Your child's overall health as well as any medications that your child takes could have an important relationship with the dental care your child needs and is able to receive safely. Please answer each of the following questions completely.

PATIENT NAME_____ **DATE OF BIRTH**_____

HEALTH HISTORY:

Asthma	yes or no	Rheumatic Fever	yes or no
Allergies	yes or no	Congenital Heart Defect	yes or no
Cancer	yes or no	Handicaps/Disabilities	yes or no
Hepatitis	yes or no	Seizures/Epilepsy	yes or no
HIV/AIDS	yes or no	Tuberculosis	yes or no
Hemophilia	yes or no	Abnormal Bleeding	yes or no
Diabetes	yes or no	Heart Murmur	yes or no
COVID-19	yes or no		

Please explain **any medical problems** that your child has and **list any medications** they are taking: _____

_____

_____

DENTAL HISTORY:

Has your child had difficulty with previous dental visits?_____

How often does your child brush?_____ floss?_____

Previous Dentist and last appointment date_____

Child's Physician_____ Physician's Phone # _____

Is your water fluoridated____ Does or has your child taken fluoride supplements_____

Circle all the apply to your child: suck thumb/finger suck/bite lips bite/chew hard objects

grind teeth clench jaws other Please explain other_____

AUTHORIZATION AND RELEASE To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care to third part payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient or parent/guardian if minor_____ **Date** _____

DENTIST REVIEW

Notes_____ Dr. Signature _____Date_____

Notes_____ Dr. Signature _____Date_____

Notes_____ Dr. Signature _____Date_____

Notes_____ Dr. Signature _____Date_____

I, (printed name of parent/legal guardian)_____ give permission for the following person/people to bring my child/children to the dental office to be treated by Dr. Severson. Until further notice, the following people are able to make decisions regarding any dental and/or medical treatment necessary while under the care of Dr. Severson. This permission includes, but is NOT limited to cleanings, fluoride, x-rays, fillings, crowns, extractions, laughing gas (nitrous oxide), conscious sedations, space maintainers, sealants, emergency treatment, impressions, local anesthesia (Novocain), nerve treatment for a tooth, and referrals to another dentist or doctor.

People who can make decisions:

Parents:_____

Grandparents:_____

Nanny:_____

Other:_____

Child this consent applies to:

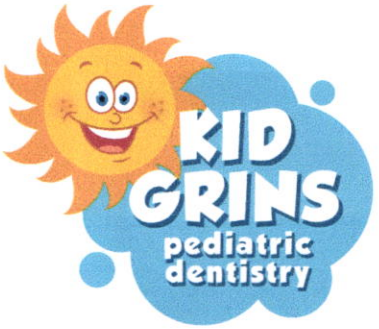
Child's Name:_____

Signature of parent/legal guardian_____

Date:_____

Relationship to patient/patients:_____

*** PLEASE NOTE: AN ADULT MUST BE PRESENT FOR THE ENTIRE APPOINTMENT. THIS ADULT MUST BE AN ADULT THAT IS ABLE TO CONSENT TO TREATMENT FOR THE CHILD/PATIENT. ***



Please sign only one of the sections below. It should be the section that you agree with.

KID GRINS PEDIATRIC DENTISTRY PRIVACY AND CONSENT FORM:

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

I, _____ have received a copy of
(Parent/Legal Guardian Name)

Kid Grins Pediatric Dentistry Notice of Privacy Practices.

_____

Name of Patient

_____

Signature of Parent/Legal Guardian

Date_____

OR

REVOCATION OF CONSENT:

I revoke my consent for your use and disclosure of my protected Health/Dental information for treatment, payment activities, and healthcare operations.

I understand that revocation of my consent will not affect any action you took in reliance on my consent before you received this written notice of revocation. I also understand that you may decline to treat or to continue to treat my child/children after I have revoked my consent.

I also understand that if I do not include my social security number, the office will not be able to submit insurance claims for your children. This means that you are responsible to pay, in full, for treatment on the day of service.

_____

Name of Patient

_____

Signature of Parent/Legal Guardian

Date_____

PATIENT REGISTRATION FORM

TODAY'S DATE _____

PATIENT INFORMATION:

FIRST NAME_____ MIDDLE NAME_____ LAST NAME_____

NICKNAME _____ GENDER _____ DATE OF BIRTH _____

HOME ADDRESS _____ CITY _____STATE_____ ZIP CODE_____

RACE (please circle) American Indian Asian Black or African American Hispanic or Latino More than one Race

Native Hawaiian or Other Pacific Islander Other Race White Prefer Not To Answer

RESPONSIBLE PARTY/GUARANTOR FIRST NAME _____ LAST NAME_____

PARENT INFORMATION:

PARENT 1 FIRST NAME _____ MIDDLE NAME_____ LAST NAME_____

RELATIONSHIP TO PATIENT _____ GENDER _____ DATE OF BIRTH _____

HOME ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

EMPLOYER _____ OCCUPATION _____ EMAIL _____

MARITAL STATUS (please circle) Single Married Widowed Divorced Separated Other_____

PARENT 2 FIRST NAME _____ MIDDLE NAME_____ LAST NAME_____

RELATIONSHIP TO PATIENT _____ GENDER _____ DATE OF BIRTH _____

HOME ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

EMPLOYER _____ OCCUPATION _____ EMAIL _____

MARITAL STATUS (please circle) Single Married Widowed Divorced Separated Other_____

DENTAL INSURANCE INFORMATION:

PRIMARY INSURANCE COMPANY _____GROUP # _____ ID # _____

INSURANCE COMPANY ADDRESS _____

FULL NAME OF POLICY HOLDER _____ RELATIONSHIP TO PATIENT _____

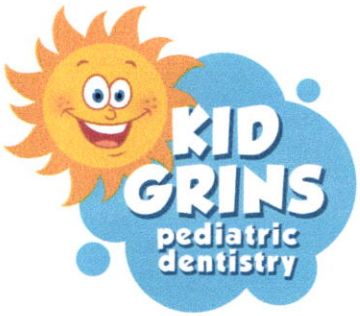
POLICY HOLDER DATE OF BIRTH _____ INSURED'S SOCIAL SECURITY # _____

SECONDARY INSURANCE COMPANY _____GROUP # _____ ID # _____

INSURANCE COMPANY ADDRESS _____

FULL NAME OF POLICY HOLDER _____ RELATIONSHIP TO PATIENT _____

POLICY HOLDER DATE OF BIRTH _____ INSURED'S SOCIAL SECURITY # _____



Please read and sign our Office Policy information Sheet:

- Please be advised that our office submits your dental claims as a courtesy to you. This does not mean that we know what your insurance coverage is or will be. It is your responsibility to know your insurance coverage.
- You are responsible for any amount that your insurance does not cover.
- You will be required to pay an estimate of the patient portion due for each date of service, on each date of service.
- It is your responsibility to provide us with any change to insurance, address, or phone number.
- A $30.00 fee will be charged for any non-sufficient funds checks we receive.
- We accept checks, cash, Visa, MasterCard, Health Savings Cards and debit cards.
- A finance charge will be assessed on ALL balances over 60 days old with the exception of money due from an insurance company.
- There will be a charge of $28 .00 per half hour scheduled on any cancelled or failed appointments unless a 24-hour notice is received.
- Patients without insurance are expected to pay their balance in full the day of service. In return, we will reduce the balance due by 5%.
- In cases of shared custody and/or divorce/separated parents, the parent/guardian signing below is responsible for the charges incurred.
- If you are 15 or more minutes late for an appointment the appointment will have to be rescheduled.
- This policy applies to all appointments and procedures provided by our office staff beginning today and including all future appointments.

I have read, understand and agree to the financial policy of this office and have received a copy upon my request.

Printed Name:_____

Signature:_____Date:_____

information for certain marketing purposes. Providers must get your specific authorization before sending you any materials other than those related to treatment.

Use only the minimum amount of information necessary. In general, uses or disclosures of information will be limited to the minimum necessary. This does not apply to disclosure of records for treatment purposes, because physicians, specialists and other providers may need access to the full record to provide quality care.

Exceptions

There are situations where healthcare providers may not have to follow these privacy rules. They include: emergency circumstances; identification of a body or the cause of death; public health needs; judicial and administrative proceedings; limited law enforcement activities; and activities related to national defense and security.

We understand your right to have your medical information kept confidential. Our compliance with the Health Information Portability and Accountability Act is one example of our advocacy and leadership on issues of patient's rights and privacy of information. We encourage you to ask questions and look forward to working together to improve the quality of your healthcare experience.

Item# 079-0279/9380

HIPAA & Your Privacy Rights

HIPAA & Your Privacy Rights

We strongly believe in doing everything we possibly can to safeguard the privacy and security of your health information and records.

As a result, we have made some changes in our office management procedures to make sure we follow the Health Information Portability and Accountability Act (HIPAA). Passed into law in 1996, HIPAA sets federal standards for the privacy and security of patient information for all healthcare providers, plans, insurance companies and anyone they do business with.

HIPAA gives you additional rights regarding control and use of your health information, meaning **you have more access and control than ever.** Please take a few minutes to review these new rights. We're happy to answer any questions you may have.

Control Over Your Health Information

All healthcare providers (and health plans) are now required to give you a written explanation of how they use and disclose your personal health information before they can treat you. This way, you can decide if a provider is doing everything they should to protect your privacy before you choose them as your caregiver.

We must, by law, post a Notice of Privacy Practices, which outlines how we secure the privacy of patient information, in a place where you can easily see it.

We must get your signature for non-routine uses and disclosures of your information. A non-routine use is any situation not directly related to treatment, payment or operations. For example, if your child is going to summer camp and the camp needs a medical history, you will be asked to authorize us to release it before we can send the information. You have the right to say no, and you don't have to tell anyone why.

Authorizations of non-routine information are one-time-only, case by case, for the use defined by you.

Access To Your Health Information

You can get copies of your medical records simply by asking for them. Healthcare providers are required to get you a copy of your records within 60 days of your request. There may be a cost for this service.

Providers also must give you a history of non-routine disclosures if you ask for it. All you need to do is ask for the record and it is provided to you – no justification is needed.

You can also amend your medical records. You cannot change the existing record, but you can add notes or comment on any procedures, treatments, payments or operations.

The provider then has the right to respond to your amendment. This way, you can be sure your records reflect your side of the story about treatment and payment issues.

Patient Recourse If Privacy Protections Are Violated

Every healthcare provider must also inform you of grievance procedures. If your privacy is violated, **report the incident to our Privacy Officer immediately.** You also have the right to report any violation to the Department of Health and Human Services, Office of Civil Rights, 200 Independence Avenue, S.W., Washington, D.C. 20201.

If you decide to file a grievance either with us or with the Department of Health and Human Services, we are not allowed to discriminate or retaliate against you in any way.

Aside from these new rights to access and control of your medical information under HIPAA, there are also clear limits on all healthcare providers regarding how they disclose medical information. Here are some of the key aspects of these boundaries:

Providers must ensure that health information is not used for non-health purposes. Health information (covered by the privacy rules) generally may not be used for purposes not related to health care – such as disclosures to employers to make personnel decisions, or to financial institutions – without your explicit authorization.

There are clear, strong protections against using health information for marketing. The privacy rules set new definitions, restrictions and limits on the use of patient