MEDICAL HISTORY

Minor/Child's Physician _____ City/State _____ Phone (____) _____

Date of last physical examination _____

	YES	NO
Receiving any medication or drugs?	❑	❑
Ever been hospitalized?	❑	❑
Ever had surgery?	❑	❑
Is there excessive bleeding when cut?	❑	❑

Medications _____

_____

_____

Allergies _____

_____

Has minor/child had any history of or difficulty with any of the following? If yes, please check (✓).

❑ ADHD	❑ Cerebral Palsy	❑ Epilepsy	❑ Kidney Disease	❑ Rheumatic Fever
❑ A.I.D.S./H.I.V.	❑ Chicken Pox	❑ Fainting	❑ Liver Disease	❑ Sinus Problems
❑ Anemia	❑ Convulsions	❑ Hearing Problems	❑ Measles	❑ Thyroid Disease
❑ Asthma/Lung Problems	❑ Diabetes	❑ Heart Problems/ Murmur	❑ Mononucleosis	❑ Tuberculosis
❑ Bladder Problems	❑ Drug/Alcohol Abuse	❑ Hepatitis	❑ Mumps	❑ Other
❑ Cancer				

Is there any disease, condition or problem that is not listed above?

Please describe _____

EMERGENCY CONTACT

Name of nearest friend or relative, in case of emergency. (Person Not Living With You)

Name _____ Relationship _____ Phone (____) _____

Name _____ Relationship _____ Phone (____) _____

AUTHORIZATIONS

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health. Int. _____

Minor/Child Consent

I am the parent, guardian, or personal representative of _____

Please Print Name of Minor/Child

and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor. I understand I must be present when the treatment is rendered unless prior written consent is given. _____

Signature of Parent/Guardian

Insurance Assignment and Release

As a courtesy to you, we will process your insurance forms and claims. **However, your insurance policy is an agreement you have with your insurance carrier. If you have questions regarding payments from your insurance company, we recommend that you call your insurance provider directly for the most accurate and speedy answer.** It is the parent's/guardian's responsibility to pay for any deductible or other balance not covered by the insurance. Regardless of insurance, I agree the balance will be paid in full within 60 days of treatment, unless previous arrangements have been made. Should my account exceed ninety days, one percent (1%) interest per month, twelve percent (12%) per year will be charged. I certify that my dependent is covered by insurance with _____ and assign all insurance benefits directly to Smiles 4 Kids. I authorize the use of my signature on all

Name of Insurance Carrier

insurance submissions. I give permission for Smiles 4 Kids to use health care information and may disclose such information for the purpose of obtaining payment for service and determining insurance benefits.

_____ _____

Signature of Parent/Guardian Print name of Parent/Guardian

_____ _____

Relationship to Patient Date

Smiles 4 Kids
Dentistry for Children

Welcome!

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.

PATIENT INFORMATION

Date _____ Birthdate _____

Name of Minor/Child _____ Sex ❑ M ❑ F Age _____
Last Name First Name Middle Initial

Nickname _____

Home Address _____
Street City State Zip

Mailing Address _____
Street City State Zip

Person financially responsible _____

How did you hear about our office? _____

PARENT/GUARDIAN INFORMATION

Father's/Guardian's Name _____

Address (if different from patient's) _____

Home Phone (____) _____ Work Phone (____) _____

E-mail _____ Cell Phone (____) _____

Employer _____

Soc. Sec. # _____ Birthdate _____

Do you have dental insurance coverage for minor/child? ❑ Yes ❑ No

Carrier: _____ Phone (____) _____

Address _____

Group # _____ Subscriber ID: _____

Mother's/Guardian Name _____

Address (if different from patient's) _____

Home Phone (____) _____ Work Phone (____) _____

E-mail _____ Cell Phone (____) _____

Employer _____

Soc. Sec. # _____ Birthdate _____

Do you have dental insurance coverage for minor/child? ❑ Yes ❑ No

Carrier: _____ Phone (____) _____

Address _____

Group # _____ Subscriber ID: _____

Is your child eligible under the Idaho Smiles Program? ❑ Yes ❑ No Idaho Smiles # _____

DENTAL HISTORY

Date of last visit to a dentist _____ For what service? _____

	YES	NO		YES	NO
Has child complained about dental problems?	❑	❑	Is flouride taken in any form?	❑	❑
Does child brush teeth daily?	❑	❑	Any injuries to mouth, teeth, head?	❑	❑
Does child use floss every day?	❑	❑	Any unhappy dental experiences?	❑	❑

Any mouth habits - thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc.? ❑ ❑

See Back Please ⇨

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW RECENT LEGISLATION
REQUIRES US TO INFORM YOU ON HOW WE OBTAIN
AND PROTECT NONPUBLIC PERSONAL INFORMATION
ABOUT YOU WHICH WE REQUIRE
PLEASE REVIEW IT CAREFULLY
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice took effect April 1, 2003, 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. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use the disclosed health information about you for treatment, payment, and healthcare operations.
For example:

Treatment: We may use or disclose your health information to obtain payment for services we provide to you.

HealthCare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your authorization: In addition to our use of your health information for treatment, payment, or healthcare operations, you may give written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care or your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practices to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not share your health information for marketing communication without your authorization.

Required by law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

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, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

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.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us at 208-734-7415

If you are concerned that we may have violated your privacy rights or 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. You also may submit a written complaint to the US Department of Health and Human Services. We will provide you with the address to file your complaint with the US 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 US Department of Health and Human Services.

Patient's Name: _____
Last First Initial Date of Birth

I am aware of and understand the HIPAA Privacy Act.

I,_____, acknowledge that I have received a
(Print Parent/Guardian)
copy of this office's Notice of Privacy Practices.

Parent/Guardian's Signature: _____

Address: _____ Phone: _____

I also give consent to the following to discuss and make decision about my child's dental with the Smile 4 Kids dental staff (continue at bottom of page if additional space is needed):

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining acknowledgement
- An Emergency situation prevented us from obtaining acknowledgement
- Other (please specify)