R. James Richardson II, M.S. D.D.S., Inc.
Pediatric Dentistry

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We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive dental care. We strive to teach good oral health care that will enable your child to have a beautiful smile that lasts a lifetime.

1 Tell Us About Your Child

Todays Date: _____

Child's Name: _____

Nickname: _____ ☐ Male ☐ Female

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

Last Dental Visit Date: _____ X-ray: _____

School: _____ Grade: _____

Name/Age of Child's Siblings: _____

Child's Hobbies/Pets: _____

Patient Resides With: ☐**Parent 1** ☐**Parent 2** ☐**Both**

2 Who Is Accompanying The Child Today?

Name: _____

Relation to Child: _____

Address: _____

City: _____ Zip_____ Phone #: _____

Do You Have Legal Custody Of This Child? Yes ☐ No ☐

Emergency Contact Outside The Home: _____

Phone #: _____

Other Family Members Seen By Us: _____

_____

Whom May We Thank For Referring You? _____

Parents Marital Status: ☐ Married ☐ Widowed ☐ Separated ☐ Single ☐ Divorced ☐ Domestic Partner

NOTES: _____

_____

_____

_____

_____

_____

_____

3 Parent 1 Information: (☐ Stepparent M/F ☐ Guardian)

Name: _____ Birthdate: _____
(Circle Best Contact #)

Wk #: _____

Hm #: _____ Cell #: _____

Employer: _____ Occupation: _____

Business Address: _____

City: _____ State: _____ Zip: _____

SS #: _____ DL #: _____

Home Address: _____

Email: _____

4 Parent 2 Information: (☐ Stepparent M/F ☐ Guardian)

Name: _____ Birthdate: _____
(Circle Best Contact #)

Wk #: _____

Hm #: _____ Cell #: _____

Employer: _____ Occupation: _____

Business Address: _____

City: _____ State: _____ Zip: _____

SS #: _____ DL #: _____

Parent 2's Home Address If Different Than Parent 1: _____

_____

Email: _____

5 Dental Insurance Information

Insured's Name: _____

SS# or ID#: _____

Insurance Co. Name: _____

Insurance Co. Phone # _____

Secondary Ins. if any: Y N

Insured's Name: _____ SS# or ID #: _____

Insurance Co. Name: _____

Phone #: _____

Please continue on back of form

6 Why did you bring your child to the Dentist today?

_____

_____

Has your child ever had a serious/difficult problem associated with previous dental care? ☐ Yes ☐ No

Name of previous Dentist _____

Is your child's water fluoridated? ☐ Yes ☐ No

Is your child taking fluoridated supplements? ☐ Yes ☐ No

Has your child ever had any pain/tenderness in their jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Does your child brush their teeth daily? ☐ Yes ☐ No

Who helps your child brush/floss their teeth daily? _____

7 Does your child have any of the following habits?

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

Our office is committed to meeting or exceeding the standards of infection control and sterilization mandated by OSHA, the CDC and the ADA. We are also HIPAA Compliant.

8 Medical

Child's Physician: _____ Medical #: _____

Phone #: _____ Date of last visit: _____

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

Please describe your child's current physical health:
☐ Good ☐ Fair ☐ Poor

Has your child been immunized? ☐ Yes ☐ No

Has your child ever had any of the following medical problems?

Y	N	Allergies to any drugs / latex	Y	N	Asthma
Y	N	Heart Murmur	Y	N	Tuberculosis
Y	N	Congenital Heart Defect	Y	N	Convulsions / Epilepsy
Y	N	Rheumatic Fever	Y	N	Kidney / Liver Problems
Y	N	Hepititis	Y	N	Eyes / Ears
Y	N	Blood Transfusion	Y	N	Cancer
Y	N	Abnormal Bleeding	Y	N	Any stays in a hospital
Y	N	Hemophilia	Y	N	Any Operations
Y	N	HIV+ / AIDS	Y	N	Handicaps / Disabilities
Y	N	Diabetes	Y	N	Autism Spectrum

Please discuss all medical problems that your child has:

_____

_____

_____

Please list all drugs that your child is currently taking: _____

_____

_____

Please list all drugs / latex that your child is allergic to: _____

_____

_____

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

I understand that I must give 48 business hours notice if I need to change my child's appointment to avoid a possible cancellation fee.

Treatment plans and financial arrangements are based on the information provided by my insurance company.

I understand that Dr. Richardson's office cannot guarantee what my insurance will cover and that I am financially responsible for all services rendered.

I understand that payment is due when services are rendered. There will be a service charge of 5% per month (with a minimum service charge of $12.00 per month) on all accounts over 30 days. If collection is required, I agree to pay attorney fees and costs and to pay any account within these terms.

_____
Signature of parent or guardian Date

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

MEDICAL HISTORY UPDATE

1. Date: _____ Signature: _____

Comments: _____

_____

2. Date: _____ Signature: _____

Comments: _____

_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

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

_____

Please print your name here

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other *(Please provide specific details)*

_____

_____

_____

_____ _____

Employee signature *Date*

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.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on *(insert date)* and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, *(insert name)*. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $ *(insert fee)* for each page and the staff time charged will be $ *(insert fee)* per hour including the time required to locate and copy your health information. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons *other than* treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2003. Information prior to that date would not have to be released. *(Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.)*

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies.) Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us. In writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and 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.

HOW TO CONTACT US

Practice Name:

Privacy Officer:

Telephone: Fax:

E-Mail:

Address: