
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 couldnt not obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specity

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ Email: _____

Patient #: _____ Social Security #: _____

SECTION B: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENT CAREFULLY

Purpose of Content: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations of the uses and disclosures we may make of our protected health information and of other important information about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserved the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. These changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: _____

Telephone: _____ Fax: _____

Email: _____

Address: _____

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this Consent.

SIGNATURE

I, _____ have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT
Include completed Consent in the patient's chart.



Welcome

Thank You for selecting us.

To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential)

Name _____ Date _____
 Soc Sec # _____ Birthdate _____ Home Phone _____
 Address _____ City _____ State _____ Zip _____
 Check Appropriate Box: Minor Single Married Separated Divorced Widowed
 If Student, Name of School/College _____ City _____ State _____ Full Time Part Time
 Patient's or Parent's Employer _____ Work Phone _____
 Business Address _____ City _____ State _____ Zip _____
 Spouse or Patient's Name _____ Employer _____ Work Phone _____
 Whom May We Thank for Referring You? _____
 Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____
 Address _____ Home Phone _____
 _____ Birthdate _____ Financial Institution _____
 Employer _____ Work Phone _____ SSN# _____
 Is this Person currently a Patient in our Office? Yes No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full of each appointment.

- Cash Personal Check Credit Card VISA MasterCard I wish to discuss the office's payment policy

Insurance Information (Dental Only)

Name of Insured _____ Relationship to Patient _____
 Birthdate _____ Social Security # _____ Date Employed _____
 Name of Employer _____ Union or Local # _____ Work Phone _____
 Employer Address _____ City _____ State _____ Zip _____
 Insurance Company _____ Group # _____ Policy/ID# _____
 Ins. Co. Address _____ City _____ State _____ Zip _____
 How Much is your Deductible? _____ How much you have used? _____ Max Annual Benefit _____

Do You Have Any Additional Insurance? Yes No If Yes, Complete the following

Name of Insured _____ Relationship to Patient _____
 Birthdate _____ Social Security # _____ Date Employed _____
 Name of Employer _____ Union or Local # _____ Work Phone _____
 Employer Address _____ City _____ State _____ Zip _____
 Insurance Company _____ Group # _____ Policy/ID# _____
 Ins. Co. Address _____ City _____ State _____ Zip _____
 How Much is your Deductible? _____ How much you have used? _____ Max Annual Benefit _____



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 **preventative 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 committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA

Thank You for selecting us.

1 ABOUT YOUR CHILD

Name: _____
Last First Middle
Nickname: _____
Birthdate: ____/____/____ Male Female
SS#: ____/____/____ Age: _____
Special Interest, sports or hobbies: _____

Home Address: _____

Home Phone: _____
Referred by: _____

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ABOUT YOU

Your Name: _____
Birthdate: ____/____/____
SS#: ____/____/____
Relationship to Child: _____
Your home phone & address, if different than child's:
Home Phone _____
Address _____
City State Zip Code _____
Occupation: _____
Employer: _____
Work Phone: _____ Ext. _____
Pager/Cor Phone: _____

3 DENTAL INSURANCE COMPANY #1

Dental Ins. Co: _____
Insurance Co. Phone #: _____
Group/Policy #: _____

This Dental Insurance is provided throughout:

Policy owner's name: _____
Relationship to child: _____
Policy owner's SS #: _____
Policy owner's birthdate: _____
Policy owner's employer: _____

DENTAL INSURANCE COMPANY #2

Dental Ins. Co: _____
Insurance Co. Phone #: _____
Group/Policy #: _____

This Dental Insurance is provided throughout:

Policy owner's name: _____
Relationship to child: _____
Policy owner's SS #: _____
Policy owner's birthdate: _____
Policy owner's employer: _____

DENTAL/MEDICAL HISTORY

Has your child been to the dentist before? Yes No

If yes, the appropriate 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 appropriate date of last visit: _____

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

If your child allergic to any drugs: Yes No

If yes, please list: _____

Is your child taking any prescription drugs? Yes No

If yes, please list: _____

Does your child need to be premedicated before dental treatment? Yes No

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

Name: _____ Relationship: _____

Phone: _____ Phone#2: _____

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

- Y N Any Hospital Stays
- Y N Any Operatives
- Y N Bleeding Problems or 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 Homophilia
- 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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i understand 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 may be my responsibility to inform this office of any changes in my child's medical status. I authorized 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.

Phone: _____ Date: _____

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