**Date**_____ **Confidential Patient Information** + A B C -

Patient's Name_____
Last First Middle Nickname Gender

Address_____
Street City State Zip

Home Phone_____ Birthdate_____ Social Security #_____

If patient is a minor, give parent's or guardian's name_____

Whom may we thank for referring you to our office?_____

## Confidential Responsible Party Information

Name_____ Marital Status_____
Last First Middle

Residence_____
Street City State Zip

Mailing Address_____
Street City State Zip

How long at this address_____ Home Phone_____ Work Phone_____

Cell Phone _____Email _____

Previous Address (if less than 3 yrs.)_____
Street City State Zip

Social Security #_____ Birthdate_____ Relationship to Patient_____

Employer_____ Occupation_____ No. Years Employed_____

**Spouse's** Name_____ Rel. to Patient_____
Last First Middle

Employer_____ Occupation_____ No. Years Employed_____

Social Security #_____ Birthdate_____ Work Phone_____

## Insurance Information

Policy Holder's Name_____ and Member ID #_____

Insurance Company_____ Group No._____ Birthdate_____

Insurance Co. Address_____ Insurance Co. Phone_____

Policy Holder's Employer_____

Do you have dual coverage? No ☐ Yes ☐ If yes:

Policy Holder's Name_____ and Soc. Sec. #_____

Insurance Company_____ Group No._____ Birthdate_____

Insurance Co. Address_____ Insurance Co. Phone_____

Policy Holder's Employer_____

## Emergency Information

Name of nearest relative not living with you_____

Complete Address_____

Phone_____ Relationship:_____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor)_____

Updates (date & initial)_____

CONFIDENTIAL (for record and pretreatment evaluation)

Patient _____ Date of Birth_____

# Confidential Patient Medical History

Physician's Name_____Phone_____Last Visit_____

Has patient ever been under the extended care of a physician or had any surgeries? Yes ☐ No ☐
If yes, Please explain:

CHECK ANY OF THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN TREATED

| | | |
|---|---|---|
| ☐ Heart Conditions (murmur, etc) | ☐ HIV Positive | ☐ Hepatitis |
| ☐ Excessive Bleeding | ☐ Tuberculosis | ☐ Frequent Headaches |
| ☐ Diabetes | ☐ Asthma | ☐ Kidney Infections |
| ☐ Rheumatic Fever | ☐ Epilepsy | ☐ Cerebral Palsy |
| ☐ Liver Problems | ☐ Birth Defects | ☐ Eyesight Problems |
| ☐ Cancer | ☐ Infections | ☐ Speech Impairments |
| ☐ Hearing Loss | | |

Is your child currently on any medications? Yes ☐ No ☐
Is your child allergic to any foods or medicines? Yes ☐ No ☐
Is your child subject to any nervous disorders? Yes ☐ No ☐

# Confidential Patient Dental History

Last Dentist Name_____Phone_____Last Visit_____

Were any x-rays taken at your last dental visit? Yes ☐ No ☐
Has your child had any problems with dental exams or treatment in the past? Yes ☐ No ☐
Have any cavities been noted in the past? Yes ☐ No ☐
Does your child eat between meals? Yes ☐ No ☐
Does your child eat sweets? (Candy, soda pop, chewing gum, fruit snacks, etc) Yes ☐ No ☐
Has any family members ever needed orthodontics in the past? Yes ☐ No ☐
Has your child ever received local anesthetic? Yes ☐ No ☐
Has your child ever had occlusal sealants placed? Yes ☐ No ☐
Has parent or caregiver been diagnosed with tooth decay in past 2 year? Yes ☐ No ☐
Has your child had any baby or permanent teeth extracted in the past? Yes ☐ No ☐
Was it suggested that the space be maintained? Yes ☐ No ☐
Was an appliance placed? Yes ☐ No ☐
Has your child experienced any trauma to the teeth? (falls, blows, chips, etc) Yes ☐ No ☐
Please Explain:

Does your child currently floss? Yes ☐ No ☐
When does your child brush their teeth?
☐ Upon rising in morning ☐ After eating any food ☐ After meals ☐ Before going to bed
How does your child currently receive fluoride?
☐ Community Water, ppm_ ☐ Well Water, ppm___ ☐ Drops or Tablets ☐ Rinse or Gels
Please describe your child's diet (regular/favorite foods): _____
_____

**To help connect with child please tell us about your child's interest (favorite sports, hobbies, TV shows, movies, etc:
_____

*Thank You for taking the time to fill out!*

**I certify that the above information is complete and accurate.**
Parent/Guardian Signature_____ Date_____
Dentist Signature_____ Date_____

**Our Mission: "Quality Care and a Positive Patient Experience"**

*The Doctors and staff at Dentistry for Kids have an unwavering commitment to your child's superior oral health. We use sound scientific and ethical principles, as outlined by the AAPD, in order to provide your child with the highest standard of pediatric dental care available in our area. We also recognize that creating a fun, friendly, and comfortable environment is critical to the child's long-term oral health. We know you have a choice in dental providers and we hope that these goals are the primary reasons you have chosen our practice. Please keep in mind that all of the following policies center on accomplishing these two core philosophies.*

**Late Appointment Policy**

We ask that all parents make special effort to be at their child's appointment on time in order minimize the impact on their child's care and dental experience as well as that of those patients scheduled later in the day. If a patient is more than 5 minutes late to a 30 minute appointment or 15 minutes late to a 60 minute appointment they may be required to reschedule. However, in a situation where there is space in the schedule we will try to fit your child in provided it has minimal impact on the Doctors ability to meet the before mentioned goals. INITIAL_____

**Missed or Cancelled Appointment Policy**

Due to the busy nature of our practice and common courtesy we ask for a 2 business day notice on all cancelled or rescheduled appointments. This lead time allows us to fill your child's scheduled time with another child who may be in need of more urgent dental care. An appointment cancelled in less than 48 hours, or an appointment missed completely without notice, may not be rescheduled for up to 6-8 weeks, though you may be placed on our standby list and be seen sooner if openings occur. Regular last minute cancellations or no-shows cause such a negative impact on the practices ability to meet its mission and goals that in some situations we may only see your child on an on call basis. In rare cases where no shows persist it could lead to the end of the doctor patient relationship. However, we understand that emergencies happen and in those situations we will do all that we can to accommodate your special needs.
INITIAL _____

**Insurance and Financial Policy**

As we have mentioned our commitment is to provide the best quality dental care possible to your child. This same commitment to your child's oral health is not always shared by every insurance company or by the employer who has purchased the dental benefit on your behalf. Consequently, some preventative and most restorative services prescribed for your child are seldom covered by your insurance company at 100%. Should there be a gap between the costs of the quality dental care provided to your child by DFK and the amount your insurance company reimburses the difference will be your responsibility. At your request, we will do all we can to help you understand and maximize the benefits available to you through your insurance provider but ultimately it is your responsibility to understand the coverage's of your policy prior to care being provided and charges incurred. In addition, should you request that basic preventative care or necessary treatment (as outlined by the AAPD) not be performed on your child based on the limitations of your insurance benefit the dentists may decide not to take on the personal liability of foregoing these important steps to achieve the patients optimal oral health and comfort. INITIAL _____

**Communication**

In order to accomplish our goals we understand the importance of treating our patients and parents with courtesy and respect as well as having open and honest communication. Our top priority is to give you all the information needed to make informed decisions in regards to your child's oral health. This includes providing you with the nature of recommended procedures, the risks of those procedures, any alternatives to the procedures recommended, and an estimate of the costs involved to perform those procedures. We hope that open communication is important to you as well and that any concerns you have about treatment or our policies will be brought immediately to our attention with the same courtesy and respect. We will sincerely do all we can to develop a long-term relationship where your child's oral health and dental experience is number one for both of us.

I have read, understand, and agree to Dentistry for Kids key practice policies.

_____ _____

Parent/Guardians Signature Date

_____ _____

Printed Name Relationship to Patient

LUZ MOLINA, DMD, J JUSTIN WILKERSON, DDS, LTD
dba

# DENTISTRY FOR KIDS AND IT'S MY SMILE

## 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 08/21/2014, 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: Johana Meija

Telephone: 775-823-9797 Fax: 775-823-8677
Address: 10455 Double R Blvd., Reno, NV 89521
E-mail: jmejia@dentistryforkidsreno.com



Parent/Guardian Signature Date

**Your Name:** _____ **Today's Date:** _____

**Relationship to Patient(s):**_____ **Patient(s) Name:** _____

_____

_____

**How would you like us to communicate with you?**

*Our dental office sends appointment reminders, information about treatment, payment and insurance, and other communications including but not limited to newsletters, events, etc. Please tell us how you would like us to communicate with you.*

***Check or complete <u>all that apply</u> (please print clearly):***

☐ Contact me by U.S. Mail at the following address: _____

☐ Contact me by email at the following email address: _____

**<u>For Phone and Text Communications</u>:**

***This form is optional. You are not required to sign this form, and you do not need to sign it to receive care in our dental office.***

Phone Number: _____

☐ **By checking this box, I consent to the following:** The dental practice or its service provider may contact me to provide health care information such as appointment reminders and information about treatment, payment, my account or insurance, using artificial or prerecorded voice or telephone equipment that may be capable of automatic dialing. The dental practice may:

- ☐ Call me
- ☐ Text me
- ☐ Call me and text me

Signature: _____Date: _____

***Please call Dentistry for Kids right away if you get a new telephone number!***

---

*For Office Use Only:*

☐ Consent revoked. Date/Initials: _____/_____

☐ Possible reassigned number. Date/Initials: _____/_____

☐ Confirmed accurate.

Date/Initials: _____/_____ Date/Initials: _____/_____

Date/Initials: _____/_____ Date/Initials: _____/_____

Date/Initials: _____/_____ Date/Initials: _____/_____

Remainder of the form is for exisitng patients only

For Existing Patients Only

Patient_____ Date of Birth_____

## Confidential Patient Medical History

Physician's Name_____Phone_____Last Visit_____

Has patient ever been under the extended care of a physician or had any surgeries? Yes ☐ No ☐
If yes, Please explain:

CHECK ANY OF THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN TREATED

| | | |
|---|---|---|
| ☐ Heart Conditions (murmur, etc) | ☐ HIV Positive | ☐ Hepatitis |
| ☐ Excessive Bleeding | ☐ Tuberculosis | ☐ Frequent Headaches |
| ☐ Diabetes | ☐ Asthma | ☐ Kidney Infections |
| ☐ Rheumatic Fever | ☐ Epilepsy | ☐ Cerebral Palsy |
| ☐ Liver Problems | ☐ Birth Defects | ☐ Eyesight Problems |
| ☐ Cancer | ☐ Infections | ☐ Speech Impairments |
| ☐ Hearing Loss | | |

Is your child currently on any medications? Yes ☐ No ☐
Is your child allergic to any foods or medicines? Yes ☐ No ☐
Is your child subject to any nervous disorders such as autism, ADHD, or any other mental illness? Yes ☐ No ☐

## Confidential Patient Dental History

Does your child currently floss? Yes ☐ No ☐

When does your child brush their teeth?
☐ Upon rising in morning ☐ After eating any food ☐ After meals ☐ Before going to bed

How does your child currently receive fluoride?
☐ Community Water, ppm_ ☐ Well Water, ppm___ ☐ Drops or Tablets ☐ Rinse or Gels

Please describe your child's diet (regular/favorite foods): _____

_____

**To help connect with child please tell us about your child's interest (favorite sports, hobbies, TV shows, movies, etc:

_____

*Thank You for taking the time to fill out!*

**I certify that the above information is complete and accurate.**

Parent/Guardian Signature_____ Date_____

Dentist Signature_____ Date_____

For Existing Patients Only

**AUTHORIZATION FOR MINOR CHILD ACCOMPANY**

Child(ren)'s full name (s):_____

DOB (s):_____, _____, _____, _____

I, _____ give _____
(Parent or Legal Guardian) (Authorized Person's Full Name)

permission to accompany my child(ren) to the office of **Dentistry for Kids** dental appointments.

I also give permission to _____ to make necessary decisions
(Authorized Person's Full Name)

regarding dental treatment for my child(ren) including, but not limited to:

- This consent for the authorized person to accompany and sign informed consent(s) for my child(ren)'s for exams, dental cleanings, x-rays and fluoride treatment and to discuss post-operative instructions.
- This consent of **Dentistry for Kids** gives permission to the authorized person to discuss finances treatment charges, account balances and next visit charges.
- This consent for this authorized person to discuss my child(ren)'s dental findings, future dental treatment needs and any pertinent personal health information (PHI).

As the parent or legal guardian, I understand that I must sign any treatment plans and/or informed consents before any restorative procedures or invasive dental treatment can be performed for my child(ren). I further understand that it is my responsibility to provide payment or a source of payment on the day that services are rendered, even when this authorized person brings the child, or no treatment will be performed for my child.

_____

(Signature of Parent or Legal Guardian) (Date)

_____

(Dentistry for Kids Representative) (Date)