WELCOME!

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health.

Please fill out this form completely. The better we communicate, the better we can care for you.

1 Tell Us About Your Child

Today's Date: _____

Child's Name: _____

Nickname: _____ ❑ Male ❑ Female

Child's Birthdate: ___/___/___ Child's Age: _____

School: _____ Grade: _____

Child's Home #: (___)_____ **SS #:** _____

Child's Home Address: _____
APT / CONDO #

_____
CITY STATE ZIP

2 Who Is Accompanying The Child Today?

Name: _____

Relation: _____

Do you have legal custody of this child? ❑ Yes ❑ No

Whom may we **Thank** for referring you: _____

Other family members seen by us: _____

_____

Previous / Present Dentist: _____

Last visit date: _____

Parent's Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated

3 Mother's Information

❑ Step Mother ❑ Guardian

Name: _____ Birthdate: ___/___/___

Wk #: (___)_____ Ext: ___ Hm #: (___)_____

Employer: _____

SS #: _____ DL #: _____

Father's Information

❑ Step Father ❑ Guardian

Name: _____ Birthdate: ___/___/___

Wk #: (___)_____ Ext: ___ Hm #: (___)_____

Employer: _____

SS #: _____ DL #: _____

4 Person Responsible For Account

Name: _____ Relation: _____

Billing Address: _____

_____

Wk #: (___)_____ **Ext:** ___ **Hm #:** (___)_____

DL #: _____ SS #: _____

Who is responsible for making appointments?

Name: _____

Wk #: (___)_____ **Ext:** ___ **Hm #:** (___)_____

5 Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (___)_____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Relationship to patient: _____

Policy Owner's Birthdate: ___/___/___ SS #: _____

Policy Owner's Employer: _____

Orthodontic coverage? ❑ Yes ❑ No

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (___)_____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Relationship to patient: _____

Policy Owner's Birthdate: ___/___/___ SS #: _____

Policy Owner's Employer: _____

Orthodontic coverage? ❑ Yes ❑ No

CONTINUED ON BACK

6 Has the child ever had the following medical problems?

Y	N	Abnormal Bleeding	Y	N	Handicaps / Disabilities
Y	N	Allergies to any drugs	Y	N	Hearing Impairment
Y	N	Any Hospital Stays	Y	N	Heart Murmur
Y	N	Any Operations	Y	N	Hemophilia
Y	N	Asthma	Y	N	Hepatitis
Y	N	Cancer	Y	N	HIV+ / AIDS
Y	N	Congenital Heart Defect	Y	N	Kidney / Liver Problems
Y	N	Convulsions / Epilepsy	Y	N	Rheumatic / Scarlet Fever
Y	N	Diabetes	Y	N	Tuberculosis (TB)

Please discuss any medical problems that the child has had:

_____

_____

_____

7 Why did you bring the child to the dentist today?

_____

_____

Has the child ever had a serious / difficult problem associated with previous dental work? ❑ Yes ❑ No

Is the child's water fluoridated? ❑ Yes ❑ No

Is the child taking fluoridated supplements? ❑ Yes ❑ No

Has the child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD)? ❑ Yes ❑ No

Does the child brush his / her teeth daily? ❑ Yes ❑ No

Floss his / her teeth daily? ❑ Yes ❑ No

Child's Physician: _____

Phone #: _____ Last Visit Date: _____

Is the child currently under the care of a physician? ❑ Yes ❑ No

Describe the child's current health: ❑ Good ❑ Fair ❑ Poor

Please list all drugs that the child is currently taking:

_____

_____

_____

Please list all drugs/materials that the child is allergic to: ___

_____

8 Does the child have the following habits?

Y	N	Lip Sucking / Biting
Y	N	Nail Biting
Y	N	Nursing Bottle Habits
Y	N	Thumb / Finger Sucking

Our office is HIPAA compliant and is commited to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

9

I understand that 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 is my responsibility to inform this office of any changes in my child's medical status.

I authorize the dental staff to perform the necessary dental services my child may need.

_____

Signature of parent or guardian Date

The Parent or Guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.

OFFICE USE ONLY OFFICE USE ONLY **OFFICE USE ONLY** OFFICE USE ONLY **OFFICE USE ONLY**

I verbally reviewed the medical / dental information above with the parent / guardian & patient named herein.

Initials: _____ **Date:** _____

Doctor's Comments: _____

_____

_____

_____

_____

_____

Medical History Update

1. Date: _____ Signature: _____

Comments: _____

_____

2. Date: _____ Signature: _____

Comments: _____

_____

3. Date: _____ Signature: _____

Comments: _____

_____

Documentation of HIPAA Security Implementation Standards

The HIPAA Privacy regulations required the adoption of formal policies and procedures. For the HIPAA Security Standards, the documentation is even more important. Clinical practices must assess their need to comply with an addressable or required standard, implement an alternative measure, or not implement any measure at all as long as the practice will still meet the security standard to which it applies. The rationale behind such decisions must be adequately documented.

To assist our insureds in this process, what follows is an example of documentation of a security decision. In this example, our fictitious practice, Dental Practice Group (DPG) has looked at an addressable implementation specification under the transmission security standard. The standard requires the practice to "implement technical security measures to guard against unauthorized access to EPHI transmitted over an electronic communications network."

DPG has looked at the addressable implementation specification of encryption. They assessed the situation and ultimately decided not to use encryption to address the security standard. Here is the documentation they used to back up their decision.

SAMPLE POLICY

Current State Assessment Criteria

To ensure:

1. That EPHI that is transmitted electronically is not vulnerable to interception; and

2. That DPG's policies and procedure address HIPAA security requirements.

Current State Security Assessment

Readily available network access to claims information by clearinghouses is a benefit to DPG as well as its business associates. It promotes good business relations and services as a cost-efficient tool that allows DPG's staff to access information more quickly and efficiently.

The following gaps in security have been observed:

- There is no organization-wide policy governing access to PHI by health care clearinghouses. Sometimes information is e-mailed to other organizations, other times the organizations are given access to the private network containing EPHI and claims information;
- E-mail transmissions of EPHI over the Internet to clearinghouses are not protected, and could be intercepted by unauthorized users.

Risk Assessment

The risk of interception of claims information by unauthorized users over an open network is high, and the consequences of such interception are substantial. E-mail transmissions may be intercepted, allowing others to gain access to EPHI. DPG has no way of knowing whether e-mail transmissions have been intercepted and access to EPHI has been acquired. Intercepted information substantially increases the risk of wrongful disclosure of patient health information. Improperly secured information can subject DPG to penalties, possible civil and/or criminal action, including imprisonment, and irreparable harm to its reputation.

Options and Consequences

Option #1 (Implementation Specification):
Encrypt all information made available to clearinghouses. Consequence: Information is protected it if is intercepted, but computer response time is slowed considerably as a result of each piece of information that needs to be encrypted.

Option #2 (Alternative)
Limit electronic communications involving EPHI to the existing Web link for each clearinghouse, which permits unencrypted information to flow only to that organization. Clearinghouses will be given authentication codes to ensure that they are entitled to access and receive information. Consequence: Unauthorized third parties will not have access to information if it is intercepted, and computer systems remain at optimum speed.

Decision

To comply with HIPAA and protect the security of EPHI, DPG must implement technical policies and procedures for electronic information system that maintain EPHI to allow access only to those persons or software programs that have been granted access rights.

DPG has decided to adopt Option #2 as an alternative to the implementation specification in the HIPAA security regulations that suggests encryption as a method of access control. Option #2 establishes reasonable and appropriate measures and demonstrates the commitment of DPG to protect against unauthorized access to EPHI. This option allows access of EPHI only to those organizations that are authorized to receive it and allows DPG to meet its obligation to keep EPHI secure.

Encrypting the information as outlined in Option #1 is not reasonable or appropriate. The slowed computer time would inhibit DPG to operate at an effective level. Encryption outlined in Option #1 would provide a higher degree of protection from unauthorized access to EPHI, however, such instances of unauthorized access are unlikely to occur, and Option #1 would therefore be excessive. The small likelihood of unauthorized access would not justify the negative business effects associated with encryption.

CONSENT FOR ORAL CONSCIOUS SEDATION

Patient's Name Date

Please initial each paragraph after reading. If you have any questions, please ask your doctor BEFORE initialing.

You have chosen **oral conscious sedation** for your treatment. You have the right to be informed about this so that you can decide whether to have it or not after knowing the risks and benefits. These common procedures are considered quite safe. Nevertheless, all procedures have some risks. They include the following and others:

_____1. Allergic reactions (previously unknown) to any of the medications used.

_____2. Nausea and vomiting, although not common, are possible unfortunate side effects. Bed rest, and sometimes medications, may be required for relief.

____ 3. Oral conscious sedation is a serious medical procedures and, whether given in a hospital or office, carry the risk of brain damage, stroke, heart attack or death.

YOUR OBLIGATIONS:

_____4. Because anesthetic or sedative medications (including oral premedication) causes drowsiness that lasts for some time, I MUST be accompanied by a responsible adult to drive me to and from surgery, and stay with me for several hours until you are recovered sufficiently to care for myself. Sometimes the effects of the drugs do not wear off for 24 hours.

_____5. During recovery time (normally 24 hours), I should not drive, operate complicated machinery or devices or make important decisions such as signing documents, etc.

_____6. I must have a completely empty stomach. It is vital that I have NOTHING TO EAT OR DRINK for **six (6) hours** prior to your treatment. TO DO OTHERWISE MAY BE LIFE-THREATENING.

_____7. **Unless instructed otherwise**, it is important that I discuss which regular medications (high blood pressure, antibiotics, etc.) I should take prior to my oral conscious sedation. **If instructed to take medications, take using only a small sip of water**.

CONSENT

I have read and understand the above paragraphs and realize that conscious sedation has certain serious risks. I request that my choice be used for my treatment. I fully understand the risks involved. I have given a complete and truthful medical history, including all medicines, drug use, pregnancy, etc. I certify that I speak, read and write English. All my questions have been answered before signing this form.

Patient's (or Legal Guardian's) Signature Date

Doctor's Signature Date

Witness' Signature Date