Capital Children's Dental Center

Patient's Name_____ **Date**_____

I. Medical History

Child's Physician_____ Phone_____

Date of last exam _____

☐ Yes ☐ No Is your child allergic to any medicines or foods? If yes, what?_____

_____

☐ Yes ☐ No Is your child taking any medications? If yes, what?_____

_____

☐ Yes ☐ No Has your child ever been hospitalized or had an operation? If yes, explain

_____

☐ Yes ☐ No Does your child have any physical, mental, emotional, or muscular disabilities? If yes, explain_____

_____

☐ Yes ☐ No Does your child have any hearing, sight, speech or learning problems? Please explain_____

☐ Yes ☐ No Does your child need an antibiotic prescription (recommended by your physician, for a heart condition – artificial valves/shunts, etc.) before any dental work?

Please check any that pertain to your child

☐ Heart/Cardiovascular Condition	☐ Allergies	☐ Rheumatic Fever
☐ Liver/Kidney Problem	☐ Asthma	☐ Heart Murmur
☐ Bleeding Disorder	☐ Hepatitis	☐ Sickle Cell Anemia
☐ Epilepsy	☐ Diabetes	☐ HIV/AIDS
☐ ADD/ADHD	☐ Cerebral Palsy	☐ Eczema/Skin Disorders

II. Dental History

☐ Yes ☐ No Is your child experiencing dental pain today? If so, where?_____

☐ Yes ☐ No Is this your child's first visit to the dentist?

If not, how long has it been since the last visit to the dentist?_____

Name of previous dentist _____

☐ Yes ☐ No Were any x-rays taken?

☐ Yes ☐ No Has your child experienced an unfavorable reaction from previous dental care?

☐ Yes ☐ No Does your child have a thumb, finger, or pacifier habit? (circle)

☐ Yes ☐ No Do you have well water?

☐ Yes ☐ No Does your child take fluoride supplements?

☐ Yes ☐ No Does your child take a bottle at night?

How often does your child brush his/her teeth?_____Floss_____

How often do you clean your child's teeth?_____

I have read my child's medical history dated _____ and confirm that it accurately states past and present conditions.

Date	Exceptions/Changes	Parent's Signature	Reviewed by:

Patient Registration

III. Social History

Patient's First Name _____ Middle _____ Last _____

Preferred Name _____ Age ___ Sex ___ Date of Birth _____ SS# _____

Hobbies _____

Child lives with:

☐ Both parents ☐ Mother ☐ Father
☐ Grandparents ☐ Stepmother ☐ Stepfather
☐ Other _____ _____

Any Siblings who are patients? _____

Patient's Address _____ Home Phone # _____

City/State/Zip _____

Father/Guardian's Full Name _____ SS# _____

Driver's License # _____ Father's Date of Birth _____

Address _____ Home Phone # _____

Where Employed _____ Work # _____ Cell # _____

Occupation _____

Mother/Guardian's Full Name _____ SS# _____

Driver's License # _____ Mother's Date of Birth _____

Address _____ Home Phone # _____

Where Employed _____ Work # _____ Cell # _____

Occupation _____

Whom may we thank for referring you to our office? _____
(Please enter full name of doctor, school, or person)

Name of closest relative or friend not residing with patient who we may contact in case parents cannot be reached _____ Home # _____ Cell # _____

Reason for bringing child to the dentist _____

As Parent or Guardian of the above named child, I give my consent to needed dental services and use of proper and acceptable methods to complete dental exams. I authorize release of any and all information: radiographs, photographs, and models.<-Per Madelyn this is not needed. I allow for photographs to be used at the discretion of Capital Children's Dental Center. I also accept responsibility of payment of the services provided for my child. **For the safety of your child, please remain in the office during your child's visit in case you are needed by our staff.**

_____ _____
Parent or Guardian Signature Date

Office Policy

Capital Children's Dental Center

Child/children's name(s)_____

We are committed to providing your child with the best possible dental health care, and we are pleased to discuss with you at anytime our office policy and your responsibilities. We respect the trust you've placed in us as caregivers, and our pledge to you is to treat your child as we would our own. Your clear understanding of our Office Policy is important to our professional relationship. The following is an agreement between our Dental Practice and you as the parent or guardian of the child.

For the parent or guardian...

1. Only children who have an appointment should come to the dental office accompanied by an adult who has the authority to take responsibility for treatment decisions.
2. You must **stay in the office during your child's treatment**. Your child's safety and welfare depend on you being available to make treatment decisions. We cannot proceed with emergency treatment or treatment changes without your permission.
3. Our office makes every effort to stay on schedule. However, sometimes emergencies do occur which require an interruption in our schedule. We will inform you if this occurs and do our best to accommodate all involved.
4. Please help us keep our waiting room clean and neat by not bringing food or drink into the office.
5. Your child's dental health depends on you keeping your scheduled appointments. **If you must cancel an appointment, please notify our office at least 48 hours in advance. Otherwise, after 2 broken appointments, your child will be dismissed from our practice.** Please be sure we have your correct address and telephone number to help avoid broken appointments.
6. Should your child be dismissed from our practice, we will only see them on an emergency basis for 30 days after which we will transfer the dental records to the office of your choice.
7. Please **remember to bring your child's current insurance information and/or Medicaid card to each visit or we cannot treat your child.**
8. Understand that some dental procedures may not be covered by your insurance. If this occurs, we will accept cash, check, MasterCard or Visa for any portion not covered by your insurance.
9. In **divorce or custody cases,** we must consider the parent or guardian who **brings** the child as the responsible party, regardless of the provisions in the divorce decree, who has custody of the child or who has the insurance coverage.

Thank you for understanding our Office Policy. Please let us know if you have any problems, concerns, or questions. We are here to help you. Please sign below to indicate that you have read and understand each section and intend to abide by this policy.

(Signature of Parent or Guardian) (Date)

Date _____

Dental Insurance Information

(Please note we are not a contracted provider with any private insurance plan however, we do participate with all Medicaid plans for children.)

Patient's Name _____ Patient's Birthdate _____

Patient's SS# or Member ID# _____

Insured's Name _____ Insured's Birthdate _____

Insured's SS# or Member ID# _____

Insured's Employer (if applicable) _____

Group/Policy # _____

Insurance Company Phone Number _____

Claims Address _____

City _____ State _____ Zip _____

Insurance Company Contact Name (if applicable) _____

Capital Children's Dental Center

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

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

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

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

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

Notice Of Privacy Practices
for the office of
Capital Children's Dental Center
655 St. Andrew's Rd., Ste. 8
Columbia, SC 29210
803-252-7725

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and disclosures to carry out treatment, payment, and health care operations

Treatment- This practice may use or disclose your protected health information in consultation between health care providers relating to your treatment or for your referral to another health care provider for your treatment.

Payment- This practice may use or disclose your protected health information
for billing, claims management, collection activities, or obtaining payment.

Health care Operation- This practice may use or disclose your protected health information for reviewing the competence or qualifications of health care professionals, or for conducting training programs in which students, trainees, or practitioners participate. This practice may use or disclose your protected health information for accreditation, certification, licensing, or credentialing activities. This practice may use or disclosure your protected health information to our business associates who participate in our healthcare operations. These disclosures will only be made after we have satisfactory assurances in the form of a Business Associates Agreement from the business associate. These assurances will include their agreement to comply with the HIPAA rules and the compliance of any subcontractor with which they do business.

Authorized Uses or Disclosures

The following uses or disclosures require a valid authorization as defined by the HIPAA standards.

Uses or Disclosures for Psychotherapy Notes- Not applicable to this practice

Uses or Disclosures for Marketing Purposes- Not applicable to this practice

Disclosures for a Sale of Protected Health Information- This practice will require an authorization for any disclosures that would constitute a sale of protected health information.

For any other use or disclosure you wish us to make, you can give us a written, valid authorization. Your authorization must have specific instructions for the use and disclosure you want us to make. You will have the right to revoke the authorization in writing at any time before the information is used or disclosed.

Uses or disclosures requiring an opportunity for the individual to agree or object

For disclosures to others involved with your health care or payment, we will inform you in advance and give you the opportunity to agree or object. These disclosures will be limited to the information necessary to help with your health care or payment. These disclosures will only be made if you do not object.

Uses and disclosures for which an authorization or opportunity to agree or object is not required

The following uses or disclosures do not require an authorization or the opportunity for you to agree or object.

Uses and disclosures required by law-This practice may use or disclose protected health information to the extent required by law. The use or disclosure will comply with and be limited to the relevant requirements of such law.

Uses and disclosures for public health activities-This practice may use or disclose protected health information for the purpose of preventing or controlling disease, injury, or disability, including, but not limited to, the reporting of disease, injury, and vital events such as birth or death.

Disclosures about victims of abuse, neglect or domestic violence This practice may disclose protected health information about an individual whom this practice reasonably believes to be a victim of abuse, neglect, or domestic violence.

Uses and disclosures for health oversight activities-This practice may disclose protected health information to a health oversight agency for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations, inspections, licensure, or disciplinary actions.

Disclosures for judicial and administrative proceedings- This practice may,
in response to an order of a court or administrative tribunal, provide only the protected health information expressly authorized by such order or a subpoena.

Disclosures for law enforcement purposes- This practice may disclose protected health information as required by law including laws that require the reporting of certain types of wounds or other physical injuries.

Uses and disclosures about decedents- This practice may disclose protected health information to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law. We may disclose protected health information to a funeral director, as authorized by law, to carry out their duties. This disclosure will be made in reasonable anticipation of death.

Uses and disclosures for cadaveric organ, eye or tissue donation purposes- This practice may use or disclose protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.

Uses and disclosures for research purposes- This practice may use or disclose protected health information for research, when the research has been approved by an institutional review board or privacy board, to protect your protected health information.

Uses and disclosures to avert a serious threat to health or safety- This practice may, consistent with applicable law and standards of ethical conduct, use or disclose protected health information, in good faith, if we believe the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Uses and disclosures for specialized government-This practice may use and disclose the protected health information of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission, if the appropriate military authority has published by notice in the Federal Register.

Disclosures for workers' compensation-This practice may disclose protected health information as authorized by and to the extent necessary, to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

Patient rights under HIPAA

The following information describes your rights under the HIPAA Standards. This practice requires that all requests for the various rights be made in writing and we will provide our decision on your request in writing. You should be aware that there may be some situations when there could be limitations placed on your rights. We are required to permit you to request these rights, but we are not required to agree to your request, except as discussed in the Right of Restriction section.

Right of an individual to request a restriction of uses and disclosures
This practice will permit an individual to request that we restrict uses or disclosures of protected health information about the individual to carry out treatment, payment, or health care operations or to others involved in your care or in payment. We will consider these requests, but we are not required to agree to them, except as discussed in the next section.

Under your right of restriction, you may restrict certain disclosures of protected health information to a health plan for payment or healthcare operation, where payment in full is made out of pocket for a healthcare item or service

Confidential communication requirements
This practice will permit an individual to request and will accommodate reasonable requests to receive communications of protected health information from our practice by alternative means or at an alternative location.

Access of individuals to protected health information
An individual has a right of access to inspect and obtain a copy of protected health information about the individual in a designated record set except as prohibited by state or federal law or certain other exemption. Your access may be provided in electronic form if producible at your request or in another form or format. As permitted by state and federal law, we may charge you a reasonable cost based fee for a copy of your record. Questions about the fee should be addressed to our Privacy Officer at the phone number listed at the end of this document.

Amendment of protected health information
An individual has the right to ask to have this practice amend protected health information or a record about the individual in a designated record set for as long as the protected health information is maintained in the designated record set.

Accounting of disclosures of protected health information
An individual has a right to receive an accounting of disclosures of protected health information made by this practice in the past six years but not before April 14, 2003. The accounting will not include disclosures made for treatment, payment, or operations, as well as authorized disclosures or disclosures made for which you had an opportunity to agree or object. You may receive one free accounting in a 12 month period. There will be a reasonable cost based fee for additional requests.

Right of Breach Notification
An individual has the right to and will receive a notification of any breach of their unsecured protected health information as defined by the Breach Notification Rule. We will fulfill our obligation to provide notice in accordance to HIPAA standards.

Copy of this notice
You have a right to a copy of this notice. Even if you agreed to receive an electronic copy, you may request and receive a paper copy.

Our Duties

This practice is required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information.

This practice is required to abide by the terms of the notice currently in effect.

This practice is required to notify you of any change in a privacy practice that is described in the notice to protected health information that we created or received prior to issuing a revised notice. We reserve the right to change the terms of our notice and to make the new notice provisions effective for all protected health information that we maintain. Revised Notices with be available and posted at our offices(s) and posted on our web site, if applicable.

Complaints

If at any time you feel we have violated your HIPAA rights, please contact our Privacy Officer or the Secretary of Health and Human Services. This practice will not retaliate against any individual for filing a complaint.

Contact

You have the right to file a complaint with our Privacy Officer at the address and phone number at the top of this notice, or with the Office of Civil Rights, US Department of Health and Human Services, 61 Forsyth St., SW, Suite 3B70, Atlanta, GA 30323.

Effective Date of the Notice is 05/01/2015

Capital Children's Dental Center
655 St. Andrew's Rd., Ste. 8
Columbia, SC 29210

Privacy Officer
Kelly Purini
803-252-7725