dental Treatment

I request and authorize Dr. Rose and The Pediatric Dental Studio's staff to provide my child with a comprehensive examination and prescribe X-rays that may be considered necessary to diagnose and/or treat my child's dental condition. Thereafter, I will be presented the treatment recommendations, risks, benefits and options to make informed decisions about my child's care. At that time I request and authorize Dr. Rose and his staff to complete the accepted treatment for my child.

Signature _____ Date _____

THE PEDIATRIC DENTAL STUDIO

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN 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 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 takes effect April 14, 2003, 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 your child for treatment, payment, and healthcare operations. For example:

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

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

Healthcare Operations: We may use and disclose health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications for healthcare professionals, evaluating practitioner and provider performance, conduction 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 legal guardians, 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 your child's healthcare or with payment for your child's healthcare, but only if you agree 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 child's care, of your child's location, your child's 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 obtain dental 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 use or disclose your child's health information to appropriate authorities if we reasonably believe that your child is a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your child's health information to the extent necessary to avert a serious threat to your child's 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).

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, we will charge you five dollars for each page, twenty-five dollars per hour for staff time to locate and copy your 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 child's health information in that format. If you prefer, we will prepare a summary of an explanation of your child's 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 our business associates or we 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 of 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 our 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 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 your child's health information or to have us communicate with you by alternative means or at 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 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.
