



## GENERAL INFORMATION

Patient's Name: \_\_\_\_\_  
Last First Middle Initial  
Preferred Name \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  Male  Female  
How did you hear about our office? \_\_\_\_\_  
What is the name of the patient's school? \_\_\_\_\_  
What is the name and phone number of the patient's pediatrician? \_\_\_\_\_

## PATIENT MEDICAL HISTORY

Does the patient have any of the following conditions:

- |   |  |
|---|--|
| <input type="checkbox"/> Heart Murmur                   | <input type="checkbox"/> Asthma                                |
| <input type="checkbox"/> Heart Disease                  | <input type="checkbox"/> Lung Disease                          |
| <input type="checkbox"/> Cardiac Pacemaker              | <input type="checkbox"/> Tuberculosis                          |
| <input type="checkbox"/> High Blood Pressure            | <input type="checkbox"/> Epilepsy                              |
| <input type="checkbox"/> Rheumatic Fever                | <input type="checkbox"/> ADD/ADHD                              |
| <input type="checkbox"/> Prolonged Bleeding when cut    | <input type="checkbox"/> HIV/AIDS                              |
| <input type="checkbox"/> Blood transfusion; Date: _____ | <input type="checkbox"/> Metallic Implant                      |
| <input type="checkbox"/> Cancer, Tumor                  | <input type="checkbox"/> Glaucoma                              |
| <input type="checkbox"/> Kidney Disease                 | <input type="checkbox"/> Female patients, are you pregnant?    |
| <input type="checkbox"/> Diabetes                       | <input type="checkbox"/> Chemical Dependency                   |
| <input type="checkbox"/> Hepatitis, Liver Disease       | <input type="checkbox"/> Puberty/Growth Spurt                  |
| <input type="checkbox"/> Thyroid Disease                | <input type="checkbox"/> Bone Density Medication (EX: Fosomax) |
| <input type="checkbox"/> Latex Allergy                  | <input type="checkbox"/> Cold sore, Fever Blister              |

Does the patient have any food or drug allergies?  YES  NO If yes, please list: \_\_\_\_\_

Is the patient taking any medications/vitamin supplements/recreational drugs?  YES  NO If yes, please list medications and reason: \_\_\_\_\_

Is there any other health information that should be known?  YES  NO If yes, please explain: \_\_\_\_\_

Has the patient recently been under the care of a physician or had a serious illness or operation in the last 5 years?  YES  NO  
If yes, please explain & list contact information of physician: \_\_\_\_\_

Has the patient ever experienced unfavorable reaction from any previous dental or medical care?  YES  NO If yes, please explain: \_\_\_\_\_

## PREVIOUS DENTAL HISTORY

Last Dental Visit & Reason: \_\_\_\_\_

Is this the patient's first dental visit?  YES  NO If no, who was the patient's previous dentist? \_\_\_\_\_

Does the patient have a specific dental problem that needs attention?  YES  NO If yes, please explain: \_\_\_\_\_

Does the patient have a finger or thumb sucking habit?  YES  NO

Does the patient have a pacifier habit?  YES  NO

Has the patient experienced any dental trauma?  YES  NO If yes, please explain: \_\_\_\_\_

Does the patient snore or experience restless sleeping?  YES  NO

## ORTHODONTIC SECTION

Has the patient previously completed an orthodontic consult?  YES  NO

If yes, who was the provider? \_\_\_\_\_

Chief Orthodontic Complaints:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Crowding       | <input type="checkbox"/> Overbite           | <input type="checkbox"/> Shifting/Relapse of Teeth |
| <input type="checkbox"/> Spaces         | <input type="checkbox"/> Underbite          | <input type="checkbox"/> Dental Referral           |
| <input type="checkbox"/> Missing Teeth  | <input type="checkbox"/> Jaw Pain           | <input type="checkbox"/> Oral Habits/Tongue Thrust |
| <input type="checkbox"/> Impacted Teeth | <input type="checkbox"/> Sleeping/breathing | <input type="checkbox"/> Other: _____              |

## RESPONSIBLE PARTY INFORMATION

Parent/Guardian Name: \_\_\_\_\_  
Last
First
Middle Initial

Marital Status: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Address: \_\_\_\_\_  
Street

City
State
Zip Code

How long at this address? \_\_\_\_\_ Phone: \_\_\_\_\_ Preferred Method of Contact: Email or Phone

Email: \_\_\_\_\_ Social Security # \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work phone: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_  
Last
First
Middle Initial

Marital Status: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Address: \_\_\_\_\_  
Street

City
State
Zip Code

How long at this address? \_\_\_\_\_ Phone: \_\_\_\_\_ Preferred Method of Contact: Email or Phone

Email: \_\_\_\_\_ Social Security # \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work phone: \_\_\_\_\_

## DENTAL INSURANCE INFORMATION

Insured's Name #1 \_\_\_\_\_  
Last
First
Middle Initial

Insured's ID # \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Primary Insurance Company: \_\_\_\_\_ Group # \_\_\_\_\_

Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Insurance Company Phone: \_\_\_\_\_

Insured's Employer \_\_\_\_\_ Do you have dual coverage? If Yes:

Insured's Name #2 \_\_\_\_\_  
Last
First
Middle Initial

Insured's ID # \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Primary Insurance Company: \_\_\_\_\_ Group # \_\_\_\_\_

Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Insurance Company Phone: \_\_\_\_\_

Insured's Employer \_\_\_\_\_

### EMERGENCY CONTACT & CONSENT TO RELEASE INFORMATION

I give my consent to allow the release of healthcare information or to secure payment on my behalf to the following persons and I understand I can revoke this consent at any time by providing written notice.

Persons who have consent in my absence are:

1. \_\_\_\_\_
2. \_\_\_\_\_

Name & Phone of the nearest relative not living with you \_\_\_\_\_

I give my consent for the Doctors of Happy Campers Pediatric Dentistry and Orthodontics to perform a complete oral examination on the patient named previously. X-Rays that are necessary may be taken. Any additional treatment received will be fully explained at each visit.

Insurance portions are an estimate based on information released by my insurance company. **IT DOES NOT GUARANTEE PAYMENT.** I am aware that the insurance coverage is a contract between me and my carrier. As a courtesy, claims may be filed on my behalf. Should any dispute occur or if I fail to provide accurate information, I understand I am financially responsible to the doctors for all dental treatment.

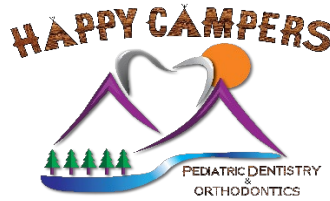
A credit report will be obtained for insurance submission or to establish credit with this office. I agree to inform the doctor of any changes in medical or financial information.

I acknowledge that I have read the Notice of Privacy Act and that a copy will be made available to me upon request.

Comments: \_\_\_\_\_

Parent Signature: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_



## Happy Campers Pediatric Dentistry Office Policies & Statements

CHILD'S NAME

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### Financial

I understand my Financial & Insurance Information including details regarding my financial responsibility towards care rendered by doctors at Happy Campers Pediatric Dentistry and understand that the parent or legal guardian who accompanies my child to an appointment will be responsible for payment at the time services are rendered. \_\_\_\_\_(initial)

### Insurance

If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for any unpaid/denied claims. It is important that you understand that your insurance coverage is a contract between you and your insurance company, and we are not a party to that contract. \_\_\_\_\_(initial)

### Cancellation/No Show Policy

Happy Campers Pediatric Dentistry values your business and ask that you respect our scheduling policies. There will be a **\$25 cancellation/no-show fee** if you are unable to make your appointment without giving at least 24 hours prior notice. \_\_\_\_\_(initial)

### Confirm Your Appointment

We will contact you via text, email, and telephone. You must reply to one of these contacts to confirm, cancel, or reschedule your appointment. Unconfirmed appts may be subject to cancellation by our staff. \_\_\_\_\_(initial)

### Late Arrivals

Please keep in mind that we maintain a very full schedule. If you are running late please call us and let us know. If you are more than **15 minutes late** for your appointment, we reserve the right to take another patient in your appointment slot and you will need to reschedule to a different day. \_\_\_\_\_(initial)

### Notice of privacy practices

Health Insurance Portability & Accountability Act of 1996

I have read the form entitled, "Notice of Privacy Practices" and understand its contents concerning the privacy of my child's confidential healthcare information. I do hereby provide consent for the standard use of such information and understand that these provisions prohibit Happy Campers Pediatric Dentistry from selling or transferring this information to any unauthorized location without my prior approval. I have reviewed this information and all questions have been answered to my satisfaction. \_\_\_\_\_(initial)

# NOTICE OF PRIVACY PRACTICES

**This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.**

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## 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 June 1st, 2017 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 the changes. Before we make a significant change in our privacy practices, we will change 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.

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## USE OF DISCLOSURES AND HEALTH INFORMATION

Your child's health information and the rights associated with that health information also rest with the "personal representative" of that individual, generally the parent or legal guardian.

We use and disclose health information for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to your child.

**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:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation 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 and our experience with common practice to make reasonable inferences of 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, or 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. Happy Campers Pediatric Dentistry

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal official's health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of 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, texts, postcards, or letters).

## Patient's Right

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. Contact us using the information listed at the end of this Notice for a full explanation of time and fees involved.

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 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).

**Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and it 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.

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## 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, or you disagree with a decision we made about access to your health information, you may complain to 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 anyway if you choose to file a complaint.

Contact Officer: Privacy Officer  
25255 N Lake Pleasant Parkway  
Suite 1235  
Peoria, AZ 85383

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Authorization for additional disclosure: I am the "personal representative" of (generally parent or legal guardian) and have legal authority to make health care decisions about the following minor patient:

**Patient Name:** \_\_\_\_\_

As the "personal representative" of the above name patient, I authorize the following individuals to accompany my child, have access to health information, and make any decisions regarding any dental treatment.

<b>Name</b>	<b>Relationship</b>
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____

\_\_\_\_\_  
"Personal Representative" (Parent or Legal Guardian)

\_\_\_\_\_  
Date