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:

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

- ☐ Crowding
- ☐ Spaces
- ☐ Missing Teeth
- ☐ Impacted Teeth
- ☐ Overbite
- ☐ Underbite
- ☐ Jaw Pain
- ☐ Sleeping/breathing
- ☐ Shifting/Relapse of Teeth
- ☐ Dental Referral
- ☐ Oral Habits/Tongue Thrust
- ☐ 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: _____/ _____/ _____

Consent statements

CHILD'S NAME

_____

The following consent statements refer to documents containing information regarding specific policies of Happy Campers Pediatric Dentistry. Please sign these statements only after carefully reading such information.
These informative documents should be retained for future reference.

Financial and Insurance information

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, unless prior arrangement have been made.
Parent or Legal Guardian Signature _____
Date _____

Cancellation policy

I understand and take full responsibility for the cancellation of any needed appointments and I am aware that without prior notification or a valid reason, a $25 fee will be incurred.
Parent or Legal Guardian Signature _____
Date _____

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.

Parent or Legal Guardian Signature _____
Date _____

I attest that the information above were provided to the parent or legal guardian of the child noted above. All questions have been answered and I have witnessed the signing of these consent statements.

Witness Signature

_____

Date _____

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.

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 de- scribed 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 con- tact us using the information listed at the end of this Notice.

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 dis- close 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.

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

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.

Name	**Relationship**
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____

_____ _____

"Personal Representative" (Parent or Legal Guardian) Date