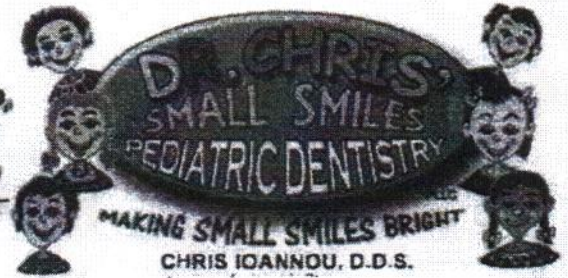


Welcome

Health History Form

Today's Date _____



NOTE: The person who accompanies the child to their appointment must present ID and is responsible for payment at the time of service.

1. Tell Us About Your Child

Child's legal Name _____
Goes by: _____ Gender: _____
Siblings we treat _____
Child's Birthdate ____/____/____ Child's Age _____
School _____ Grade _____
Child's Home # _____ SS # _____
Parents' relationship status (please circle):
Single Married Divorced Widowed Separated
Child's primary address: _____

City State County Zip

2. Parent/Guardian #1 Information

Name _____
Relationship to Child: _____ Birthdate ____/____/____
Employer _____
Home Address (if different from child) _____

City State County Zip
Work # (_____) Ext. _____
Home # (_____) _____
Cellular Phone # (_____) _____
SS # _____ DL# _____
Email address: _____

3. Parent/Guardian #2 Information

Name _____
Relationship to the child: _____ Birthdate ____/____/____
Employer _____
Home Address (if different from child) _____

City State County Zip
Work # (_____) Ext. _____
Home # (_____) _____
Cellular Phone # (_____) _____
SS # _____ DL# _____
Email address: _____

4. Who is Accompanying the Child Today?

Name _____
Relationship _____
Do you have legal custody of this child? Yes No

5. Person Responsible for Account

Name _____
Relationship _____
Billing Address _____

City State Zip
Home # (_____) _____
Work # (_____) _____
Cellular # (_____) _____
E-mail _____

6. Primary Dental Insurance

Insurance Co. Name _____
Insurance Co. Address _____

Insurance Co. Phone # (_____) _____
Group # (Plan, Local, or Policy #) _____
Policy Owner's Name _____
Relationship to Patient _____
Policy Owner's Birthdate ____/____/____
Social Security # _____
Policy Owner's Employer _____

7. Secondary Dental Insurance

Insurance Co. Name _____
Insurance Co. Address _____

Insurance Co. Phone # (_____) _____
Group # (Plan, Local, or Policy #) _____
Policy Owner's Name _____
Relationship to Patient _____
Policy Owner's Birthdate ____/____/____
Social Security # _____
Policy Owner's Employer _____

8. Who may we thank for referring you to our office?

9. Dental History

Is this your child's first visit to the dentist? _____

If not, how long since the last visit to the dentist? _____

Previous Dentist's Name _____

Were any x-rays taken at previous dental visits? _____

Have there been any injuries to the teeth, face or mouth? _____

If yes, please explain _____

Why did you bring the child to the dentist today? _____

Does the child have any of the following habits?

Y N Lip Sucking / Biting Y N Nail Biting

Y N Nursing / Bottle Habits Y N Thumb / Finger Sucking

Has the child ever had a serious or difficult problem associated with previous dental work? Yes No

If yes, please explain _____

Is the child's water fluoridated? Yes No

Is the child taking fluoride supplements? Yes No

Has the child ever had any pain or tenderness in his/her jaw joint? (TMJ/TMD)? Yes No

Does the child brush his/her teeth daily? Yes No

Floss his / her teeth daily? Yes No

10. Health History

Has the child ever had any of the following conditions?

- | | |
|------------------------------|--------------------------------|
| Y N Abnormal Bleeding | Y N Disabilities/Special Needs |
| Y N Allergies to any Drugs | Y N Hearing Impairment |
| Y N Any Hospital Stays | Y N Heart Disease/Murmur |
| Y N Any Operations | Y N Hemophilia/Blood Disorders |
| Y N Asthma | Y N Hepatitis |
| Y N Cancer | Y N HIV + / AIDS |
| Y N Congenital Birth Defects | Y N Kidney/Liver Conditions |
| Y N Convulsions/Epilepsy | Y N Rheumatic/Scarlet Fever |
| Y N Pregnancy | Y N Allergies to Latex Product |
| Y N Tuberculosis | Y N Diabetes |
| Y N ADD / ADHD | Y N Autism |

Please discuss any serious medical conditions the child has had

Please list all drugs the child is currently taking _____

Please list all drugs the child is allergic to _____

Child's Physician _____

Phone (_____) _____

Is the child currently under the care of a physician? Yes No

Please describe the child's current physical health...

Good Fair Poor

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA the CDC, and the ADA.

11. I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

Signature of Parent or Guardian _____ Date _____ Relationship to Patient _____

For Office Use Only

I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein.

Initials _____ Date _____

Doctor's Comments _____

FINANCIAL AGREEMENT

Name: _____

DOB: _____

We are required by applicable federal and state laws 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 as of 2/25/2003, 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 federal and state laws. We reserve the right to make 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 privacy notice at any time. For more information about our privacy practices, or 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: 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 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.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited expectations. You may request that we provide copies in a format other than photocopies. We use the format your request unless we cannot practicably do so. (You must make a request in writing to obtain 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 for each page, \$0 per hour for staff time to locate the copy of 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 health information in that format. If you prefer, we will prepare a summary or 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 request.

Restriction: You have the right to request that we place additional restrictions on our use or discloser of your health information. We are not permitted 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 payment will be handled under the alternative means or location you request.

Signature: _____

Date: _____

DISCLOSURE

Name: _____

DOB _____

I have been informed and acknowledge that the dental treatment/services listed below may not be covered by my insurance plans benefits and fee schedule. I am aware that I will be financially responsible for paying for these services if not covered. Fees are not to exceed providers UCR.

Code	Dental Description	Fee
D9230	Nitrous Oxide	\$100
D1354	SDF	\$85
D1206	Fluoride Varnish	\$60

I have been informed that if I pay for a non covered service that has changed to a covered service the time the service was rendered, I will be reimbursed whatever fees were paid by me for that covered service.

Signature: _____

Date _____

NOTICE OF PRIVACY PRACTICES – HIPAA & 42 CFR PART 2

This Notice of Privacy Practices ("Notice") describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Protected health information (PHI) includes information that identifies you and relates to your past, present, or future physical or mental health or condition, the healthcare services you receive, or payment for those services.

Some types of health information, including records related to Substance Use Disorder (SUD), receive additional protections under federal law, including regulations found at 42 CFR Part 2, in addition to HIPAA. These enhanced protections are explained later in this Notice.

OUR PLEDGE REGARDING YOUR HEALTH INFORMATION

We understand that your health information is personal and confidential. We are committed to protecting the privacy and security of your protected health information (PHI). We are required by law to:

- Maintain the privacy of your PHI
- Provide you with this Notice of our legal duties and privacy practices
- Follow the terms of this Notice
- Notify you if a breach occurs that may have compromised the privacy or security of your information

HOW WE MAY USE AND DISCLOSE YOUR PHI

Treatment – We may use and disclose your PHI to provide, coordinate, or manage your dental care and related services.

Payment – We may use and disclose your PHI to obtain payment for services provided to you.

Healthcare Operations – We may use and disclose your PHI for practice operations, including quality assessment, staff training, legal compliance, auditing, and business planning.

Appointment Reminders – We may use or disclose your PHI to contact you about appointments, reminders, or treatment alternatives.

Required by Law – We may use or disclose your PHI when required by federal, state, or local law.

Emergencies – We may use or disclose your PHI in emergency situations as necessary to protect your health or safety.

Public Health Activities – We may disclose PHI for public health purposes, including disease prevention and reporting.

Military, National Security, and Protective Services – We may disclose PHI as required for military activities, national security, and protective services.

Research – We may use or disclose your PHI for research purposes when approved by law and with appropriate safeguards.

Legal Proceedings – We may only disclose PHI in response to a valid court order or other lawful process or by your written consent.

Marketing – We will not use your PHI for marketing purposes without your written authorization.

Personal Representatives – We may only disclose your PHI to a personal representative authorized by you in writing.

Business Associates – We may share your PHI with business associates who perform services on our behalf. These business associates are required by law to safeguard your information.

Workers' Compensation – We may disclose PHI for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

SPECIAL PROTECTIONS FOR SUBSTANCE USE DISORDER (SUD) RECORDS

Some health information is considered especially sensitive and receives enhanced protection under federal law, including information related to Substance Use Disorder (SUD).

Even if this practice is not a substance use treatment provider, these protections may apply if we receive, maintain, or transmit SUD-related information as part of your health record.

How SUD Information May Be Used

SUD-related records may be used and disclosed for treatment, payment, and healthcare operations, as permitted by law, unless you request additional restrictions.

Prohibition on Legal Use

SUD-related records may not be used against you in criminal, civil, or administrative proceedings without your written consent or a specific court order.

Redisclosure Limitations

SUD-related information may not be redisclosed unless permitted by law. Additional restrictions may apply beyond standard HIPAA rules.

Fundraising Restrictions

Your SUD-related information will not be used for fundraising purposes without your consent. You have the right to opt out of fundraising communications.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the right to:

- **Access** – Obtain a copy of your PHI
- **Amendment** – Request corrections to your PHI
- **Accounting of Disclosures** – Receive a list of certain disclosures of your PHI
- **Restrictions** – Request limitations on how we use or disclose your PHI
- **Confidential Communications** – Request communications in a specific manner/location
- **Fundraising Opt-Out** – Opt out of fundraising communications
- **Breach Notification** – Be notified of breaches of unsecured PHI
- **Complaints** – File a complaint with the Office for Civil Rights without retaliation

CHANGES TO THIS NOTICE

We reserve the right to change this Notice. Any changes will apply to all PHI we maintain. The updated Notice will be available upon request, in our office, and on our website.

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGMENT

CONTACT INFORMATION

If you have questions, would like additional information, or wish to exercise your rights, please contact:

Practice Name: _____
Address: _____
Phone Number: _____
Email (optional): _____

PATIENT ACKNOWLEDGMENT OF NOTICE

By signing below, you acknowledge that you have received a copy of this Notice of Privacy Practices and understand your rights under HIPAA and applicable federal confidentiality laws, including special protections related to Substance Use Disorder (SUD) information.

- I acknowledge receipt of this Notice of Privacy Practices.
- I understand that SUD-related information may have additional protections.
- I understand my right to opt out of fundraising communications.
- I understand that certain disclosures may require my written authorization.
- Their SUD-related information cannot be used for fundraising without consent.

Patient Name (Print): _____
Signature: _____
Date: _____

If the patient is unable or unwilling to sign, staff should document the reason here.

Staff Initials: _____ Date: _____

If you believe your privacy rights have been violated, you may file a complaint with us or with OCR. You will not be penalized for filing a complaint.

Practice Privacy Officer: _____
Practice Address: _____
Phone Number: _____
Email (Optional): _____