Welcome!

We would like to welcome you and your child to our office. Our goal is to make every child's visit **pleasant and educational.** Our practice is based on **preventive care.** We strive to teach good oral care that will enable your child to have a **beautiful smile** ***that lasts a lifetime.***

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

1 ABOUT YOUR CHILD

Name: ______________________
Last First Initial

Nickname: ______________________

Birthdate: ____/____/____ ☐ Male ☐ Female
Month Day Year

SS #: ______________ Age: ________

Special interests, sports or hobbies: ______________________

Home address: ______________________

Apt/Condo # City State Zip Code

Home phone: (____) ______________

Referred by: ______________________

2 ABOUT YOU

Your name: ______________________

Birthdate: ____/____/____

SS #: ______________________

Relationship to child: ______________________

Your home phone and address, if different from child's:

(____) ______________
Home Phone

Address

Apt/Condo # City State Zip Code

Occupation: ______________________

Employer: ______________________

Work phone: (____) ______________

Cell phone: (____) ______________

3 INSURANCE

DENTAL INSURANCE COMPANY #1

Dental Ins. Co.: ______________________

Insurance Co. Phone #: (____) ______________

Group / Policy #: ______________________

This Dental Insurance is provided through:

Policy owner's name: ______________________

Relationship to child: ______________________

Policy owner's SS #: ______________________

Policy owner's birthdate: ______________________

Policy owner's employer: ______________________

Employer's Address: ______________________

City State Zip

DENTAL INSURANCE COMPANY #2

Dental Ins. Co.: ______________________

Insurance Co. Phone #: (____) ______________

Group / Policy #: ______________________

This Dental Insurance is provided through:

Policy owner's name: ______________________

Relationship to child: ______________________

Policy owner's ID #: ______________________

Policy owner's birthdate: ______________________

Policy owner's employer: ______________________

Employer's Address: ______________________

City State Zip

CONTINUED ON BACK

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DENTAL/MEDICAL HISTORY

Has your child been to the dentist before? ☐ Yes ☐ No

If yes, the approximate date of last visit: ____________

Are there any dental problems that you are aware of at present? ☐ Yes ☐ No If yes, please explain: ____________

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

Please rate your child's oral health: ☐ Good ☐ Fair ☐ Poor

Is your child currently under the care of a physician? ☐ Yes ☐ No

Child's physician: ____________

His / Her phone #: ____________

The approximate date of last visit: ____________

Please rate your child's medical health: ☐ Good ☐ Fair ☐ Poor

Is your child allergic to any drugs or other things? ☐ Yes ☐ No

If yes, please list: ____________

Is your child taking any prescription drugs? ☐ Yes ☐ No

If yes, please list: ____________

Does your child require antibiotics before dental treatment? ☐ Yes ☐ No

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Has your child ever had any of the following medical conditions or problems?

Y N Any Hospital Stays
Y N Any Operations
Y N Bleeding Problems of Any Kind
Y N Cancer
Y N Convulsions / Epilepsy
Y N Diabetes
Y N Hearing Impairment
Y N Heart Murmur
Y N Heart Problems of Any Kind
Y N Hemophilia
Y N HIV+ / AIDS
Y N Hyperactive
Y N Rheumatic / Scarlet Fever

Are there any other medical conditions or problems relating to your child? ☐ Yes ☐ No

If yes, please list: ____________

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In the event of any emergency, whom should we contact?

Name: ____________ Relationship: ____________

Phone: ____________ Phone #2: ____________

I understand that the information that 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.

The Parent or Guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.

Signature of parent or guardian: ____________ Date: ____________

Thank you for filling out this form completely. It will enable us to give your child the best dental care possible. If you or your child have any questions, please feel free to ask us at any time.

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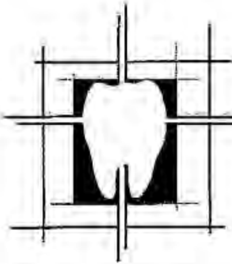


Dental Health Associates

210 W. Airport Hwy. • PO Box 270 • Swanton, Ohio 43558
419-826-2525 • fax: 419-825-5067
swanton.office@dentalha.com • www.itneverhurtstosmile.com

Notice of Privacy Practices

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.***

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health insurance information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information.

As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means discussing, providing, coordinating, or managing dental care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute non-identifiable health information by removing all reference to your identity such as before and after photographs of treatment procedures.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures such as DHA childrens "No Cavity Club" will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications or protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health insurance.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of June 10, 2002 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information, by asking to speak to our Privacy Officer or for written inquiries, note "Attention Privacy Officer."

For more information about HIPAA or to file a complaint:

The US Department of Health & Human Services, Office of Civil Rights
200 Independence Avenue, S.W.
Washington DC 20201
(202) 619-0257 • Toll Free: 1-877-696-6775

Notice of Privacy Practices Acknowledgment

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address on the front of this acknowledgment document to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment of health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ______________________________

Relationship to Patient: ______________________________

Signature: ______________________________

Date: ______________________________

Statement of Responsibility

The patient is responsible for notifying our office of any changes in address, telephone number(s), or insurance information. If the office is unable to contact you because of outdated or incorrect information, we cannot take responsibility for your care.

Patient Initials: ________

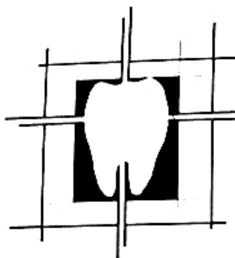
Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area. Please remember that your insurance policy is a contract between you and your insurance carrier. Co-payments are due at the time of service. Patients without insurance are expected to pay at the time the service is rendered.

Patient or Responsible Party Signature: ______________________________ Date: ____________

Assignment of Benefits

I authorize the release of all dental information necessary to process insurance claims on my behalf. I authorize the assignment of benefit payment to which I am entitled to Dental Health Associates. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Patient or Responsible Party Signature: ______________________________ Date: ____________



Dental Health Associates

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Date ____________________

Your Name: ____

Getting to know a little more about you...

Thank you for being a part of our dental family. To get to know you even better, please tell us a few more things about yourself.

What are your favorite hobbies or activities? (circle all that apply)

Golf   Reading   Hunting/Fishing

Gardening   Other: ____

Are there any other special interests, sports, or hobbies that you would like to share with us?

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What is your favorite restaurant?

____