Welcome!

We are glad you have chosen to allow us the privilege of serving your child's dental health needs.
Please provide the following information before we see your child. Thank you.

Your Child

Child's Full Name: _____
Nickname: _____ Gender: _____
Birthdate: _____ Age: _____
Social Security Number: _____
School: _____ Grade: _____
Child's Home Address:: _____
_____
Phone Number: _____
Is child adopted or under foster care?: _____
Child's Hobbies, Favorite Activities: _____
_____
Any Pets?: (What, names) _____

☐ **Mother** ☐ **Stepmother** ☐ **Guardian**

Name: _____
Soc. Sec. Number: _____ Birthdate: _____
Home Address: _____
_____
Home Phone #: _____ Work Phone #: _____
Occupation: _____
Employer: _____
Employer's Address: _____
Hobbies/Interests: _____

☐ **Father** ☐ **Stepfather** ☐ **Guardian**

Name: _____
Soc. Sec. Number: _____ Birthdate: _____
Home Address: _____
_____
Home Phone #: _____ Work Phone #: _____
Occupation: _____
Employer: _____
Employer's Address: _____
Hobbies/Interests: _____

Parents' Marital Status:
☐ Married ☐ Single ☐ Divorced
☐ Separated ☐ Widowed ☐ _____

Brothers, Sisters: (Names, ages) _____
_____

General Information

Referred by: Dr. _____
☐ Yellow Pages ☐ Drove by / saw sign
☐ Friend / another patient: (who?) _____
☐ Blue Pages ☐ Received Welcome Card

Reason for visit:
☐ Check up ☐ Consultation
☐ Problem: _____

Who is primarily responsible for financial arrangements?
_____
Address/phone # (if different than already listed:
_____
Other than a parent, whom should we contact in case of an emergency? (Name/phone #) _____
_____

Primary Dental Insurance:

Insured's Name: _____
Insured's Phone #: _____ Work #: _____
Address: _____
Birthdate: _____ Relationship to Child: _____
Employer: _____
Insurance Company: _____
Group #: _____ Ins. Comp. Phone #: _____
Ins. Comp. Address: _____
_____
ID#: _____ Soc. Sec. #: _____

Secondary Dental Insurance:

Insured's Name: _____
Insured's Phone #: _____ Work #: _____
Address: _____
Birthdate: _____ Relationship to Child: _____
Employer: _____
Insurance Company: _____
Group #: _____ Ins. Comp. Phone #: _____
Ins. Comp. Address: _____
_____
ID#: _____ Soc. Sec. #: _____

Is child covered by any other policy? Yes / No

>>> Please continue on the other side of this form >>>

Children are a heritage from the Lord. - Psalm 127:3

Patient Health History

Patient's Name: _____ Date of Birth: _____ Today's Date: _____

General Information regarding your child:

Does your child currently suck ☐ *a thumb* ☐ *finger(s)* ☐ *a pacifier* ☐ *none.*
Did he/she suck one of the above in the past? How long?
Does your child have any other habits, such as biting nails?
As an infant, did your child ☐ *drink from a bottle or* ☐ *breast-feed? Age discontinued:* _____
Does your child take vitamins, fluoride, iron, or other nutritional supplements? ☐ Yes ☐ No *What?* _____
Is your child doing well in school: ☐ Yes ☐ No *Does your child get along well with other children?* ☐ Yes ☐ No
Has your child had previous "bad" experiences at the doctor, dentist, or other health care facility?
☐ Yes ☐ No *If yes, please explain:* _____
Name of the child's Pediatrician / Physician: _____ *City:* _____
Date of last dental visit: _____ *Dr's. Name:* _____ *City:* _____
Do you think your child will be a cooperative dental patient? ☐ Yes ☐ No *Why?*

Please check whether or not your child now has or <u>has</u> <u>ever</u> had any of the following:

☐ Yes	☐ No	*Hearing Problems*	☐ Yes	☐ No	*Eye Problems*
☐ Yes	☐ No	*Speech Problems*	☐ Yes	☐ No	*Feeding / Eating Problems*
☐ Yes	☐ No	*Immunology / Endocrine Problems*	☐ Yes	☐ No	*Liver , Stomach, or GI Problems*
☐ Yes	☐ No	*Eczema / Skin Problems*	☐ Yes	☐ No	*Kidney / Bladder Problems*
☐ Yes	☐ No	*Allergies / Sinus Problems*	☐ Yes	☐ No	*High Cholesterol*
☐ Yes	☐ No	*Asthma / Wheezing*	☐ Yes	☐ No	*Diabetes*
☐ Yes	☐ No	*Other Respiratory Problems*	☐ Yes	☐ No	*Blood transfusions*
☐ Yes	☐ No	*Hepatitis*	☐ Yes	☐ No	*Congenital Birth Defect(s)*
☐ Yes	☐ No	*HIV / AIDS*	☐ Yes	☐ No	*Heart Murmur, Rheumatic Fever*
☐ Yes	☐ No	*Tuberculosis, other major infections*	☐ Yes	☐ No	*Other Heart Problems*
☐ Yes	☐ No	*Hemophilia, other Blood Disorders*	☐ Yes	☐ No	*Emotional Problems, Disorders or any Suicide Attempts*
☐ Yes	☐ No	*Seizures / Epilepsy or Head Concussion*			
☐ Yes	☐ No	*High Blood Pressure*	☐ Yes	☐ No	*Sexually Transmitted Disease*
☐ Yes	☐ No	*Cancer or any Tumors*	☐ Yes	☐ No	*Physical or Mental Delays, Handicaps, or Disabilities*
☐ Yes	☐ No	*Pregnancy*			

Please explain any yes answers: _____

_____

_____

Allergies: Does your child have any known allergies, sensitivities or reactions to any drugs, foods, or chemicals?
If yes, please explain: _____

_____

Medications: Please list all medications your child currently takes.

Drug	Strength	Frequency	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Hospitalizations or Serious Illnesses: Please list any hospitalizations, serious, and/or unusual illnesses which your child has experienced.

Date(s)	Reason/Problem	Hospital/Physician	City, State
_____	_____	_____	_____
_____	_____	_____	_____

Anything else we should know about?

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the doctor's office of any changes in my child's medical status. I authorize Dr. Creath and his staff to perform the necessary services my child may need.

_____ _____
Signature of parent / guardian (or patient, if appropriate) Today's Date

Doctor's Signature: _____ Review Date: _____

Authorization to Bring Patient, Consent to Treatment, Be Informed of Patient's Personal Information:

Please note that at least one of the child's legal guardians must be physically present during the patient's initial elective visit to our office. Exception to this policy requires prior authorization from our office.

Besides the parents / legal guardians listed on the front of this form, we need to know who else may have your permission to: 1) bring the child to a future appointment, 2) consent to treatment or changes in treatment, 3) be informed of the status of the patient's financial account, and 4) be informed regarding the patient's personal health information. For example, we cannot tell another person whether the patient has a cavity or what the balance is on the patient's account without prior written authorization from the patient's legal guardians.

Carefully consider all those people who may be involved in the patient's future visits to our office. For instance, treatment which was planned may change once procedures have begun that day because of unexpected findings or complications. Can another person authorize a necessary change to the treatment or must we contact you during the middle of the procedure? *Please note that if someone other than the individuals listed below bring the child to our office, we will be unable to see the child without your written permission.* Please understand this policy is for you and your child's protection and to facilitate good communication between our office and you.

Name	Relationship to Child*	Phone No.	May Bring Child	May be Informed of Patient's Info.	Consent To Treatment Changes
_____	_____	_____	yes / no	yes / no	yes / no
_____	_____	_____	yes / no	yes / no	yes / no
_____	_____	_____	yes / no	yes / no	yes / no
_____	_____	_____	yes / no	yes / no	yes / no
_____	_____	_____	yes / no	yes / no	yes / no
_____	_____	_____	yes / no	yes / no	yes / no

* Father, mother, step-parent, grandparent, older sibling, baby sitter, aunt, etc.

Financial Arrangements:

For your convenience, we offer the following methods of payment. Please check the option which you prefer. Payment is expected in full at each appointment, unless prior arrangements have been made.

☐ Cash ☐ Personal Check ☐ Credit Card

Late or Unpaid Payments:

I understand that failure to keep this account current may result in your office being unable to provide additional dental services except for genuine dental emergencies or where there is a prepayment for additional services. In case of default on payment of this account, I agree to pay collection costs and reasonal attorney fees incurred in attempting to collect on this amount or any future outstanding account balances. I further understand that there is a $[redacted] service fee for all returned checks. My insurance company, if any, is not responsible for paying this fee.

Authorization and Release:

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care to third party payors and/or health practitioners.

I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree that I am ultimately responsible for payment of all services rendered on behalf of my child.

I warrant that I am the child's legal guardian and am authorized to provide the above information and consent to the child's treatment at this dental office.

X _____ _____

Signature of legal guardian (or patient, if of age) Today's Date

Milford Pediatric Dentistry, Inc
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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect September 23,2013 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

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 if 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. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

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.

Our Privacy Official: Pamela Smith

Telephone:513-831-3434 Fax: 513-965-3412

Address: 1106-C Main Street, P.O. Box 267, Milford, Ohio 45150-0267

E-mail: milfordpediatricdentistry@fuse.net

Milford Pediatric Dentistry, Inc.

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)

_____

_____

_____