1872 Avenue of the Cities
Moline, IL 61265
Phone: 309-797-3020

Child Medical History Form

Child's name:_____ Birth Date:_____ Gender: Male_____ Female_____

Please complete the following form so we may better serve your child.

Has your child ever had any of the following	**Yes**	**No**	**Comments**
Heart Murmur			
Congenital heart Disease			
Asthma, Cystic Fibrosis, Respiratory Disease			
Diabetes, Thyroid, Glandular or other Endocrine Disease			
Liver Disease, Hepatitis or Jaundice			
Kidney Disease			
Skin, Bone, Muscle or Joint Disease			
Seizures, Convulsions, Loss of Consciousness			
Cerebral Palsy, Neurological Disease			
Anemia, Hemophilia or other Blood Disease			
Sickle Cell Disease or Trait			
Cancer			
Speech or Hearing Disorder			
Sight or Eye Disorder			
Frequent Headaches			
Mental, Emotional or Developmental Delays			
Autism, ADHD, ADD			
Genetic Disorder or Syndrome			
Frequent Infections			
Has your child ever been seriously ill?			
Has your child ever been hospitalized?			
Has your child had any surgeries?			
Does your child take any medications? (if so please list)			
Is your child allergic to any foods or medicines? (if so please list)			

In general how is your child progressing: **Slow**_____ **Normal**_____ **Accelerated**_____

Is there any other disease or medical condition that we should know about in order to care for your child?

_____

Child Dental History

Child's name:_____ Birth Date: _____

Has your child ever been to the dentist? **Yes**_____ **No**_____

If so what was the name of the last dentist and the date of last visit with them?

_____

Has your child experienced any unfavorable reaction from previous dental care? **Yes**___ **No**___

If so please explain_____

Does your child suck a finger, thumb or pacifier? **Yes**____ **No**_____

Is there any additional information we should know that will help us provide a positive dental experience for your child?_____

Has your child had any of the following	**Yes**	**No**	**Comments**
Pain or sensitivity in the teeth			
Swelling of the mouth and face			
Injury to the face or teeth			
Cavities			
Gum infections			
Jaw Sounds			
Orthodontics			

Consent For Dental Treatment

I, being the parent or legal guardian of _____ authorize, request and permit Dr. Richards and any employees under his supervision to perform any and all manner of dental treatment that may be indicated in connection with my child and to do whatever procedures that the judgement of Dr. Richards may indicate during treatment. I further authorize the administration of such anesthetics and the taking of x-rays as may be deemed advisable by Dr. Richards. The risks and nature of treatment have and shall continue to be explained to me as treatment progresses and no warranty or guarantee has been made as to the result or cure. I assume responsibility for any and all charges incurred on behalf of my child for dental treatment.

Signed_____ Relationship_____
Date_____

How Did You Hear About Our Office or Who May We Thank For Referring You To Us

_____

Emergency Contact/ Alternate Number

Please List a Local Person To Be Notified when The Parent or Guardians Are Unavailable

Name_____ **Relationship**_____

Phone Number_____

Please List an E-Mail Address or Alternate Number Where you Can Be Reached For Appointment Confirmations

E-Mail Address_____

Alternate Phone Number_____

Fee For Service Agreement

I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand that I am financially responsible for payments in full of all accounts. A service charge of 1.5% or $5.00, whichever is greater, per month will be charged on all balances thirty days or more past due. In the event of an action to collect the balance due on this invoice, the undersigned agrees to pay attorney's fees, expenses and court costs.

Patient's or Guardian's Signature

_____

Date

_____

NOTICE OF PRIVACY PRACTICES

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

• Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.

• Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

• Healthcare operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the privacy officer.

• The right to request restrictions on certain uses and disclosures of protected health information, including those related to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

• The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

• The right to inspect and copy your protected health information.

• The right to amend your protected health information.

• The right to receive an accounting of disclosures of protected health information.

• The right to obtain and we have the obligation to provide to you a paper copy of this notice from us at your first service delivery date.

• The right to provide and we are obligated to receive a written acknowledgement that you have received a copy of our Notice of Privacy Practices.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is in effect as of today and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

Laura Battin, Privacy Officer
Dr. Brian Richards
1872 Avenue of the Cities
Moline, Il 61265
(309)797-3020

For more information about HIPAA or to file a complaint:

The US Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202)619-0257
Toll Free: 1-877-696-6775

Notice of Privacy Practices Acknowledgement

Dr. Brian J. Richards
1872 Avenue of the Cities
Moline, Illinois 61265

I understand that, under the Health Insurance Portability & Accountability Act of 1996(HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

• Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
• Obtain payment from third party payers.
• Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have read and/or received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____
Relationship to patient: _____
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 of the following reason:

□ Individual refused to sign

□ Communications barriers prohibited obtaining the acknowledgement

□ An emergency situation prevented us from obtaining the acknowledgement

□ Other (please specify)

_____

_____

_____