CHILD'S HISTORY & INFORMATION

Child's Name _____ / _____ / _____ Nickname _____
First Middle Last

Address: Street _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

Age _____ Sex _____ Birthdate _____ SSN _____ Is Child Adopted _____

Name and Age of Siblings _____

Child's Physician _____ Physician Phone _____

Family Dentist _____ Dentist's Phone _____

Whom may we thank for referring you to us _____

Father's Name _____ / _____ / _____
First Middle Last

Birthdate _____ SSN _____

Employer _____ Phone _____

Mother's Name _____ / _____ / _____
First Middle Last

Birthdate _____ SSN _____

Employer _____ Phone _____

Person Responsible for this account: Father _____ Mother _____ Other _____

Primary Dental Insurance _____ Group #: _____ Phone _____

Secondary Dental Insurance _____ Group #: _____ Phone _____

CHIEF COMPLAINT

PURPOSE OF VISIT

_____

_____

_____

_____

_____

_____

_____

Current medications/Medical treatments

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Remarks:

PAST MEDICAL HISTORY

DOES THE CHILD HAVE OR HAS THE CHILD HAD ANY OF THE FOLLOWING-INDICATE WITH AN (X)

- ☐ Allergies
- ☐ Anemia or Blood Problems
- ☐ Arthritis/Joint Pain
- ☐ **Asthma/Breathing problems**
- ☐ Bleeding problems
- ☐ Bone or Muscular problems
- ☐ Bronchitis
- ☐ Cancer/Other tumors
- ☐ Cerebral Palsy
- ☐ Diabetes
- ☐ Ear/Hearing difficulties
- ☐ Endocrine/Glandular problems
- ☐ Eye/Vision problems
- ☐ Disabilities (mental, physical, emotional)
- ☐ **Heart defects**
- ☐ Is premedication needed Y or N
- ☐ Hepatitis/Jaundice
- ☐ HIV Infection
- ☐ Hospitalization-date _____
- ☐ Kidney/Urinary tract problems
- ☐ Learning disorders
- ☐ Nervous/Seizure problems
- ☐ Rheumatic fever
- ☐ Radiation treatments
- ☐ Stomach/Digestion problems
- ☐ Surgery-date _____

Height _____

Weight _____

PAST DENTAL HISTORY

HAS THE CHILD HAD ANY PREVIOUS DENTAL EXPERIENCES WHICH WERE UNFAVORABLE?

(YES) ◯ (NO) ◯

DOES THE CHILD HAVE OR USE ANY OF THE FOLLOWING-INDICATE WITH AN (X)

- ☐ Bad Breath
- ☐ Bedtime nursing bottle
- ☐ Bleeding Gums
- ☐ Brushing frequency _____
- ☐ Clinching or grinding of teeth
- ☐ Complications from extractions
- ☐ Dental flossing frequency _____
- ☐ Fluoride supplements
- ☐ Food impaction
- ☐ Frequent blisters on lips or mouth
- ☐ Mouth breathing
- ☐ Mouth Ulcers
- ☐ Oral habits (thumbsucking, nail biting, pacifier, cheek biting, tongue thrust)
- ☐ Orthodontic treatment
- ☐ Pain around ears
- ☐ Sensitivity to cold, hot, sweet, pressure
- ☐ Swelling or lumps in mouth
- ☐ Toothbrush texture _____
- ☐ Traumatic injury to mouth or teeth

PLEASE READ AND SIGN REVERSE SIDE

OFFICE POLICY AND TREATMENT CONSENT

APPOINTMENTS: Each appointment represents a specific amount of time reserved for your child's dental care. If some problem arises so that you are unable to keep this time, we request a proper notification of cancellation (24 hours). **A broken appointment fee will be charged for all missed appointments.**

INSURANCE: To avoid misunderstanding regarding dental insurance, we wish the persons responsible to know that all professional services rendered are charged directly to them and that they are responsible for payment of fees. We will be happy to complete and assist in filing your insurance claim, upon receipt of full (or partial) payment. We do not render our services on the basis that insurance companies will pay all our fees. **You are responsible for knowing your own insurance coverage.**

CONSENT: I hereby certify that the foregoing information is correct. Because the child is a minor, it becomes necessary that signed permission be obtained from the parent (guardian) before any necessary dental treatment can be started. If the use of premedication and/or anesthesia is indicated, I consent to the administration of such premedication and/or anesthesia as the doctor may deem advisable and proper. Furthermore, I will be responsible for any financial obligations incurred on this child for dental treatment. In the event that my account requires collections and/or attorney services, I understand that I will be held responsible for all fees. We will inform you of all services and their charges before any of the services are rendered for your child.

_____

Signature of Parent/Guardian Date

I have read over my child's history and information. To the best of my knowledge, there are currently NO changes.

X _____ Date	X _____ Date	X _____ Date
X _____ Date	X _____ Date	X _____ Date
X _____ Date	X _____ Date	X _____ Date
X _____ Date	X _____ Date	X _____ Date
X _____ Date	X _____ Date	X _____ Date

Associated Pediatric Dentistry

Belleville, Edwardsville, O'Fallon, IL

Patient Name:_____ DOB:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT

****You May Refuse to Sign This Consent Acknowledgement****

I, _____, have been informed of this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice. I fully understand that I can refuse to sign this consent acknowledgement or I may revoke my consent at any time in writing.

Please note that refusal to sign would affect our ability to submit insurance claims on your behalf. This action would require payment in full at the time of service.

_____
{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)

Staff Signature_____ Date_____

Associated Pediatric Dentistry

Belleville, Glen Carbon, O'Fallon

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 (10/01/15), 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

How We May Use and Disclose Health Information About You:

Your protected health information (PHI) includes information relating to your mental or physical health and to the health care provided to you, including materials like your dental records, dental x-rays, and payment records. Some documents containing PHI may include such sensitive personal information as Social Security number, credit card number, mental health diagnosis, genetic information, alcohol/substance abuse records, positive HIV status, and other kinds of sensitive information.

Sometimes our dental practice needs to send PHI to the patient or to someone else, such as a specialist. There are various ways to send PHI, including email or other electronic means. Our dental practice does use encrypted email and has proper safeguards in place for hackers and or unintended recipients. If you are concerned about the security of PHI that is sent electronically, please let us know and we will send it a different way, which may include providing the information to you to deliver.

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 reasonable inferences of your 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 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, text messages, emails 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 do so.

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 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 website or by email, you are entitled to receive this notice in written form.

QUESTIONS AND COMPLAINTS

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(s): Dr. Markarian, Dr. Beyersdorfer and or Dr. Mello-Burstadt
Telephone: 618-233-8667-Belleville
618-288-5437-Glen Carbon
618-622-0212-O'Fallon

IN ORDER TO REQUEST RECORDS PLEASE CONTACT OUR FRONT DESK STAFF