

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	owing Yes	No	Comments	
Heart Murmur				
Congenital heart Disease				
Asthma, Cystic Fibrosis, Respiratory Dis	ease			
Diabetes, Thyroid, Glandular or other E	ndocrine			
Disease				
Liver Disease, Hepatitis or Jaundice				
Kidney Disease				
Skin, Bone, Muscle or Joint Disease				
Seizures, Convulsions, Loss of Consciou	sness			
Cerebral Palsy, Neurological Disease				
Anemia, Hemophilia or other Blood Dis	ease			
Sickle Cell Disease or Trait				
Cancer				
Speech or Hearing Disorder				
Sight or Eye Disorder				
Frequent Headaches				
Mental, Emotional or Developmental D	elays			
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 me	dicines?			
(if so please list)				
In general how is your child progres	sing: Slow _	_ No	rmal Accelerated	i
Is there any other disease or medica your child?	al condition tha	at we	should know about in o	rder to care for

Child Dental History

Child's name:			Birth Date:	
Has your child ever been to the dentist?	Yes	N	o	
If so what was the name of the last denti-	st and	the da	ite of last visit with them?	
Has your child experienced any unfavoral	ble rea	ction	from previous dental care? Yes No	
If so please explain				
Does your child suck a finger, thumb or p	acifier	? Yes_	No	
Is there any additional information we sh	ould kı	now t	nat will help us provide a positive dental	
experience for your child?				
	1			
Has your child had any of the following	Yes	<u>No</u>	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 De	ental 1	<u> Freatment</u>	
I, being the parent or legal guardian of			authorize, request and	
permit Dr. Richards and any employees u	nder h	is sup	ervision 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. Ric	hards i	may ir	ndicate 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				
,			all charges incurred on behalf of my child	
for dental treatment.		, aa	an enarges mean ea en senan er my enna	
Signed	_ Relat	ionsh	ip	
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 Numbe	er	
	s or Alternate Number Where you Can Be Reached For ppointment 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 Sign	nature
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.

- <u>Treatment</u> 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.
- <u>Payment</u> 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.
- <u>Healthcare operations</u> 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 (

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)