Welcome!

Pediatric Patient Information

Patient's Name: _____ DOB: _____

Address: _____ City: _____ Zip Code: _____

*Home Phone: _____ *Cell Phone: _____

*E-Mail Address: _____ Pediatrician/Medical Group Name: _____

Referred by: _____Friend _____Postcard _____Drive-by/Signage ____Internet ____Other:_____

Responsible Party Information

Mother/Guardian

Name:_____

DOB:_____ Marital Status: ___ Single ___Married

Address:___ Same as Patient

_____

City:_____ Postal Code:_____

Tel (H)_____

Tel (C)_____

Father/Guardian

Name:_____

DOB:_____ Marital Status: ___ Single ___Married

Address:___ Same as Patient

_____

City:_____ Postal Code:_____

Tel (H)_____

Tel (C)_____

Insurance Information

Insurance Company: _____

ID Number: _____

Group Number: _____

Policy Holder:_____

DOB of Policy Holder:____/____/____

Employer:_____

Insurance Company: _____

ID Number: _____

Group Number: _____

Policy Holder:_____

DOB of Policy Holder:____/____/____

Employer:_____

Dental History

Date of your child's last dental visit:_____Dentist Name:_____

Were x-rays taken at that visit? ☐ Yes ☐ No

Please check Yes or No to any of the following conditions that apply to your child:

Y	N	(Please Check)	Y	N	(Please Check)	Y	N	(Please Check)
☐	☐	Problems Associated w/ Previous Dental Treatment	☐	☐	Bleeding Gums	☐	☐	Grinding or Clenching Teeth
☐	☐	Tooth Pain	☐	☐	Earaches or Neck Pain	☐	☐	Food/Floss Catches Between Teeth
☐	☐	Serious Injury to Head/Mouth	☐	☐	Sores or Ulcers in Mouth	☐	☐	Clicking/Popping/Pain in Jaw
☐	☐	Dry Mouth	☐	☐	Orthodontic(braces)Treatment	☐	☐	Drinks Bottled or Filtered Water
☐	☐	Home Water Supply Fluoridated	☐	☐	Reports Sensitivity of Teeth to Cold/Heat/Sweets/Pressure			

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Is your child under a physician's care now? ☐Yes ☐No If yes, please explain: _____

Has your child ever been hospitalized or had a major operation? ☐Yes ☐No If yes, please explain: _____

Is your child taking any medications, pills, or drugs? ☐Yes ☐No If yes, please explain: _____

_____

_____

Is your child currently undergoing chemotherapy and/or radiation treatment? ☐Yes ☐No

If yes, are they experiencing dry mouth associated with this treatment? ☐Yes ☐No

Is your child on a special diet? ☐Yes ☐ No If yes, please explain: _____

Does your child currently use tobacco or controlled substances? ☐Yes ☐No If yes, please explain:

_____

Is your child allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

Does your child currently have, or have had, any of the following?

Y N (Please Check)	Y N (Please Check)	Y N (Please Check)	Y N (Please Check)
☐☐ AIDS/HIV Positive	☐☐ ADHD	☐☐ Hemophilia	☐☐ Down Syndrome
☐☐ Anaphylaxis	☐☐ Disabilities/Special Needs	☐☐ Hepatitis A	☐☐ Recent Weight Loss
☐☐ Anemia	☐☐ Cortisone Medicine	☐☐ Hepatitis B or C	☐☐ Renal Dialysis
☐☐ Angina	☐☐ Herpes	☐☐ Rheumatic Fever	☐☐ Yellow Jaundice
☐☐ Artificial Heart Valve	☐☐ Drug Addiction	☐☐ High Blood Pressure	☐☐ Rheumatism
☐☐ Artificial Joint	☐☐ Easily Winded	☐☐ High Cholesterol	☐☐ Scarlet Fever
☐☐ Epilepsy or Seizures	☐☐ Hives or Rash	☐☐ Shingles	☐☐ Venereal Disease
☐☐ Blood Disease	☐☐ Excessive Bleeding	☐☐ Hypoglycemia	☐☐ Sickle Cell Disease
☐☐ Blood Transfusion	☐☐ Excessive Thirst	☐☐ Irregular Heartbeat	☐☐ Sinus Trouble
☐☐ Breathing Problem	☐☐ Fainting Spells/Dizziness	☐☐ Kidney Problems	☐☐ Spina Bifida
☐☐ Bruise Easily	☐☐ Frequent Cough	☐☐ Leukemia	☐☐ Stomach Disease
☐☐ Cancer	☐☐ Frequent Diarrhea	☐☐ Liver Disease	☐☐ Intestine Disease
☐☐ Autism	☐☐ Frequent Headaches	☐☐ Low Blood Pressure	☐☐ Swelling of Limbs
☐☐ Chest Pains	☐☐ Hay Fever	☐☐ Lung Disease	☐☐ Thyroid Disease
☐☐ Cold Sores/Fever Blisters	☐☐ Heart Failure	☐☐ Mitral Valve Prolapse	☐☐ Tonsillitis
☐☐ Congenital Heart Disorder	☐☐ Heart Murmur	☐☐ Osteoporosis	☐☐ Tuberculosis
☐☐ Convulsions	☐☐ Heart Pacemaker	☐☐ Parathyroid Disease	☐☐ Tumors or Growths
☐☐ Asthma *Controlled:* ☐*Yes* ☐*No*	☐☐ Heart Trouble/Disease	☐☐ Psychiatric Care	☐☐ Ulcers

☐☐ Diabetes *If yes, is your child Type 1* ☐ *or Type 2*☐ *Has you/they checked their blood sugar today?* ☐*Yes* ☐*No*

*Indicate their most recent blood sugar/A1C reading*_____

Does your child have or have had a serious illness not listed above? ☐Yes ☐No If Yes, please explain:

_____

_____

Responsible Party Signature Date

_____

Dentist Signature Date

Request and Consent for Pediatric Dental Treatment

Welcome to our practice. We are so glad that you have chosen our practice for your child's dental needs. Please read the information and sign below indicating that you have read and understand this form. If you have any questions regarding this form, please feel free to ask any one of our team members to assist you. We look forward to treating your child!

1. I further request and authorize the need to obtain dental x-rays considered necessary to treat my child's dental needs.

2. I understand that the treating provider will explain to me my child's dental condition/problem(s), the planned procedures and treatment, and the benefits to be reasonably expected from the proposed treatment plan, compared with alternative approaches and/or no treatment.

3. I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. Any changes in treatment plans will be discussed with you prior to proceeding.

4. I understand that antibiotics, analgesics, and other medications may be used or prescribed during the course of treatment. I also understand the possible risks of such medications, including allergic reactions, causing redness and swelling, pain, itching, vomiting, and/or anaphylactic shock.

5. I understand it is important to monitor my child following treatment in which local anesthesia was administered. The length of time children will remain numb and unable to feel their cheek and/or lips, differs for every child. The possible risks include the child biting their lips or inside of their cheek.

6. Although it is extremely rare for any of the following risks or complications to occur, we do need to inform you of the possible risks/complications that may occur during the course of treatment. These risks or complications include but are not limited to: the possibility of pain or discomfort during treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of a temporomandibular joint (TMJ) disorder, temporary or permanent numbness, and allergic reactions.

7. I understand it is the goal of this dental office to accomplish dental treatment by the use of warmth, friendliness, persuasion., humor, charm, gentleness, kindness, and understanding. I understand that treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms that are appropriate for their age. Behavior will be guided using praise, explanation, and demonstration of procedures and instruments, using variable voice tone and loudness.

8. I understand that should my child become uncooperative during dental procedures with movement of the head, arms, and/or legs, dental treatment cannot be safely provided. During such disruptive behavior, it may be necessary for the assistant (s) and/or doctor to hold my child's hands, stabilize the head, and/or control leg movements for their safety. Additionally, I also understand that it is not uncommon for my child to cry before, during, and/or after dental treatment and the dental team will work on behavior management techniques to minimize my child's anxiety.

9. Nitrous oxide/oxygen sedation may be recommended for children who are unable complete treatment due to their behavior, ability to cooperate, and/ or restorative dental needs. A separate consent form for nitrous oxide/oxygen sedation will be obtained prior to treatment. I understand that most insurance plans do not cover the administration of nitrous oxide/oxygen sedation, and **I will be responsible for the entire fee for each visit in which my child receives nitrous oxide/oxygen sedation.**

10. It is also not uncommon for your dentist to recommend dental care performed under general anesthesia. For children who are unable to complete their dental treatment due to behavior, ability to cooperate, disabilities/special healthcare needs, and/or extent of restorative care, treatment performed under general anesthesia may be recommended. A separate consent form and medical history form will be required prior to treatment.

This form will remain in effect until terminated by either this dental office or by you.

By signing below, you agree to the following:

- You are the legal guardian of this patient and are legally authorized to consent for treatment.
- You completely understand the information above.
- All of your questions have been answered to your satisfaction. You agree to the treatment plan proposed for your child.

Patient Name | Patient Date of Birth

Parent/Legal Guardian Name | Date

Parent/Legal Guardian Signature | Witness Signature

NOTICE OF PRIVACY PRACTICE

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 8/15/2013, 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: Joanne Tavano

Telephone: (978) 840-0300 Fax: (978) 840-0310

Address: 80 Erdman Way, Suite 201
Leominster, MA. 01453

E-mail: info@allurefamilydental.com

Acknowledgement of Receipt of Notice of Privacy Practices

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of this notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Patient Name: _____

Responsible Party (If different than patient): _____

Responsible Party/Patient Signature: _____

Date: _____

I hereby give my permission to discuss all aspects of my dental treatment to the individuals listed below:

q Mother q Husband

q Father q Wife

q Other (Please Specify):_____

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
- ❑ Communication barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (Please Specify): _____

NO SHOW / CANCELLATION POLICY

In an effort to provide the highest quality care and service to our patients, we ask that you notify us 48 hours in advance to cancel and/or reschedule your reserved appointment.

We require confirmation for all appointments. As a courtesy to you we employ the use of a confirmation service to improve the efficiency of your ability to confirm you appointments by

- Email
- Text Message
- Phone Call

This system was implemented to limit the amount of last minute cancelations/no shows due to the high demand for dental care.

If appointments are not confirmed within 48 hours, the appointment will be cancelled.

We value our patient/doctor relationships and will do everything we can to accommodate you. Your communication and compliance are not only very much appreciated but will help us to help you achieve a positive outcome.

Thank you in advance for your cooperation. Your cooperation enables us to serve the needs of all our patients.

By signing below, I acknowledge I have read and understand the No Show/Cancelation Policy

_____

Patient Name DOB

_____

Patient/Parent Signature Date