PATIENT INFORMATION

Date_____/_____/_____ Email: _____

Patient Name (Last, First, Middle): _____

Gender: ☐ M ☐ F Age: _____ Birthdate:_____/_____/_____ Home Phone : (_____) _____

Best phone number to reach you (_____) _____

Address: _____

How did you hear about our office? _____

Who is accompanying your child today? _____

Relation to the child: _____ Do you have legal custody of the child? ☐Yes ☐No

In case of emergency, who should we contact? _____Phone: (____) _____

What school does your child attend?_____

How would you like to receive communication from our office (check all that apply) ? ☐ Phone ☐ Text ☐ Email

GUARDIAN INFORMATION (Both Parent/Guardian information required)

Your Name (Last, First)_____

Date of Birth: ____/____/____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

SS#_____-_____-_____

Address:_____

City:_____ State:____ Zip:_____

Home Phone: (_____) _____

Work Phone: (_____) _____

Cell Phone: (_____) _____

Occupation: _____

Employer: _____

Your Name (Last, First)_____

Date of Birth: ____/____/____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

SS#_____-_____-_____

Address:_____

City:_____ State:____ Zip:_____

Home Phone: (_____)_____

Work Phone: (_____)_____

Cell Phone: (_____) _____

Occupation: _____

Employer: _____

INSURANCE INFORMATION

PRIMARY

Adult who has insurance for the child _____

Employer _____

Plan Name _____

Phone Number (_____)_____

Address _____

_____

ID# _____

Group# _____

SECONDARY

Adult who has insurance for the child _____

Employer _____

Plan Name _____

Phone Number (_____)_____

Address _____

_____

ID# _____

Group# _____

DENTAL/MEDICAL HISTORY

Is this your child's first dental visit? ☐ Yes ☐ No If no, when and where was previous visit?_____

Has your child ever had problems receiving dental care? _____

Is there a particular problem with your child's teeth that prompted you to bring him/her to our office?

_____

_____

Does your child brush his/her teeth at home? ☐ Yes ☐ No

Is your child receiving fluoride in any form? ☐ Yes ☐ No ☐ I don't know

Has there been any injuries to the teeth, face or mouth? ☐ Yes ☐ No If yes, describe: _____

_____

Does your child have a history of any of the following habits? ☐ Nursing ☐ Bottle ☐ Sucking thumb/finger

☐ Pacifier ☐ Grinding teeth ☐ Snoring ☐ Mouth breathing Age Discontinued?_____

Physician's Name:_____ Phone number: (____)_____

Address _____

Has your child ever had any of the following diseases or medical problems? If so, please check:

☐ Congenital heart defect/disease	☐ Epilepsy/seizures	☐ Eye problems
☐ Heart murmur	☐ Psychological disorders	☐ Hearing problems
☐ Rheumatic fever	☐ Nervous system disorders	☐ Food, metal, dye allergies _____
☐ Cancer	☐ Hives/Rashes	☐ Autism
☐ Diabetes	☐ Cerebral palsy	☐ Speech problem/delay
☐ Liver problems	☐ HIV/AIDS	☐ Developmental delay
☐ Hepatitis	☐ Tuberculosis	☐ Sensory disorder/PDD
☐ Kidney problems	☐ Lung problems	☐ ADD/ADHD
☐ Joint replacement	☐ Asthma	☐ Any overnight hospital stays
☐ Excessive bleeding (Hemophilia)	☐ Sinus problems	☐ Any operations
☐ Pregnancy	☐ Cleft lip / palate	☐ Other:_____

Is your child taking any medications? ☐ Yes ☐ No

If yes, please list: _____

_____

Does your child need antibiotic treatment **prior** to dental appointments? ☐ Yes ☐ No

Is your child allergic to any medications, anesthetic, or latex? ☐ Yes ☐ No

If yes, please list: _____

Is your child in good health? ☐ Yes ☐ No

Is your child up to date on all immunizations? ☐ Yes ☐ No

Is there anything else you would like us to know about your child that can help us treat his/her needs better?

_____

_____

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.

X _____

Signature Printed name of parent/guardian Date

For office use only:

ROS:_____

Meds: _____

OR/Hosp: _____

ALL: _____

I verbally interviewed the medical/dental information above with the parent/guardian and patient name herein. Initials:_____Date_____

Arlington Pediatric Dentistry

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

□ Communications barriers prohibited obtaining the acknowledgement

□ An emergency situation prevented us from obtaining acknowledgement

□ Other (Please Specify)_____

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 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 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 12/31/12, 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 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.

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

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: 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 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 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 $1.00 for each page, $20.00 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 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 purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before December 31, 2012. 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 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 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 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 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 complaint to the U.S. Department of Health and Human Services. The address for the U.S. Department of Health and Human Services is also listed below.

We support your right to the privacy of your 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.

Contact Officer: Julie Holman

Address: Arlington Pediatric Dentistry 7410 South Cooper Street, Suite 100 Arlington, TX 76001

Telephone: (817) 465-0044 Fax (817) 465-0055 E-mail: julieh@arlingtonkidsdentist.com

Region VI, Office for Civil Rights

U.S. Department of Health and Human Services

1301 Young Street, Suite 1169 Dallas, TX 75202

HEALTH INFORMATION ACCESS
ARLINGTON PEDIATRIC DENTISTRY

The following are names of people, including myself, that I would like to be involved in or have access to my child's protected health information. I give permission for Arlington Pediatric Dentistry to share my child's protected health information with:

Name	Relationship	DL# or SS#
Name	Relationship	DL# or SS#
Name	Relationship	DL# or SS#

If you wish to add or terminate information access to or from the above list, you must submit your request in writing to:

Arlington Pediatric Dentistry ATTN: JULIE H
7410 South Cooper Street, Suite 100
Arlington, TX 76001

You may also fax your request to 817.465.0055. Please sign and date your request.