PDA
Pediatric Dental
ASSOCIATES
Board Certified Pediatric Dentists

New Patient's Name:

Date of Birth:

PATIENT INFORMATION

Child's Custodial Parent ○ Both ○ Father ○ Mother ○ Other

Names of Both Parents or Responsible Guardian

Mother's D.O.B. Father's D.O.B.

Mother's Place of Employment

Position Mother's Employment Phone

Father's Place of Employment

Position Father's Employment Phone

Child's School Grade

Child's Phsyician:

Date of Last Exam: Physician's Phone

Whom may we thank for referring you? ○ Person

○ Facebook ○ Website ○ Sign ○ Other

Child's Pets/Hobbies

Participates in sports/Wears mouthguards

Is mother living?	○ Yes ○ No
Is father living?	○ Yes ○ No
Are parents living together?	○ Yes ○ No
Names and ages of brothers	
Names and ages of sisters	
Does mother see dentist regularly?	○ Yes ○ No
Are mother's teeth and gums in good health?	○ Yes ○ No
Does mother have missing teeth?	○ Yes ○ No
Did mother have orthodontic treatment?	○ Yes ○ No
Does mother have dental anxiety??	○ Yes ○ No
Does father see dentist regularly?	○ Yes ○ No
Are father's teeth and gums in good health?	○ Yes ○ No
Does father have missing teeth?	○ Yes ○ No
Did father have orthodontic treatment?	○ Yes ○ No
Does father have dental anxiety??	○ Yes ○ No

Names and address of parents' dentist

What was your child's birth weight?

Were there any problems during pregnancy? ○ Yes ○ No

If yes, what?

Did mother take any medication during pregnancy? ○ Yes ○ No

If yes, what?

Were there any problems with the delivery? ○ Yes ○ No

If yes, what?

Was your child born premature? ○ Yes ○ No

Did your child exhibit any birth defects? ○ Yes ○ No

If yes, what?

Did your child require any medical care in the first few days of life? ○ Yes ○ No

If yes, what?

Did your child go home with mother from the hospital? ○ Yes ○ No

Is your child adopted? (For evaluation of hereditary factors) ○ Yes ○ No

Any other pertinent information

Has your child been hospitalized? ○ Yes ○ No

If Yes, explain:

Has your child ever sustained any significant injury?? ○ Yes ○ No

If Yes, explain:

Have there ever been any physical concerns about your child's development? ○ Yes ○ No

If Yes, explain:

Did your child ever repeatedly nap/sleep while nursing or drinking a bottle? ○ Yes ○ No

If Yes, until what age?

Does your child?

Suck fingers or thumb? ○ Yes ○ No

Use a pacifier? ○ Yes ○ No

Lip, bite or suck? ○ Yes ○ No

Breathe through their mouth? ○ Yes ○ No

Clench/grind teeth? ○ Yes ○ No

When?

Follow instructions? ○ Yes ○ No

Have any speech concerns? ○ Yes ○ No

Receive any special assistance in school? ○ Yes ○ No

If yes, what?

Are there any concerns that you would like us to know about? ○ Yes ○ No

If Yes, explain:

Does your child have a history or difficulty with any of the following?

☐ Measles	☐ HIV	☐ Liver Disease
☐ Mumps	☐ Tuberculosis	☐ Seizures
☐ Chicken Pox	☐ Breathing Problems	☐ Frequent Colds
☐ Whooping Cough	☐ Adrenal Gland Disorders	☐ Ear Infection
☐ Rheumatic Fever	☐ Hearing Problems	☐ Cancer/Tumors
☐ Asthma	☐ Frequent headaches	☐ Frequent Infections
☐ Diabetes	☐ Bleeding Problems	☐ Sinus Problems
☐ Digestive Orders	☐ Blood Disorders	☐ Cyclic Vomiting
☐ Eye Problems	☐ Heart Disease	☐ ADHD
☐ Hepatitis	☐ Heart Murmur	☐ Allergies

☐ Other

Specialist Phone

Does your child have regular medical check-ups? ○ Yes ○ No

Are immunizations up to date? ○ Yes ○ No

Is your child currently being treated by a physician? ○ Yes ○ No

If Yes, explain:

Does your child have any chronic or leng-term medical conditions? ○ Yes ○ No

If Yes, explain:

Is your child currently taking any medicine? ○ Yes ○ No

If yes, please list any medications the patient is currently taking:

Medication	*Start Date*	*Dose*

Address and phone of doctor:

Does your child take any herbal supplements? ○ Yes ○ No

If Yes, explain:

Has your child had an unfavorable reaction to medications, including antibiotics and local anesthetics? ○ Yes ○ No

If Yes, explain:

Does your child bruise easily? ○ Yes ○ No

Does your child bleed excessively when cut? ○ Yes ○ No

Patient Dental History

Purpose of today's visit:

Has your child had any problems with the following?

☐ Toothache ☐ Broken tooth ☐ Thumb habit ☐ Cavities ☐ Bleeding gums

☐ Sore spots in mouth ☐ Lost fillings ☐ Bad breath ☐ Crooked teeth

☐ Headaches ☐ Jaw pain/Limitations ☐ Other habits

Last visit to the dentist: Date Dentist

Services Rendered Were x-rays taken ○ Yes ○ No

Has your child had accidents involving teeth? ○ Yes ○ No

If Yes, explain:

Does your child brush/floss daily? ○ Yes ○ No

If Yes, how often? Do you assist? ○ Yes ○ No

Is fluoride taken?

☐ Water ☐ Toothpaste ☐ Chewable Tablets ☐ Rinse ☐ Drops

Is your home on ○ City or ○ Well water?

If well water, what is the fluoride content?

CONSENT FOR EXAMINATION AND TREATMENT

I, the undersigned, have completed the above questionnaire to the best of my knowledge. Any information that I feel may not be complete will be discussed with the doctors and/or staff.

I authorize the doctors and their dental staff to perform an oral examination, a dental prophylaxis (cleaning), and, if appropriate, topical fluoride application. Dental radiographs (x-rays) may be taken as necessary (in accordance with the guidelines established by the American Dental Association) to complete the diagnosis of my child's oral condition. If the dental treatment becomes necessary, I authorize the performance of necessary treatment, medication, and therapy that is indicated in connection with dental care of the above minor patient and authorize the doctors to choose and employ such techniques and assistance as deemed fit during the treatment. I understand that I will have the right to be provided with answers to question which may arise during the course of my child's diagnosis and treatment.

I further understand that I am free to withdraw my consent to treatment at any time, and that thus consent will remain in effect until such time that I choose to terminate it.

Furthermore, I will be responsible for financial obligations incurred on this child for dental treatment.

☐ I acknowledge Date: Time:

Signature:

2013 NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU OR YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

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 09/23/13, 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, including health information we created or received before we made the changes. 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 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 or another physician 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 including 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/credentialing 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 a 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 circumstance. 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 to 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 you 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 you PHI for purposes other than those provided for in this Notice (of as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of this 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 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 Accoutning: 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 our 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.

Contact Information: 192 Main Street
Manchester, CT 06042

Phone: (860) 649-4655

NOTICE OF PRIVACY PRACTICES - HIPAA CONTINUED

We support your right to the privacy of your child's 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.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement *

I, _____, have reviewed and read the office's Notice of Privacy Practices.

☐ I Acknowledge Date: _____ Time: _____

Signature:_____

PAYMENT POLICY

We would like to thank you for becoming a member of our dental family, and assure you of our continued commitment to excellence. In an effort to control the costs for quality dental care, we have established the following policies:

1) We will need to make a copy of your driver's license and insurance card, if applicable, for our records.

2) As a courtesy for our patients with dental insurance, we will file your claim if you have provided *complete* insurance information to us. This includes the subscriber's social security number or insurance ID number, subscriber's date of birth, subscriber's employer, insurance carrier, insurance group number and a customer service telephone number. This information is typically found on your insurance ID card.

Although we estimate what your insurance company will pay, it is the insurance company that makes the final determination of your elibility/coverage. **You are responsible for any portion of the charges not covered by insurance.**

In situations where more than one insurance is available, we will only file to the primary insurance carrier. You would be responsible for filing to your secondary insurance.

3) **Payment** (minus any expected insurance benefit) **is expected at each appointment for services rendered and can be made by cash, check, Mastercard or Visa.** This includes **co-pays, non-covered expenses and deductibles.**

4) The parent/legal guardian who initially brings the child for examination is responsible for the account. In a situation where there is more than one parent/guardian responsible for payment of an account, statements will be sent to only one address.

5) If there is a financial burder, payment arrangements can be made through our administrative staff.

6) There will be a $25.00 charge for all returned checks.

7) Unfortunately, there are times when a past due account is ignored. We would then need to seek payment via a third party. If we have to pursue this in small claims court, you will be responsible for all court costs.

Thank you for your cooperation.

I have read and understand the above Payment Policy.

Name: _____

Signature:_____ Date:_____

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Consent to Communicate with a Non-Parent

We recommend that a parent or legal guardian accompany a child to their dental appointment. This assures that the parent has accurate information on what is being done at the child's dental appointment, as well as the findings from a dental exam.

We understand there may be circumstances when you are unable to accompany your child to their appointment.

Please list any stepparents, extended family members or other individuals other than mother and father who have your permission to bring your child to our office.

Please note that the account holder retains all financial responsibility for the patient.

First and Last name of person authorized:

Relationship to patient:

Phone:

Account Permissions:

- ☐ View, edit and discuss account information
- ☐ No account permissions

Patient Permissions:

- ☐ Accompany to appointments **ONLY**
- ☐ Accompany and schedule appointments **ONLY**
- ☐ Accompany, schedule and update/discuss medical info
- ☐ Accompany, schedule, update/discuss medical info and sign for treatment

Is this an emergency contact for the patient?

○ Yes ○ No

Please fill out next page for additional members you would like to add

First and Last name of person authorized:

Relationship to patient:

Phone:

Account Permissions:

- ☐ View, edit and discuss account information
- ☐ No account permissions

Patient Permissions:

- ☐ Accompany to appointments **ONLY**
- ☐ Accompany and schedule appointments **ONLY**
- ☐ Accompany, schedule and update/discuss medical info
- ☐ Accompany, schedule, update/discuss medical info and sign for treatment

Is this an emergency contact for the patient?

○ Yes ○ No

First and Last name of person authorized:

Relationship to patient:

Phone:

Account Permissions:

- ☐ View, edit and discuss account information
- ☐ No account permissions

Patient Permissions:

- ☐ Accompany to appointments **ONLY**
- ☐ Accompany and schedule appointments **ONLY**
- ☐ Accompany, schedule and update/discuss medical info
- ☐ Accompany, schedule, update/discuss medical info and sign for treatment

Is this an emergency contact for the patient?

○ Yes ○ No