CASA GRANDE PEDIATRIC DENTISTRY

Patient Registration Form

Child's name: _____ Preferred Name: _____ □ Male □Female
Child's birth date: _____ Child's age: _____ School: _____ Grade: _____
Child's home address: _____ City: _____ State: ____ Zip: _____
Child's home number: _____

WHO IS ACCOMPANYING THE CHILD TODAY?

Name: _____ Relation: _____ Do you have legal custody of the child? □ Yes □No
In case of emergency, contact (name and phone #): _____
Whom may we thank for this referral? _____

PERSON RESPONSIBLE FOR ACCOUNT

Father's Information:
Marital status □S □M □ D □ Other
Name: _____ DOB _____
Address: _____
_____
Employed by: _____
Occupation: _____
SS#: _____
Business phone: _____
Home phone: _____
Mobile phone: _____
Email: _____

Mother's Information:
Marital status □S □M □ D □ Other
Name: _____ DOB _____
Address: _____
_____
Employed by: _____
Occupation: _____
SS#: _____
Business phone: _____
Home phone: _____
Mobile phone: _____
Email: _____

DENTAL INSURANCE COMPANY

Insurance Co. name: _____ Insurance Co. phone: _____
Insurance Co. address: _____
Group # (plan, local or policy #): _____ Member # or ID#: _____
Insured's name: _____ Relationship to child: _____
Insured's birthday: _____ SS#: _____ Insured's employer: _____
Do you have secondary insurance? □ Yes □ No If yes, with whom? _____
_____

AUTHORIZATION

I certify the truth of all information given. I also authorize the release of pertinent information to those person requiring it for the treatment of my child or for the purpose of payment of the account or credit reference. Under certain circumstances, I authorize payment of insurance benefits directly to Casa Grande Pediatric Dentistry. I understand that my dental insurance carrier may pay less than the actual bill for services. I understand I am financially responsible for payment of services not paid, in whole or in part, by my dental care payor.

SIGNATURE OF PARENT/GUARDIAN DATE

1968 N. Peart Road, Suite 19 • Casa Grande, • Arizona 85122 • Phone (520)421-1400 • Fax(520)421-1444
www.CasaGrandeGrins.com

Child's Name_____

MEDICAL HISTORY

1. Is your child under care of a physician?..... □Yes □No
   If yes, since when and why?_____
2. Name of physician _____
3. Is your child receiving any medication?..... □Yes □No
   List current medications_____
4. Is your child allergic to any drugs, such as penicillin?..... □Yes □No
5. Does your child have other allergies?..... □Yes □No
6. Has your child had any serious illness?..... □Yes □No
7. Has your child ever had surgery or been hospitalized?..... □Yes □No

Has your child had a history of any of the following?
Please check a response for each question

Heart trouble, murmur, or surgery.....□Yes □No
Rheumatic fever or scarlet fever.....□Yes □No
Asthma, TB, or lung problems.....□Yes □No
HIV infection or AIDS.....□Yes □No
Hemophilia or bleeding problems.....□Yes □No
Sickle cell anemia or bleeding problems.....□Yes □No
Hepatitis or liver problems..... □Yes □No
Kidney infection.....□Yes □No
Diabetes.....□Yes □No
Cancer, tumor, or leukemia..... □Yes □No
Thyroid or other glandular problems.....□Yes □No
Latex or rubber allergy.....□Yes □No
Epilepsy, seizures, fainting..... □Yes □No
Cerebral palsy or developmental delay..... □Yes □No
Vision problems.....□Yes □No
Speech or hearing problems.....□Yes □No
Emotional or psychological problems.....□Yes □No
Congenital birth defects.....□Yes □No
Cleft lip or palate.....□Yes □No
Malignant hyperthermia..... □Yes □No
Other Medical condition..... □Yes □No
Is parent or patient pregnant..... □Yes □No

Comments
(For office use only)

Med, Alert

PURPOSE OF TODAY'S VISIT_____

DENTAL HISTORY

1. When and where was your child's last dental visit?_____
_____
2. What was the purpose of that visit?_____
3. Were any x-rays taken at your child's last dental visit?□Yes □No
4. Did your child have difficulty cooperating?.....□Yes □No
5. Was/ is your child bottle fed? .....□Yes □No
6, Was/is your child breast fed?..... □Yes □No
7. If your child has been weaned please indicate at what age:_____
8. When does your child brush his/her teeth?
□ Upon rising □ After eating any food
□ Right after meals □ Before going to bed
9. Do you assist/supervise your child's brushing?..... □Yes □No
10. Does your child take fluoride supplements?..... □Yes □No
11. Have any cavities been noted in the past?..... □Yes □No
12. Were any teeth (baby or permanent) removed by extraction?.....□Yes □No
13. Have there been any injuries to teeth, such as falls, blows, chips, etc..?..... □Yes □No
14. Has anyone in the family, including parents, had orthodontics?..... □Yes □No
15. Has your child has a toothache recently?..... □Yes □No
If yes, explain:_____
16. Do you expect your child to be cooperative? .....□Yes □No
17. Does your child have other siblings seen by us?..... □Yes □No

CONSENT

I understand that the information I have given is correct and to the best of my knowledge, and that it will be held in the strictest of confidence. Because my child is a minor, it is necessary that signed permission be obtained from a parent or legal guardian before any dental services can be rendered. I give my consent to Dr. James C. Johnson, Dr. Blake R. Schow and their staff to perform such treatments, services, medication, behavior management techniques, local anesthesia, and/or analgesia necessary to treat any dental/oral deficiency, abnormality, and/or infection

SIGNATURE OF PARENT/GUARDIAN DATE

Casa Grande Pediatric Dentistry

Patient HIPAA Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are them bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed_____day of_____20___
Print Patient Name_____
Signature_____
Relationship to Patient_____

Casa Grande Pediatric Dentistry
1968 N. Peart Rd. Ste. 19
Casa Grande, AZ 85122
520-421-1400

Protecting Your Confidential Health Information is Important to Us

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our Promise

Dear Patient:

This notice is not meant to alarm you. Quite the opposite! It is our desire to communicate to you that we are taking seriously Federal law (HIPAA—Health Insurance Portability And Accountability Act) enacted to protect the confidentiality of your health information. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside our office.

Why do you have a privacy policy? Very good question!

The Federal government legally enforces the importance of the privacy of health information largely in response to the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we follow to protect your health information when we use it.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment, conducting health care operations, and as otherwise described in this notice.

How your HEALTH INFORMATION may be used To Provide Treatment

We will use your HEALTH INFORMATION within our office to provide you with dental care. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between hygienist, dental assistant, dentist, and business office staff. In addition, we may share your health information with physicians, referring dentists, clinical and dental laboratories, pharmacies or other health care personnel providing you treatment.

To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your oral and general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventive and restorative care modern dentistry can provide. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

To Business Associates

We have contracted with one or more third parties (referred to as a business associate) to use and disclose your health information to perform services for us, such as billing services. We will obtain each business associate's written agreement to safeguard your health information.

NOTICE OF PRIVACY PRACTICES

Federal law generally permits us to make certain uses or disclosures of health information without your permission. Federal law also requires us to list in the Notice each of these categories of uses or disclosures. The listing is below.

As Required By Law

We may use or disclose your health information as required by any statute, regulation, court order or other mandate enforceable in a court of law.

Abuse or Neglect

We may disclose your health information to the responsible government agency if (a) the Privacy Official reasonably believes that you are a victim of abuse, neglect, or domestic violence, and (b) we are required or permitted by law to make the disclosure. We will promptly inform you that such a disclosure has been made unless the Privacy Official determines that informing you would not be in your best interests.

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want, we will use our best judgment when sharing your health information only when it will be important to those participating in providing your care.

Workers' Compensation Purposes

We may disclose your health information as required or permitted by State or Federal workers' compensation laws.

Judicial and Administrative Proceedings

We may disclose your health information in an administrative or judicial proceeding in response to a subpoena or a request to produce documents. We will disclose your health information in these circumstances only if the requesting party first provides written documentation that the privacy of your health information will be protected.

Incidental Uses and Disclosures

We may use or disclose your health information in a manner which is incidental to the uses and disclosures described in this Notice.

Health Oversight Activities

We may disclose your health information to a government agency responsible for overseeing the health care system or health-related government benefit program.

To Avert A Serious Threat To Health or Safety

We may use or disclose your health information to reduce a risk of serious and imminent harm to another person or to the public.

To The U.S. Department of Health and Human Services (HHS)

We may disclose your health information to HHS, the government agency responsible for overseeing compliance with federal privacy law and regulations regulating the privacy and security of health information.

For Research

We may use or disclose your health information for research, subject to conditions. "Research" means systemic investigation designed to contribute to generalized knowledge.

In Connection With Your Death Or Organ Donation

We may disclose your health information to a coroner for identification purposes, to a funeral director for funeral purposes, or to an organ procurement organization to facilitate transplantation of one of your organs.

If applicable State law does not permit the disclosure described above, we will comply with the stricter State law.

Authorization to Use or Disclose Health Information

Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

PATIENT RIGHTS

You have the following rights related to your health information.

Restrictions

You have the right to request restrictions on the use or disclosure of your health information for treatment, payment, or health care operations in addition to the restrictions imposed by federal law. Our office is not required to agree to your request, but we will endeavor to honor reasonable requests. We generally are not required to agree to a requested restriction. Our office will honor your request that we not disclose your health information to a health plan for payment or healthcare operation purposes if the health information relates solely to a health care item or service for which you have paid us out-of-pocket in full.

Confidential Communications

You have the right to request that we communicate with you by alternative means or at an alternative location. You may, for example, request that we communicate your health information only privately with no other family members present or through mailed communications that are sealed. We will honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information

You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable, cost-based fee to duplicate and assemble your copy. If there will be a charge, we will first contact you to determine whether you wish to modify or withdraw your request.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe the information to be changed and your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete. If we deny your request, we will provide you with a written explanation of the denial.

Accounting of Disclosures of Your Health Information

You have the right to ask us for a description of how and where your health information was disclosed. Our documentation procedures will enable us to provide information on health information disclosures that we are required to disclose to you. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We will provide the first accounting during any 12-month period without charge. We may charge a reasonable, cost-based fee for each additional accounting during the same 12-month period. If there will be a charge, the Privacy Official will first contact you to determine whether you wish to modify or withdraw your request.

Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

We are required by law to maintain the privacy of your health information and to provide to you or your personal representative with this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice. *You have the right* to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. We will not retaliate against you for submitting a complaint. Please let us know of your concerns or complaints in writing by submitting your complaint to our Privacy Officer.

Patient Acknowledgment

Patient Name(s): _____

_____

_____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not, we would appreciate very much your acknowledging your receipt of our policy by signing and returning this card. We look forward to seeing you again soon!

_____

Patient Signature

Date _____ / _____ / _____

For additional information about the matters discussed in this notice, please contact our Privacy Officer.

Effective Date: _____

© SmartPractice® • Printed in U.S.A.