welcome

PATIENT NUMBER

Age _____ Date _____

Patient's Name _____ Date of Birth _____ ❑ Male ❑ Female
Last First Initial

If Child: Parent's Name _____

How do you wish to be addressed _____
Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Minor ❑

Residence - Street _____

City _____ State _____ Zip _____

Business Address _____

Telephone: Res. _____ Bus. _____

Fax _____ Cell Phone # _____

eMail _____

Patient/Parent Employed By _____

Present Position _____

How Long Held _____

Spouse/Parent Name _____

Spouse Employed By _____

Present Position _____

How Long Held _____

Who is Responsible for this account _____

Drivers License No. _____

Method of Payment: Insurance ❑ Cash ❑ Credit Card ❑

Purpose of Call _____

Other Family Members in this Practice _____

_____

Whom may we thank for this referral _____

Patient/parent Social Security No. _____

Spouse/Parent Social Security No. _____

Someone to notify in case of emergency not living with you _____

_____

DENTAL INSURANCE 1ST COVERAGE

Employee Name _____ Date of Birth _____
Relationship to patient _____
Employer Name _____ Yrs. _____
Name of Insurance Co. _____
Address _____
_____
Telephone _____
Program or policy # _____
Social Security No. _____
Union Local or Group _____

DENTAL INSURANCE 2ND COVERAGE

Employee Name _____ Date of Birth _____
Relationship to patient _____
Employer Name _____ Yrs. _____
Name of Insurance Co. _____
Address _____
_____
Telephone _____
Program or policy # _____
Social Security No. _____
Union Local or Group _____

CONSENT:

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.

_____

_____

My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor.

I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S SIGNATURE

_____

DATE _____

REGISTRATION

welcome

PATIENT NUMBER

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

Parent's Guardian's Name _____

DENTAL HISTORY - CIRCLE THE APPROPRIATE ANSWER

1. Is this your child's first visit to a dentist? ..... YES NO
2. If not, how long since the last visit to the dentist? _____
3. Were any x-rays or radiographs taken when your child previously visited the dentist? .... YES NO
4. Does your child eat between meals? ..... YES NO
5. Does your child eat sweets, such as candy, soda pop, chewing gum? ..... YES NO
6. When does your child brush his/her teeth?
   ❒ Upon arising ❒ After eating any food ❒ Right after meals ❒ Before going to bed
7. How does your child receive Fluoride?
   ❒ Community water level ____ ppm ❒ Well water level ____ ppm
   ❒ Fluoride drops or tablets ❒ Fluoride rinse or gel
8. Have any cavities been noted in the past? ..... YES NO
9. Does your child suck his/her thumb or fingers? ..... YES NO
10. Were any teeth (baby or permanent) removed by extraction? ..... YES NO
    Was it suggested that the space be maintained ..... YES NO
    Was an appliance placed ..... YES NO
11. Have there been any injuries to teeth, such as falls, blows, chips, etc? ..... YES NO
    If so describe _____
12. Has your child had any problem with dental treatment in the past? ..... YES NO
13. Has anyone in the family, including parents, had orthodontics? ..... YES NO
14. Has your child ever received a local anesthetic? ..... YES NO
15. Has your child ever had occlusal sealants? ..... YES NO
16. Does your child think there is anything wrong with his/her teeth? ..... YES NO

MEDICAL HISTORY

1. Does your child have a health problem? ..... YES NO
2. Is your child under care of physician? ..... YES NO
   If yes, since when and why? _____
   Phone
3. Name of physician _____
4. Is your child receiving any medication? ..... YES NO
   What? _____
5. Is your child allergic to penicillin, antibiotics or other drugs? ..... YES NO
6. Is your child allergic to or sensitive to any metals or latex? ..... YES NO
7. Does your child have other allergies? ..... YES NO
8. Has your child had any serious illness? ..... YES NO
   When _____ What _____
9. Has your child ever had surgery? ..... YES NO
10. Does your child have a heart murmur? ..... YES NO
11. Is surgery contemplated? ..... YES NO
12. Does your child experience severe or prolongated bleeding? ..... YES NO
13. Does your child have AIDS or has he/she tested HIV positive? ..... YES NO
14. Has your child tested positive for hepatitis? ..... YES NO
15. Is your child subject to nervous disorders? ..... YES NO
    ❒ Fainting? ❒ Seizures? ❒ Dizziness? ❒ Behavioral/Learning problems?
16. Does your child have frequent headaches? ..... YES NO
17. Has your child had history of: (Circle appropriate responses) diabetes, heart trouble, asthma, kidney infection, rheumatic fever, epilepsy, cerebral palsy, liver problems, congenital birth defects, cognitive disability, eyesight problems, cancer, infections, speech impairments, hearing loss.

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

ANEST.

MED. ALERT

CHILD DENTAL MEDICAL HISTORY

Form No. T131CDM

Pedodontic Associates, Inc.
98-1005 Moanalua Rd. #847
Aiea, Hawaii 96701
Phone: 808-487-7933

How would you like us to contact you?

Pedodontic Associates, Inc. will be implementing a new program which will enable us to email or text you a confirmation for your appointment(s). Please update the following information for our records.

Thank you,
The Doctors and Staff

Patient's Name: _____

Parent's Name: _____

Mailing Address: _____

Home Phone: _____

Mom Cell Phone:_____ Dad Cell Phone:_____

Email Address: _____
Caution: there is some level of risk that third parties might be able to read unencrypted emails.

Would you like to receive a:
(Please choose one)

____ Text

____ Email

Signature of Parent/ Guardian _____ Date: _____

10/08/13

PATIENT NUMBER

PATIENT'S NAME _____
Last First Initial

I hereby authorize payment directly to _____
of the dental benefits otherwise payable to me. (DENTIST'S NAME)

_____
SIGNATURE (INSURED PERSON)

_____
DATE

Signature is valid for two years from the above date, unless revoked by me at an earlier date.

_____

_____

_____
ATTENDING D.D.S. NAME

is authorized to provide any insurance company(s), claim administrator (s) and consulting health care professionals, information concerning health care advice, treatment or supplies provided. This information will be used for the purpose of evaluating and administrating claims for benefits.

This authorization is valid for the term of coverage of the policy or contract, in force on this date only, or for two years, which ever is shorter.

I know I have a right to receive a copy of this authorization upon request and agree that the photographic copy of this authorization is as valid as the original.

_____
PATIENT OR AUTHORIZED PERSON'S SIGNATURE DATE

Form No. T250SF

SIGNATURE ON FILE

Agreement to Receive Electronic Communication

I agree that Pedodontic Associates, Inc. may communicate with me electronically for any health care messaging via method indicated below.

I am responsible for providing the dental practice any updates to my information.

I can withdraw my consent to electronic communications by calling:

Pedodontic Associates, Inc. @ (808) 487-7933

I would like to receive health care messaging via: ___ TEXT ___EMAIL

- Text Number : _____ - _____ This is: Mother / Father number
- Text Number: _____ - _____ This is: Mother / Father number
- Email Address: _____

***There is some level of risk that third parties might be able to read unencrypted emails.**

Name of Patient: _____
(Print)

Parent/Guardian Name: _____
(Print)

Signature: _____

Date: _____

For Office Use Only

Received by: _____Date: _____Patient's Acct. No.:_____

Pedodontic Associates, Inc.
Privacy Practice Notice Acknowledgement
*** You May Refuse to Sign This Acknowledgment***

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

Name of Patient: _____
(Print)
Parent /Guardian Name: _____
(Print)
Signature: _____

Date: _____

For Office Use Only

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

( ) Individual refused to sign

( ) Communications barriers prohibited obtaining the acknowledgment

( ) An emergency situation prevented us from obtaining acknowledgment

( ) Other (Please Specify)

_____

_____

_____

Received by: _____Date: _____Patient Acct. #_____

Pedodontic Associates, Inc.
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOUR CHILD(REN) 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 9/1/15, 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 SEND HEALTH INFORMATION ABOUT YOUR CHILD(REN)
Your child's protected health information (PHI) includes information relating to your child's mental or physical health and to the health care provided to your child, including materials like your child's dental records, dental x-rays, and payment records.

Sometimes our dental practice needs to send PHI to the patient or to someone else, such as a specialist. There are various ways to send PHI, including email and other electronic means. Our dental practice does not encrypt email or other electronic forms of communication.

There is a risk that unencrypted information may be acquired by hackers or received by unintended recipients. If you are concerned about the security of PHI that may be sent unencrypted, please let us know and we will send it a different way, which may include providing the information for you to deliver.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOUR CHILD(REN)
We may use and disclose your child's 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 child's health information for his/her treatment. For example, we may disclose your child's health information to a specialist providing treatment to him/her.

Payment. We may use and disclose your child's health information to obtain reimbursement for the treatment and services he/she receive from us or another entity involved with his/her 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 the dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your child's 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 Child's Care.
We may disclose your child's health information to your family or friends or any other individual identified by you when they are involved in your child's care or in the payment for your child's care. Additionally, we may disclose information about your child to a patient representative. If a person has the authority by law to make health care decisions for your child, we will treat that patient representative the same way we would treat you with respect to your child's health information.

Disaster Relief. We may use or disclose your child's health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your child's 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 authorize 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 child's 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 child's 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 child's 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 child's 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 child's PHI in response to a court or administrative order. We may also disclose health information about your child 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 child's 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 child's information.

Coroners, Medical Examiners, and Funeral Directors. We may release your child's 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.

OTHER USES AND DISCLOSURES OF PHI

We will also obtain your written authorization before using or disclosing your child's 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 child's PHI, except to the extent that we have already taken action in reliance on the authorization.

YOUR CHILD'S HEALTH INFORMATION RIGHTS

Access. You have the right to look at or get copies of your child's 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 child's health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your child's 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 child's 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 child's 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 child's 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 child's 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 child's 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 by electronic mail (email).

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 child's privacy rights, or if you disagree with a decision we made about access to your child's health information or in response to a request you made to amend or restrict the use or disclosure of your child's 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.

Privacy Official:

Business Address:

Telephone:

Fax:

Email Address: