Medical and Dental History-Patient under 18 years old

CHILD PATIENT NAME_____ CHILD's DATE OF BIRTH _____

Family information – to be filled out by Parent or Legal guardian

Check the box of the responsible party completing this form

- ❑ **Father** _____ **Date of Birth** _____
- ❑ **Mother** _____ **Date of Birth** _____
- ❑ **Legal Guardian** _____ **Date of Birth** _____
  - o Please indicate your relationship if you are not biologic parent to child:_____

MEDICAL INFORMATION

If "YES" to any of the following items or if you are unsure, please explain below

GROWTH AND DEVELOPMENT

Child's current weight _____lbs

Child can swallow pills ☐ Y ☐ N

1. Were there any complications during pregnancy or was child premature at birth? ☐ Y ☐ N
2. Has the child had psychological counseling or is counseling being considered for the near future? ☐ Y ☐ N
3. Any learning, behavioral, excessive nervousness, or communication problems? ☐ Y ☐ N
4. Any problems with physical growth? ☐ Y ☐ N

CENTRAL NERVOUS SYSTEM

5. Any history of cerebral palsy, seizures, convulsions, fainting, or loss of consciousness? ☐ Y ☐ N
6. Any history of injury to the head? ☐ Y ☐ N
7. Any sensory disorders? (seeing, hearing) ☐ Y ☐ N

CARDIOVASCULAR SYSTEM

8. Any history of congenital heart disease, heart murmur or other heart damage (e.g. rheumatic fever)? ☐ Y ☐ N
9. Has any heart surgery been done/recommended? ☐ Y ☐ N
10. Any history of chest pains or high blood pressure? ☐ Y ☐ N

HEMATOPOIETIC AND LYMPHATIC SYSTEMS

11. Has your child ever had a blood transfusion or blood products transfusion? ☐ Y ☐ N
12. Any history of anemia or sickle cell disease? ☐ Y ☐ N
13. Does your child bruise easily, have frequent nosebleeds, or bleed excessively from small cuts? ☐ Y ☐ N
14. Is your child more susceptible to infections than other children are? ☐ Y ☐ N
15. Is there any history of tender or swollen lymph nodes or glands? ☐ Y ☐ N

RESPIRATORY SYSTEM

16. Any history of pneumonia, cystic fibrosis, asthma, shortness of breath, or difficulty in breathing? ☐ Y ☐ N

GASTROINTESTINAL SYSTEM

17. Any history of stomach/intestinal/liver problems? ☐ Y ☐ N
18. Any history of hepatitis or jaundice? ☐ Y ☐ N
19. Any history of eating disorders, such as anorexia nervosa (not eating) or bulimia (binge/purge)? ☐ Y ☐ N
20. Any history of unusual weight loss/gain? ☐ Y ☐ N

GENITOURINARY SYSTEM

21. Any history of urinary tract infections, bladder, or kidney problems? ☐ Y ☐ N
22. Is the patient pregnant or possibly pregnant? ☐ Y ☐ N

ENDOCRINE SYSTEM

23. Any history of diabetes? ☐ Y ☐ N
24. Any history of thyroid disorders or other glandular disorders? ☐ Y ☐ N

SKIN

25. Any history of skin problems? ☐ Y ☐ N
26. Any history of cold sores (herpes) or canker sores (aphthae)? ☐ Y ☐ N

EXTREMITIES

27. Any limitations of use of arms or legs? ☐ Y ☐ N
28. Any arthritis or other joint problems? ☐ Y ☐ N
    Rheumatoid arthritis? ☐ Y ☐ N
29. Any problems with muscle weakness or muscular dystrophy? ☐ Y ☐ N

ALLERGIES

30. Is your child allergic to any medications? ☐ Y ☐ N
31. Any hay fever, hives, or skin rashes caused by allergies? ☐ Y ☐ N
32. Any other allergies?

SPECIAL ALERTS

Have you ever been told your child needs antibiotic premed for dental treatment? ☐ Y ☐ N

Explanation to Yes Answers:_____

_____

_____

CHILD'S MEDICAL DOCTOR

Name:_____ Address:_____

Phone Number:_____

MEDICATIONS OR TREATMENTS

Is your child currently taking any medication (prescription or non-prescription medicine)? ☐ Y ☐ N

If yes, Medication(s):	Diagnosis (reason for medication)	Dosage	Times Per Day
_____	_____	_____	_____
_____	_____	_____	_____

HOSPITALIZATIONS Has your child ever been hospitalized? ☐ Y ☐ N

Explanation (reason/date): _____

_____

Please check any of the following that your child has now, has recently been exposed to, or has had in the past

Immune deficiency diseases including HIV/AIDS ☐ Y ☐ N
Chicken pox (varicella) ☐ Y ☐ N
Earache (otitis) ☐ Y ☐ N
Eye infection (conjunctivitis) ☐ Y ☐ N
German measles or 3-day measles (rubella) ☐ Y ☐ N
Glandular fever or mono (infectious mononucleosis) ☐ Y ☐ N
Measles (rubeola) ☐ Y ☐ N
Mumps (parotitis) ☐ Y ☐ N
Scarlet fever (scarlatina) ☐ Y ☐ N
Sore throat (tonsillitis or pharyngitis) ☐ Y ☐ N

Substance abuse, alcoholism, drug addiction ☐ Y ☐ N

Upper respiratory infection (URI), or common cold (pharyngitis, rhinitis, sinusitis, or tonsillitis) ☐ Y ☐ N
Sexually transmitted diseases ☐ Y ☐ N
Are you interested in protecting your child from HPV with a vaccine? There is a strong correlation of Human Papiloma Virus infection (genital warts) and Oral/Cervical Cancers. ☐ Y ☐ N

GIRLS

Taking oral birth control ☐ Y ☐ N
Currently pregnant ☐ Y ☐ N
Currently nursing ☐ Y ☐ N

ORAL HEALTH HISTORY

Does your child have a toothache or other immediate dental problem? ☐ Y ☐ N
Has your child ever had a toothache? ☐ Y ☐ N
Has your child had any injury to the mouth, teeth, or jaws (fall, blow, etc.)? ☐ Y ☐ N
Date of last dental visit _____
Date of last dental x-rays _____
Is this the first dental visit for your child? ☐ Y ☐ N
Has your child ever had an unfavorable dental experience? ☐ Y ☐ N
Is (was) your child nourished by nursing beyond one year of age? ☐ Y ☐ N
If yes, check: Breast _____ Nursing bottle _____
To what age?_____
Does your child eat a well-balanced diet? ☐ Y ☐ N
If no, what foods or food groups are not adequate?
_____
Does (or has) your child have (or had) sucking habit beyond one year of age? ☐ Y ☐ N
If yes, check: Thumb(s) _____ Finger(s) _____
Pacifier _____ Other _____
Does (or has) your child have (or had) frequent headaches or pain in or about the ears, eyes, or cheeks? ☐ Y ☐ N

Does (or has) your child have (or had) any other oral habits beyond one year of age? ☐ Y ☐ N
If yes, check: Lip Biting _____ Mouth Breathing _____
Nail Biting _____ Teeth Grinding _____ Other _____

Please explain if you answered "YES" to, or are uncertain about, any of the above items:_____

_____

_____

How often is tooth brushing performed?
_____ time(s) per _____
Does your child use dental floss? ☐ Y ☐ N
Does someone assist your child with brushing and cleaning the teeth? ☐ Y ☐ N
Does someone inspect for thoroughness after the procedure? ☐ Y ☐ N
Does your child use fluoride toothpaste? ☐ Y ☐ N
Has your child ever had a fluoride treatment? ☐ Y ☐ N
Has your child ever taken a fluoride supplement or vitamins with fluorides? ☐ Y ☐ N
Does your child drink tap water? ☐ Y ☐ N
Does your child drink bottled water? ☐ Y ☐ N

To the best of my knowledge, the above information is complete and correct.

Signature of responsible party completing patient form:_____ Date _____
Relationship to Patient:_____

FINANCIAL AGREEMENT FOR
THOMAS COOMBS, DDS AND COLLEEN DELACY, DDS

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the most comprehensive dental care using only the highest quality materials and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is an agreement between you, your employer, and the insurance company. Our practice is not a party to that agreement. If payment from your insurance company is not received within 60 days from date of service, you will be expected to pay the balance in full.

As a courtesy to you we will help you process all your insurance claims. You may direct your insurance company to pay your benefits directly to our practice by signing the authorization on the Assignment of Benefits Agreement. In order for our practice to file your insurance claim, you must bring us a completed dental insurance form or proof of insurance.

Your **estimated** copayment for treatment, which is the amount not covered by your insurance, is due at the time treatment is provided. Your **estimated** copayment may be adjusted after the time of treatment depending upon the final reconciliation of insurance payments. Our practice accepts cash, personal checks, MasterCard, Visa, and Discover. Third party, extended payment financing is available upon request and approval through CareCredit.

Returned checks and balances older than 60 days may be subject to collection fees and finance charges at the rate of 1.5% per month (18% annually).

Please do not hesitate to ask if you have any questions regarding this financial agreement. We are committed to providing you with the ultimate experience in dental care.

_____

Print Name of Patient or Responsible Party

_____ _____

Signature of Patient or Responsible Party Date

ASSIGNMENT OF BENEFITS AGREEMENT FOR THOMAS COOMBS, DDS AND COLLEEN DELACY, DDS

Our practice will accept an assignment of benefits from your insurance company with the conditions listed below. It is important to understand, though, that the agreement regarding your dental benefits is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for all treatment and services we provide to you, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims.

- Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to save you time and to facilitate payment to our practice from your insurance company. By having our practice process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.

- We require you to sign this agreement and/or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our practice.

- We require you to pay the estimated copayment, which is the amount not covered by your insurance company, at the time we provide service to you. The copayment is only an estimate of charges and may be found to be insufficient after review by your insurance company.

- Insurance payments ordinarily are received within 30-60 days from the time of billing. If your insurance company has not made payment to our practice within 60 days, we will ask you to pay the entire balance at that time. You will be responsible for seeking reimbursement from your insurance company at that time.

- Our practice does not guarantee that your insurance company will pay for treatment you receive from our practice. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at that time.

- Our practice will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company to our practice.

I HAVE READ AND ACCEPT THE TERMS AND CONDITIONS OF THIS ASSIGNMENT OF BENEFITS AGREEMENT. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO THE PRACTICE.

_____

Print Name of Patient or Responsible Party

_____ _____

Signature of Patient or Responsible Party Date

SANDUSKY DENTAL CARE
30 Dawson Street • P.O. Box 231
Sandusky, MI 48471-0231
(810) 648-4740

LEXINGTON DENTAL CARE
7305 Huron Avenue
Lexington, MI 48450
(810) 359-7321

Privacy Officer: Business Administrator **Effective Date: April 14, 2003**

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.

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

Who Will Follow This Notice

Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates (e.g. a billing service), sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

How We May Use and Disclose Medical Information About You

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not every possible use or disclosure in a category is listed.

For Treatment. We may use medical information about you to provide you with medical treatment or services. Example: In treating you for a specific condition, we may need to know if you have allergies that could influence which medications we prescribe for the treatment process.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

For Health Care Operations. We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Uses or Disclosures That Can Be Made Without Consent or Authorization

- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health or safety
- As required by military command authorities for their medical records
- To workers' compensation or similar programs for processing of claims
- In response to a legal proceeding
- To a coroner or medical examiner for identification of a body
- If an inmate, to the correctional institution or law enforcement official
- As required by the US Food and Drug Administration (FDA)
- Other healthcare providers' treatment activities
- Other covered entities' and providers' payment activities
- Other covered entities' healthcare operations activities (to the extent permitted under HIPAA)
- Uses and disclosures required by law
- Uses and disclosures in domestic violence or neglect situations
- Health oversight activities
- Other public health activities

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 to you.

(over)

Uses and Disclosures of Protected Health Information Requiring Your Written Authorization

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care we have provided you.

Your Individual Rights Regarding Your Medical Information

Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations or to someone who is involved in your care or the payment for your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must submit your request in writing to the Privacy Officer at this practice. In your request, you must tell us what information you want to limit.

Right to Request Confidential Communications. You have the right to request how we should send communications to you about medical matters, and where you would like those communications sent. To request confidential communications, you must make your request to the Privacy Officer at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information compiled for use in a civil, criminal, or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer at this practice. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

Right to an Accounting of Non-Standard Disclosures. You have the right to request a list of the disclosures we made of medical information about you. To request this list, you must submit your request to the Privacy Officer at this practice. Your request must state the time period for which you want to receive a list of disclosures that is no longer than six years, and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (example: on paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we reserve the right to charge you for the cost of providing the list.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy. To obtain a paper copy of the current Notice, please request one in writing from the Privacy Officer at this practice.

Changes To This Notice

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice, with the effective date in the upper right corner of the first page.