We would like to say thank you for selecting our dental team! So that we may better serve you, please provide or update this information for us. This practice is HIPPA compliant and all information is secured for treatment and insurance purpose only. Your thoroughness is greatly appreciated.

Child's Information

Your Child: ____ Date: ___________
Last, First MI (Preferred Name)

Birth Date: __________ Gender: ☐ Male ☐ Female Child's Social Security #: ______________________

Phone (Home): ________________ School: ________________________ Grade: _________________

How do you prefer us to notify you for your child's appointments? ☐ Home ☐ Work ☐ Cell ☐ E-Mail ☐ Text Message

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐ M ☐ T ☐ W ☐ TH ☐ F

Child's Home Address: ____
Street Apartment #

____
City State Zip Code

Health Information

Date of Last Dental Visit: ________________ Reason for that visit: ____________________________

Has your child ever had any of the following? Please check those that apply:

MEDICAL HISTORY
- ☐ AIDS/HIV
- ☐ Allergies __________
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Eye Disorders
- ☐ Handicaps/ Disabilities
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur / MVP
- ☐ Hepatitis / Jaundice
- ☐ Immune Disorders
- ☐ Kidney Disease
- ☐ Latex Allergy
- ☐ Liver Disorders

DRUG ALLERGIES
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Other Drug Allergies

DENTAL HISTORY
- ☐ Bad Breath
- ☐ Bite/ Chew Nails
- ☐ Biteguard Therapy
- ☐ Bleeding Gums
- ☐ Bleaching Treatment
- ☐ Blisters/ Sores on Lips
- ☐ Clench/ Grind Teeth
- ☐ Mouth Breathing
- ☐ Severe Gag Reflex
- ☐ Suck/ Bite Lip
- ☐ Suck Thumb/ Finger
- ☐ Wisdom Teeth removed

- Has your child ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: ____
- Has your child been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: ____
- Is your child under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: ____
- Name of Physician: ______________________________________ Phone: ______________
  ☐ Prescribed Medications: ____
- Does your child have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: ____
- Has your child had orthodontic treatment? ______________ If so when ______________________________

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other ________________

Name of person or office referring you to our practice: ______________________________________

Parent or Responsible Party Information

The following is: ☐ Mother ☐ Stepmother ☐ Father ☐ Stepfather ☐ Guardian

Name: ____________________

☐ Male ☐ Female

Social Security #: ____________________ Birth Date: ____________________

Phone (Home): ____________ (Work): ____________ Ext: ______ Best time to call: ____________

Address: ____________________ Cell Phone (optional) ____________________

Street Apartment #

____

City State Zip Code E-MAIL ADDRESS

Responsible Party
Employer Name: ____________________ Occupation: ____________________

Address: ____________________

Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: ____________________ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: ____________ ID #: ____________ Group #: ____________

Insured's Address: ____________________

Street City State Zip Code

Insured's Employer Name: ____________________

Address: ____________________

Street City State Zip Code

Patient's relationship to insured: ☐ Child ☐ Other ____________

Insurance Plan Name and Address: ____________________

____

Secondary

Name of Insured: ____________________ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: ____________ ID #: ____________ Group #: ____________

Insured's Address: ____________________

Street City State Zip Code

Insured's Employer Name: ____________________

Address: ____________________

Street City State Zip Code

Patient's relationship to insured: ☐ Child ☐ Other ____________

Insurance Plan Name and Address: *«SIns_Name»*

____

Consent for Services

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information could be dangerous to my child's health. It is my responsibility to inform your office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/ or other health practitioners.

____________________ Date: ____________ Relationship to Patient: ____________

Signature of parent or guardian

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Health Insurance Portability Accountability Act (HIPAA), 1996

http://www.hhs.gov/ocr/hipaa/finalreg.html

SECTION A: PATIENT/GUARDIAN GIVING CONSENT

Name: ____

Address: ____

Telephone:__________________________________Social Security #: _____________________

SECTION B: TO THE PATIENT/GUARDIAN — 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.
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, and 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:
«Practice_Name» «Practice_Address» «Practice_CitySTZip» «Practice_Phone»

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.

SIGNATURE

I, «FName» «LName», 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 health care operations.

Signature: ____ Date: ___________________________

If a personal representative on behalf of the patient signs this Consent, complete the following:

Personal Representative's Name: ____________________________________

Relationship to Patient: ____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. PLEASE ADVISE US IF YOU WANT A COPY.

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: __________________

Acknowledgement of Receipt
Notice of Privacy Practices
Purpose: This form is used to obtain acknowledgement that you have been notified that our *NOTICE OF PRACTICE POLICIES* can be obtained via our office. This document is printable via the web site for your records.
HIPAA web-site: **http://www.hhs.gov/ocr/hipaa/finalreg.html**

You May Refuse to Sign This Acknowledgement*

I, «FName» «LName» , have received acknowledgement of this office's Notice of Privacy Practices.

____ September 20, 2006
Signature

For Office Use:

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)

____
____
____