EAST LAKE SMILES
PEDIATRIC DENTISTRY

# PATIENT HISTORY FORM

## PATIENT INFORMATION

Patient Name: ______________________ Today's Date: ____ / ____ / ____

Preferred Name: ______________________

Age: ______ Gender: ☐ Male ☐ Female

Primary Language: ______________________

Date of Birth: ____ / ____ / ____

Emergency Contact
Name / Relationship: ______________________

Address: ______________________

City: __________ State: __________ Zip: __________

Phone Number: ______________________

## RESPONSIBLE PARTY INFORMATION

Legal guardian 1: ______________________ Relationship: ______________________

Legal guardian 2: ______________________ Relationship: ______________________

Address if different from above: ______________________

Preferred Phone Number for Communications: ______________________ ☐ Home ☐ Cell

Alternative Phone Number: ______________________ ☐ Home ☐ Cell

Email Address for Confirmations: ______________________

Primary Dental Insurance: ______________________

Group or Plan Number: ______________________

Employer: ______________________

Policy Holder (Employee): ______________________

Date of Birth: ____ / ____ / ____ SSN: ______________________

Subscriber Number: ______________________

Secondary Insurance: ______________________

Group or Plan Number: ______________________

Employer: ______________________

Policy Holder (Employee): ______________________

Date of Birth: ____ / ____ / ____ SSN: ______________________

Subscriber Number: ______________________

## FINANCIAL INFORMATION

If my account requires servicing by a collection agency or an attorney, I understand that I will be liable for collection fees, attorney fees and applicable court costs in addition to my outstanding balance. I hereby authorize payment directly to East Lake Smile Pediatric Dentistry, the group insurance benefits otherwise payable to me and authorize release of information regarding treatment to the insurance company.

Print Name: ______________________ Signature: ______________________

# PATIENT'S MEDICAL HISTORY

**Indicate your child's past / current conditions.**

- ADD / ADHD ☐
- Anemia / Sickle Cell Anemia ☐
- Asthma / Reactive Airway ☐
- Autism Spectrum Disorder ☐
- Bleeding or Blood Disorder ☐
- Cerebral Palsy ☐
- Stomach / Intestinal Disorder ☐
- Hearing Impairment ☐
- Epilepsy / Seizures ☐
- Heart Condition ☐
- Hepatitis / Liver Condition ☐
- HIV + / AIDS ☐
- Cancer / Chemotherapy / Radiation ☐
- Pregnancy ☐
- Severe Headaches / Migraines ☐
- Other, please explain: ____________________
- Cleft Lip / Palate ☐
- Diabetes Type I or II ☐
- Sensory Integration Disorder ☐
- Endocrine Disorder ☐
- Kidney Condition ☐
- Positive TB test ☐
- Developmental Delay ☐

List any **allergies** your child may have (examples: local anesthetic, NSAIDs, antibiotics, metals, latex, seasonal allergies, animals, food, etc.):

____________________

Current **medications** (over-the-counter and prescription) and reason for use:

____________________

Has your child been **hospitalized** or had **surgery** for any reason? Explain.

____________________

**Physician Contact Information**

Name: ____________________ Phone Number: ____________________

Office Address: ____________________

**Medical Specialist Contact Information (if applicable)**

Name: ____________________ Phone Number: ____________________

Office Address: ____________________

Specialty: ____________________

# DENTAL HISTORY

Is this your child's first visit to the dentist? ☐ Yes ☐ No

If no, how long since the last visit to the dentist? ____________________

Indicate any **habits** your child may have.

- Thumb / Finger / Tongue Sucking Habit ☐
- Pacifier Habit ☐
- Nail Biting ☐

Does your child have any **current** dental issues?

- Abscess ☐
- Mouth / Tooth Trauma ☐
- Teeth Grinding ☐
- Cavities ☐
- Bleeding Gums ☐
- Sensitivity ☐
- Toothache ☐
- Bad Breath ☐
- Discolored Teeth ☐

How did you hear about us?

- ☐ Online
- ☐ Drove by
- ☐ Health provider. Name: ____________________
- ☐ Friend / Family. Name: ____________________

## Designation of Representation or Consent to Dental Care for a Minor Child

This form is to be used when the parent/legal guardian cannot accompany a minor child (under 18 years of age) to an appointment. In addition, it may be used to designate an adult to represent the parent or guardian at the appointment. **This authorization must be brought to the appointment by the accompanying adult.**

**Release Statement**
I cannot accompany my child, _________________to the scheduled dental appointment today. I hereby give consent for my child to be evaluated and receive routine dental treatment at East Lake Smiles Pediatric Dentistry for his/her appointment dated ____ / ____ / ____.

I hereby appoint _________________ as my representative. I empower him/her to act as legal guardian during this appointment. The dental provider may reach me during the appointment at (      ) _____ - ________ to discuss any significant changes to the agreed upon dental treatment plan.

I understand that a medical history will be taken and a comprehensive dental examination may be performed. Necessary procedures such as x-rays, cleanings, and dental treatment may be done if needed. I accept responsibility for all costs related to such treatment.

The following is a list of specific procedures that may not be performed unless there is express permission from me (via contact by telephone) ______________________________________.

This authorization will automatically expire one week from the date of signature, except as specified: ____ / ____ / ____ (date).

I understand that I may revoke this consent at any time by written notice.

Name of patient: ___________________________________ DOB: ____ / ____ / ____

Print name of parent / legal guardian: ___________________________________

Signature of parent / legal guardian: _____________________________________

# East Lake Smiles Pediatric Dentistry Consent / Agreement

**Consent to Treatment**

I authorize Dr. Brown to perform, in general terms, indicated dental procedures with informed consent. Dental procedures may include but not be limited to x-rays, a cleaning, behavior management, nitrous oxide, fillings, crowns, extractions, nerve treatment, space appliances, sealants, and other such dental treatment. No dental procedures will be rendered without a detailed treatment plan and informed consent.

I may elect to decline specific procedures. Dr. Brown may decline to treat my child without x-rays, an adequate diagnosis or treatment plan.

___________
Initials

**Photo Release**

I authorize ☐ I do not authorize ☐ East Lake Smiles to use and/or publish still or video photography of my child

________________________________, on printed materials or in electronic formats, including on the internet to promote or advertise the company. In giving this consent, I release East Lake Smiles from liability for any violation or any personal proprietary right I may have in connection with such sale, reproduction, use, or compensation.

___________
Initials

**Privacy Practices**

I authorize East Lake Smiles Pediatric Dentistry to release to insurance companies, or their representative, information and records about my child regarding services rendered that is needed to review, investigate or evaluate any claim for benefits.

___________
Initials

**Patient Rights and Responsibilities**

I acknowledge that I read and understand East Lakes Smiles Pediatric Dentistry's Patient Rights and Responsibilities.

___________
Initials

**Payment**

- Full payment is due on the day service Is provided or by special arrangements with the office manager.
- Cash, debit and credit card are accepted for payment.
- I have reviewed East Lake Smiles Financial Policy, and I understand and accept responsibility of cooperating with these policies. I understand that I will be responsible for financial balances resulting from treatment received that is not paid for by my insurance company, Medicaid, or any third-party agency.

___________
Initials

**Insurance**

- All insurance information must be registered at the initial appointment and updated when information changes
- I understand that I must provide a current insurance card/form of all insurance coverage for my child at each visit so that my insurance information can stay up-to-date with the office.
- Prior approval can be submitted after the presentation of a treatment plan. This is not a guarantee of payment. Patients must initiate the request.
- I authorize East Lake Smiles to submit claims (on the patient's behalf) to insurance, Medicaid, or other third-party payer(s) and disclose health information to the extent necessary to obtain payment. The undersigned also assigns benefits paid by insurance, Medicaid, or other third-party payers(s) directly to East Lake Smiles Pediatric Dentistry.

___________
Initials

**Financial Agreement**

I agree that in consideration of the services to be rendered to the patient, I obligate myself to pay the account balance. Should the account be referred for collection, I shall pay reasonable attorney's fees and collection expenses. If a patient's account is sent to collections, the Office will provide only emergency treatment for pain and swelling until the account is current. Failure to pay for services in a timely manner may jeopardize my child's access to routine dental care.

- Either parent or legal guardian may be held responsible for payment of treatment rendered to my minor child.
- In the event of a divorce or separation, both parents may be held responsible for payment of treatment rendered to their minor child.

__________
Initials

**Missed Appointments**

**Courtesy** reminders may be provided as requested via text, email, or both, We request that you give us **48-hour notice** if you need to cancel or reschedule an appointment. If less notice is given, this will be considered a failed appointment. I understand that the practice has the right to charge a non-refundable **$35.00 fee per child** for missed appointments.

I understand that after **2 repeated** failed appointments, I may not be able to reschedule at the discretion of the dental office.

__________
Initials

**Late Arrival**

I understand that if I arrive **15 minutes** late for a scheduled appointment, I may be asked to reschedule or be informed that the scheduled treatment may have to be adjusted. Appointment modification is done to deliver quality care to your child and out of respect for other patients. Please call ahead and let us know if you are running late so we can try to accommodate you as our schedule permits.

__________
Initials

**Cell Phone Usage / Video Recording**

Use of cell phones in the treatment rooms is prohibited. Cell phones must remain off during your time in the back office.

__________
Initials

**Permission for Other Individuals to Give Consent to Routine Dental Procedures**

Please list below any individual that can bring your child to their appointments. By listing their name, you also consent to permit the individual(s) to receive information regarding the child's care and treatment, the right to sign the medical history, and consent to routine dental treatment, including exams, cleanings, x-rays, and fluoride.

| First and Last Name | Relationship | Phone Number |
| --- | --- | --- |
| | | |
| | | |
| | | |
| | | |

***Please Sign and Date Page 3***

## East Lake Smiles Pediatric Dentistry Consent / Agreement

**Acknowledgement of Understanding.** I acknowledge that (i) I have had sufficient time to review and consider the East Lake Smiles Pediatric Dentistry Consent / Agreement thoroughly; (ii) have read and understand the terms of this agreement and my obligations hereunder; (iii) and have entered into this agreement voluntarily and without any pressure.

| | |
|---|---|
| ______________________________________________ | __________________________ |
| Name of Patient (Child) | Date of Birth |
| ______________________________________________ | __________________________ |
| Signature of Parent or Legal Guardian | Date |
| ______________________________________________ | __________________________ |
| Printed Name | Relationship to Patient |

# Notice of Privacy Practices
# East Lake Smiles Pediatric Dentistry

## Patient Name ________________________________________

## Parent Signature ____________________________________

---

This 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.**

**Your Rights**
**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

**You have the right to:**
**Get an electronic or paper copy of your medical record**
- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

**Ask us to correct your medical record**
- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

**Request confidential communications**
- You can ask us to contact you in a specific way about your medical information (for example, home or office phone) or to send your medical information to a different address.
- We will say, "yes" to all reasonable requests.

**Ask us to limit what we use or share**
- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or healthcare item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

**Get a list of those with whom we've shared information**
- You can ask for a list (accounting) of the times we've shared (disclosed) your health information, for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and healthcare operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

**Get a copy of this privacy notice**
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

**Choose someone to act for you**
If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

**File a complaint if you feel your rights are violated**
You can file a complaint with us if you feel we have violated your rights by contacting our Privacy Officer.
- To file a complaint with our organization, please submit your request in writing to the Privacy Officer **(insert name of officer), (insert address, phone number, email) (insert city, state, zip)**.
- You can file a complaint with the U.S. Department of Health and Human Services' Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, by calling 877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**
- We will not retaliate against you for filing a complaint.

**Your Choices**
**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, contact us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

*If you are not able to tell us your preference - for example, if you are unconscious, we may share your information if we believe it is in your best interest to do so. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these following cases, we **never** share your information unless you give us written permission:
- Marketing purposes
- Sale of your protected health information
- Most sharing of psychotherapy notes

In the case of fundraising:
- We may contact you for fundraising efforts, but you can tell us not to contact you again. We will honor your request to not contact you again.

**Our Uses and Disclosures**
**We typically use or share your health information in the following ways:**

- **Treatment**
  We can use your health information and share it with other professionals who are treating you.
  *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*
- **Run our organization**
  We can use and share your health information to run our practice, improve your care, and contact you when necessary.
  *Example: We use health information about you to manage your treatment and services.*
- **Bill for your services**
  We can use and share your health information to bill and get payment from health plans or other entities.
  *Example: We give information about you to your health insurance plan so it will pay for your services.*

**How else can we use or share your health information?**
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

**Help with public health and safety issues**
We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

**Do research**
We can use or share your information for health research.

**Comply with the law**
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

**Respond to organ and tissue donation requests**
We can share health information about you with organ procurement organizations.

**Work with a medical examiner or funeral director**
We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

**Address workers' compensation, law enforcement, and other government requests**
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

**Respond to lawsuits and legal actions**
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

**Our Responsibilities**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

**Changes to the Terms of this Notice**
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our **website, and we will mail a copy to you.**

**Effective Date of Notice (To be Completed by Provider):** ______________________

**Other Instructions for Notice**

- The Privacy Rule requires you to describe any state or other laws that require greater limits on disclosures. For example, "We will never share any substance abuse treatment records without your written permission." Insert this type of information here. If no laws with greater limits apply to your entity, no information needs to be added.
- If your entity provides patients with access to their health information via the Blue Button protocol, you may want to insert a reference to it here.
- If your entity is part of an OHCA (organized health care arrangement) that has agreed to a joint notice, use this space to inform your patients of how you share information within the OHCA (such as for treatment, payment, and operations related to the OHCA). Also, describe the other entities covered by this notice and their service locations. For example, "This notice applies to __________Community Hospitals and Emergency Services Incorporated which operate the emergency services within all ________ hospitals in the greater _________ area."