Health History Form

Pediatric Dentistry of Flower Mound
972-724-1617 • 2701 Old Settlers Road • Flower Mound, TX 75022

Patient Information

Please complete this form thoroughly because this information is of great value in helping us to be better understand and care for your child.

Appointment Date _____

Patient Name _____ Nickname _____
LAST FIRST MI

❑ Male ❑ Female Siblings & Ages _____

Birthdate _____ E-mail _____ Age _____

Home Phone ( ) _____ School _____ Grade _____ Weight _____

Address _____
STREET APT NO.

_____
CITY STATE ZIP

Please indicate if your child has ever had any of the following.

☐ *PRE-MED NEEDED	☐ Artificial Joints	☐ Heart Murmur	☐ Pulmonary Stenosis
☐ ADHD	☐ Asperger's Syndrome	☐ Heart/VSD	☐ Radiation Treatment
☐ AIDS	☐ Asthma	☐ Hemophilia	☐ Respiratory Problems
☐ Allergies	☐ Autism	☐ Hepatitis	☐ Rheumatic Fever
☐ Allergy: Amoxicillin	☐ Behavioral Problems	☐ High Blood Pressure	☐ Shunt
☐ Allergy: Ceclor	☐ Blood Disorder	☐ Hospitalization	☐ Sinus Problems
☐ Allergy: Codeine	☐ Cancer	☐ Immunizations	☐ Skin Condition
☐ Allergy: Drug	☐ Cerebral Palsy	☐ Kidney Disease	☐ Speech Problems
☐ Allergy: Food	☐ Diabetes	☐ Liver Disease	☐ Stomach Problems
☐ Allergy: Gluten	☐ Dizziness	☐ Lung Problems	☐ Stroke
☐ Allergy: Latex	☐ Downs Syndrome	☐ Medications	☐ Surgeries (explain)
☐ Allergy: Penicillin	☐ Epilepsy	☐ Manses' Onset	☐ Thyroid Condition
☐ Allergy: Sulfa	☐ Head Injuries	☐ Mental Disorders	☐ Tuberculosis
☐ Allergy: Erythromycin	☐ Hearing Problems	☐ Nervous Disorders	☐ Tumors
☐ Anemia	☐ Heart ASD	☐ Pacemaker	☐ Ulcers
☐ Arthritis/Rheumatism	☐ Heart Condition	☐ Pregnancy	☐ x-OTHER

If you have selected any conditions or alerts above for your child, please clarify/explain below:

_____

_____

Pediatrician Name _____ Last Visit _____ Phone _____

Has your child been seen by another dentist? ❑ No ❑ Yes, Name _____ Phone _____

Date of Last Visit _____ Cleaning ❑ Yes ❑ No X-rays ❑ Yes ❑ No Sealants ❑ ❑ No Date of - Bitewings _____ Pano _____

Has your child had an unfavorable dental experience? _____ If yes, please specify: _____

Does your child have a past or <u>current</u> history of thumb/finger sucking? ❑ Yes ❑ No Pacifier? ❑ Yes ❑ No

Was your child breast fed? ❑ Yes ❑ No Bottle fed? ❑ Yes ❑No Age discontinued: _____

What is your home water source? ❑ Public System ❑ Private Well ❑ Other _____

Consent for Services

I, the undersigned parent, or legal guardian of the above-named patient, hereby authorize the completion of all agreed upon treatment and the use of those methods appropriate thereto. I understand that my child's dental condition and treatment options will be discussed prior to completion.

I have disclosed my child's health history in its entirety including allergies, reactions to medicine, heart condition, diseases, and past procedures. I understand that withholding this information may affect the outcome of the procedures and course of treatment.

I authorize Pediatric Dentistry of Flower Mound, associates, and any other dental auxiliary's or medical professional to perform dental procedure(s) or treatment(s) on my child as listed on his/her treatment plan. I also give my consent for these individuals to administer any needed medicine and to perform any compulsory life-saving procedure on my child.

I understand that as the parent/legal guardian of the above-named minor, by signing this form I claim myself as the responsible party for any charges or bill incurred on my child's behalf.

I confirm that I understand this form and the information therein.

_____ Date _____ Relationship to Patient _____
SIGNATURE OF PARENT OR GUARDIAN

Parent/Guardian

Father's Name _____ ❑ Married ❑ Single
LAST FIRST MI

Email _____ Birthdate _____ Driver's License No. _____

Phone: Home ( ) _____ Work ( ) _____ Mobile ( ) _____

Address _____
STREET APT NO.

_____
CITY STATE ZIP

Employer Name _____ Occupation _____

Employers Address _____
STREET CITY STATE ZIP

Mother's Name _____ ❑ Married ❑ Single
LAST FIRST MI

Email _____ Birthdate _____ Driver's License No. _____

Phone: Home ( ) _____ Work ( ) _____ Mobile ( ) _____

Address _____
STREET APT NO.

_____
CITY STATE ZIP

Employer Name _____ Occupation _____

Employer Address _____
STREET CITY STATE ZIP

Emergency Information — Nearest relative not living in same household.

Name _____ Phone ( ) _____

Address _____

Primary Insurance Information — *Please present your dental insurance card to the receptionist.*

Name of Insured _____
LAST FIRST MI

Insured's Birthdate _____ Subscriber ID: _____ Group No. _____

Insured's Address _____
STREET CITY STATE ZIP

Insured's Employer Name _____

Insurance Plan Name and Address _____

_____ Insurance Company's Phone _____

Patient's Relationship to Insured ❑ Self ❑ Spouse ❑ Child ❑ Other _____

I hereby authorize payment of dental benefits, otherwise payable to the insured, directly to Pediatric Dentistry of Flower Mound.

Signature of Employee/Subscriber _____

Referral Information – Whom may we thank for referring you to our practice?

office: ❑ *TYN*

❑ Another Patient ❑ Dental Office ❑ Internet ❑ School ❑ Work ❑ Facebook ❑ Drove by

Name of person or office referring you to our practice: _____

Financial Agreement

Pediatric Dentistry of Flower Mound
2701 Old Settlers Road
Flower Mound, Texas 75022

972.724.1617
www.debraduffydds.com

_____ • Payment: Payment is expected in full for each appointment as services are rendered. Payment options are:
- o Cash
- o Check
- o Credit Card (MasterCard, Visa, American Express, and Discover)
- o Care Credit (6 & 12 month Interest Free Financing Available on approved credit.)

_____ • Dental Insurance: Dental insurance is a contract between you and your insurance company. Your insurance benefits are determined by the type and design of plan chosen by you and/or your employer and we are not a party to this contract. We have no control over the terms of your contract, the method of reimbursement, or the determination of your benefits. Some and perhaps all of the services can be defined by your insurance company as "not covered", "denied" or "over UCR'·. Our office is not notified when there is a change in coverage or plan design. It is your responsibility to notify our office of such changes. We will file your primary dental insurance claims as a courtesy to you. We do not guarantee payment and are not responsible for providing you with the plan limitations, exclusions and provisions determined by your insurance company. You agree to pay any portion of the charges not covered by your insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. We will file a pre-determination for recommended treatment when it is requested by you.

_____ • Missed Appointment Fee: Our office requests 2 business days notification if you are unable to keep your scheduled appointment. If less than 2 business day notice is given, a $50 fee may be charged to your account. Patients with three missed appointments may be asked to transfer their records to another doctor.

_____ • Emergency/After Hours Appointment: If your child is seen for an emergency visit after our regular business hours, an "after hours" fee is charged in addition to any treatment on that visit. All emergency treatment must be paid in full at the time of service.

_____ • Finance Charge: A finance charge will be added to your account for any balance over $50.00 that is unpaid within (30) days of the date of service. The FINANCE CHARGE will be computed at the rate of (1%) per month.

_____ • Returned Checks: There is a minimum fee of ($35.00) for any checks returned by the bank.

_____ • Monthly Statement: To reduce costs we do not "bill" for services rendered, payment is due and expected on date services are rendered. If you have a balance on your account after insurance has paid or denied payment, we will send you a statement. It will show the previous balance, any new charges to the account, finance charge, if any and any payments or credits applied to your account during the month. Professional fees are the responsibility of the parent or guardian authorizing treatment; we cannot send statements to other persons.

_____ • Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collections costs which are incurred.

_____ • Divorce: In case of divorce or separation, the responsible party prior to the divorce or separation remains responsible for the account. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

_____ • Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

This is an agreement between Pediatric Dentistry of Flower Mound, a pediatric dentist, and the Patient/Debtor named on this form.

In this agreement the words "you," your" and "yours" means the Patient/Debtor. The word "account" means the account that has been established in your name for your child to which charges are made and payments are credited. The words "we," "us," and "our" refer to Pediatric Dentistry of Flower Mound.

By executing this agreement, you are agreeing to pay for all services that are received.

_____
Patient's Name

_____
Parent/Legal Guardian/Responsible Party (Printed)

_____ _____
Parent/Legal Guardian/Responsible Party (Signature) Date

Pediatric Dentistry of Flower Mound
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

OUR LEGAL DUTY:

We are required by applicable federal and state law to maintain the privacy of your child's health information. We are also required to give you this Notice about our privacy practices, our legal duties 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 the Notice while it is in effect. This Notice takes effect January 1, 2019 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. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available 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.

USES AND DISCLOSURES OF HEALTH INFORMATION:

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your child's health information to a physician or other healthcare provider providing treatment to your child.

Payment: We may use and disclose your child's healthcare information to obtain reimbursement for the treatment and services your child receives from us or another entity involved with their 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 your 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. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your child's health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your child's health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your child's health information to you, as described in the Patient Rights section of this Notice. We may disclose your child's health information to a family member, friend or other person to the extent necessary to help with your child's healthcare or with payment for your child's healthcare, but only if you agree that we may do so. (*See HIPAA Release and Authorization and Health/Dental Care Authorization for Minor Child provisions as described in the Patient's Rights section of the Notice*.)

Persons Involved in Care: We may use or disclose health information to notify or assist in the notification of a family member, your child's personal representative or another person responsible for your child's care, of your child's identity, of your child's location, of your child's general condition, or death. If you are present, then prior to use or disclosure of your child's health information, we will provide you with an opportunity to object to such uses or disclosure. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your child's healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your child's best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your child's health information for marketing communications without your written authorization.

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, Abuse and Neglect: We may disclose your child's health information for public health activities to the extent necessary to avert a serious threat to your child's health or safety or the health or safety of others; If we reasonably believe that your child is a victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your child's health information to report reactions to medications or problems with products; notify a person of a recall of a product and notify a person who may have been exposed to a disease or condition.

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

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.

Fundraising: We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communication.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials, health information required for lawful intelligence, counterintelligence, and other nation security activities. We may

disclose to correction institution or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

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.

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 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.

Coroner, 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.

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.

Appointment Reminders: We may use or disclose your child's health information to provide you with appointment reminders and/or treatment reminders, school excuses, office promotions or special events (Using alternate communication such as voicemail messages, postcards, letters, email, faxes and texting).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your child's health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your child's health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you a reasonable fee for each page, a reasonable rate per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your child's health information in that format. If you prefer, we will prepare a summary or an explanation of your child's health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

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 these additional requests.

Restriction: You have the right to request that we place additional restriction on our use or disclosure of your child's health information 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 of health care operations, and the information pertains solely to a health care item or service for which you, or a person on your 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 to alternative locations. You must make your request in writing. Your request must specify the alternative means or locations and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

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.

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: If you receive this Notice on our web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

HIPAA Release and Authorization: You will be given the opportunity to sign and acknowledgement of Receipt of Notice of Privacy Practices and HIPAA Release and Authorization wherein you will be asked to provide the names of any and all persons with whom we may discuss treatment, recommendations and billing matters. Please be advised that any person, including family member, personal representative, nanny, housekeeper, neighbor, to whom you find acceptable to participate in your child's healthcare treatment in any capacity should be named specifically on that HIPAA Release and Authorization. Failure to include the name of any such third party on that Release and Authorization could result in your child not receiving the treatment/care sought. The above notwithstanding, should a third party present your child and produce your written permission for them to participate in your child's treatment and to receive the information that would otherwise be made available to you if you were present, your child will then be entitled to receive the treatment/care sought and the third party written authorization will be retained and included in your child's file.

Health/Dental Care Authorization for Minor Child: By completing and signing the Acknowledgement of Receipt of Privacy Practices and as provided in Texas Family Code, Title 2, Chapter 32, Section 32.001 you will be identifying authorized representative(s) (Agent(s)) who may consent to medical, dental, psychological and surgical treatment of your child when the person having such right to consent as otherwise provided by law cannot be contacted and that person has not given actual notice to the contrary. This authorization does not apply to consent for the immunization of a child. The authorized representatives' names will be required as a prerequisite for such identified individual(s) to be able to present your child for treatment/professional services.

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 or your child's privacy rights, or you disagree with a decision we made about your 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 may also 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 privacy of your child's 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.

Contact: **Pediatric Dentistry of Flower Mound**
ATTN: Privacy Officer
2701 Old Settlers Road
Flower Mound, TX 75022

Phone: 972-724-1617
E-mail: info@pdofm.com

Pediatric Dentistry of Flower Mound

Email - Text – Photo Authorization Form

Patient/Child/Children's Names:

_____

_____

E-Mail & Text Authorization

Our practice uses E-mail & Texting as a form of communication between our office and our patients. By signing below, you agree to allow our office to communicate with you via electric mail or via texting to provide you with the following:

- Appointment Reminders & Appointment Requests
- Office Promotions and Marketing (Such as Sealant Promotions)
- Special Office Events (Such as Dress up Days), Birthdays, Treatment, Billing & Insurance Questions

☐ Check here to decline email contact.
☐ Check here to decline texting contact.
☐ Check this box to use email on file or use updated email(s) listed below.
☐ Check this box to use cell number(s) on file or use updated cell(s) listed below.

Authorized E-Mail(s): _____

Authorized Cell Number(s): _____

Please Print Your Name: _____
LAST FIRST MI

Signature: _____Date_____

Photo Authorization:

I authorize Pediatric Dentistry of Flower Mound, to photograph my child during appointments and special events held by the practice (such as dress-up days, special event days, etc.). By signing below, I am authorizing the use or non-use of these photographs and I have indicated by a check mark the extent I am authorizing the use of such photographs taken of my child/children.

☐ Post on Practice Facebook Page
☐ Display in a Photo Album in the Office
☐ Use Photo in a practice newsletter.
☐ Use my child's first name to identify him/her in the photo.
☐ Do not use my child's first name to identify him/her in the photo.
☐ I do not want my child's photo taken or used by the practice.

Please Print Your Name: _____
LAST FIRST MI

Signature: _____ Date: _____