CHILD PATIENT INFORMATION

PATIENT HISTORY RECORD:

Child's Name: _____ Date: _____

Age: _____ Date of Birth: _____ Grade: _____

Address: _____ Home Phone #: _____

FAMILY RECORD:

Father's Name: _____ Date of Birth: _____
Address (if different): _____ Cell Phone #: _____
Employer: _____ Business Phone #: _____
Business Address: _____ Social Security Number: _____

Mother's Name: _____ Date of Birth: _____
Address (if different): _____ Cell Phone #: _____
Employer: _____ Business Phone #: _____
Business Address: _____ Social Security Number: _____

Please list the first names of all brothers and sisters and their ages:

_____ _____ _____

Person Responsible for Payment: _____ E-mail Address: _____

Referred to our office by: _____

Primary Dental Insurance Information	Secondary Dental Insurance Information
Insured's Name: _____	Insured's Name: _____
Insured's Birthdate: _____	Insured's Birthdate: _____
Employer Name: _____	Employer Name: _____
Insurance Company: _____	Insurance Company: _____
Insurance Address & Phone #: _____	Insurance Address & Phone #: _____
_____	_____
Policy #: _____ Insured's ID#: _____	Policy #: _____ Insured's ID#: _____

Previous Dentist: _____ How long since last dental visit? _____

I hereby authorize Dr. Anderson and / or his associates to perform any and all treatment for my child and consent to such methods, drugs and agents as may be indicated in connection with his / her dental care. This consent shall remain in effect until cancelled.
Name: _____ *Relationship to Child:* _____

-Please Note-
Payment is expected at time of service. If you provide your insurance form and proper information, we will file your insurance as a courtesy. However, you are responsible for your account within the limits of our credit policy, regardless of insurance coverage.

SIGNATURE: _____

L. Eric Anderson, D.D.S. P.L.C.

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

	Yes	No	
Are you under a physician's care now?	◯	◯	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	◯	◯	If yes, please explain: _____
Have you ever had a serious head or neck injury?	◯	◯	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	◯	◯	If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux?	◯	◯	_____
Are you on a special diet?	◯	◯	_____
Do you use tobacco?	◯	◯	
Do you use controlled substances?	◯	◯	

Women: Are you:

Pregnant / Trying to get pregnant? ◯ Yes ◯ No ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following (check if yes)?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following? **Please check if Yes**

- ◯ AIDS/HIV Positive
- ◯ Alzheimer's Disease
- ◯ Anaphylaxis
- ◯ Anemia
- ◯ Angina
- ◯ Arthritis/Gout
- ◯ Artificial Heart Valve
- ◯ Artificial Joint
- ◯ Asthma
- ◯ Blood Disease
- ◯ Blood Transfusion
- ◯ Breathing Problem
- ◯ Bruise Easily
- ◯ Cancer
- ◯ Chemotherapy
- ◯ Chest Pains
- ◯ Cold Sores/Fever Blisters
- ◯ Congenital Heart Disorder
- ◯ Convulsions
- ◯ Cortisone Medicine
- ◯ Diabetes
- ◯ Drug Addiction
- ◯ Easily Winded
- ◯ Emphysema
- ◯ Epilepsy or Seizures
- ◯ Excessive Bleeding
- ◯ Excessive Thirst
- ◯ Fainting Spells/Dizziness
- ◯ Frequent Cough
- ◯ Frequent Diarrhea
- ◯ Frequent Headaches
- ◯ Genital Herpes
- ◯ Glaucoma
- ◯ Hay Fever
- ◯ Heart Attack/Failure
- ◯ Heart Murmur
- ◯ Heart Pace Maker
- ◯ Heart Trouble/Disease
- ◯ Hemophilia
- ◯ Hepatitis A
- ◯ Hepatitis B or C
- ◯ Herpes
- ◯ High Blood Pressure
- ◯ High Cholesterol
- ◯ Hives or Rash
- ◯ Hypoglycemia
- ◯ Irregular Heartbeat
- ◯ Kidney Problems
- ◯ Leukemia
- ◯ Liver Disease
- ◯ Low Blood Pressure
- ◯ Lung Disease
- ◯ Mitral Valve Prolapse
- ◯ Osteoporosis
- ◯ Pain in Jaw Joints
- ◯ Parathyroid Disease
- ◯ Psychiatric Care
- ◯ Radiation Treatments
- ◯ Recent Weight Loss
- ◯ Renal Dialysis
- ◯ Rheumatic Fever
- ◯ Rheumatism
- ◯ Scarlet Fever
- ◯ Shingles
- ◯ Sickle Cell Disease
- ◯ Sinus Trouble
- ◯ Spina Bifida
- ◯ Stomach/intestinal Disease
- ◯ Stroke
- ◯ Swelling of Limbs
- ◯ Thyroid Disease
- ◯ Tonsillitis
- ◯ Tuberculosis
- ◯ Tumors or Growths
- ◯ Ulcers
- ◯ Venereal Disease
- ◯ Yellow Jaundice

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain:

_____

Comments:

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Anderson DENTAL GROUP

PATIENT AUTHORIZATION FOR SERVICES

I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of _____'s dental needs. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required in providing proper care. I agree to the use of anesthetic and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks, and that I can ask for a complete recital of any possible complications.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____, acknowledge that I have been made aware of Anderson Dental Group's Notice of Privacy Practices. This notice describes how the doctor may use or disclose my protected health information, certain restrictions on the use and disclosure of my health care information, and rights I may have regarding my protected health information.

I hereby grant access to my dental information to the following individual(s):

Person	Relationship
Person	Relationship

PATIENT PAYMENT FOR SERVICES AGREEMENT

Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I agree that I shall be responsible for any and all expense incurred at this office, and I understand that payment is due at the time of service, unless other arrangements have been made, regardless if I have insurance. In the event payments are not received by the agreed upon dates, I understand a finance charge of 18% APR may be added to my account.

Anderson Dental Group values the time for each appointment scheduled at our office. We appreciate a notification 2 days prior to any appointment cancellation. Please be advised a fee may be applied for cancellations less than 24 hours prior to the scheduled appointment.

TO BE SIGNED AT YOUR VISIT

Signature _____ Date _____

Anderson
DENTAL GROUP

SMILE EVALUATION

At Anderson Dental Group, we are committed to helping you discover and obtain the smile you have always wanted. Please take a moment to complete this questionnaire. This information helps us ensure we are serving you to the best of our ability.

- *Are you happy with the way your teeth look when you smile?*

- *Are you happy with the color of your teeth?*

- *Do you have any spaces between your teeth that you are unhappy with?*

- *Do you have any old fillings or treatment you are unhappy with?*

- *Is there anything you would change about your smile? What would it be?*

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION.

PLEASE REVIEW CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 1/1/2003 , 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 changes. Prior to making a significant change in our privacy practices, we will amend 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 health information to obtain treatment information for services we provide to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your 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: Other than our use of your health information for treatment and payment of healthcare operations, we will not share - without written authorization - your health information or disclose it to anyone for any purpose. If you provide an authorization to us, you may revoke it, in writing, at any time. Your revocations 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 health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. 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 healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences in your 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 health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

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, domestic violence, or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

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 national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of an inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or obtain copies of your 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 practically do so. You must make a request in writing to obtain access to your 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 a letter to the address at the end of this Notice. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates have disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities, for the last 6 years. If you request this accounting more than once in any 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 restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your 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 a satisfactory explanation of how payment will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing and must explain why the information should be amended. We may deny your request under certain circumstances.

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.

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 privacy rights, disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use of disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may communicate with 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 chose to file a complaint with us or with U.S. Department of Health and Human Services.

Contact Officer: Dr. Anderson


Mail:

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Telephone: 515.276.8572 Fax: 515-334-7274