Spangler, Rohlfing & Lambert, DDS, PLLC

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HIPAA Form

Patient: _____

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment or health care operations.

As our patient, we want you to know that we respect the privacy of your personal dental records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about your treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal dental records. We may have indirect treatment relationships with you (such as laboratories that only interact with doctors and not patients) and may have to disclose personal health information for purpose of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse treatment should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI disclosure. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

Your have the right to review our Privacy Notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Signed: _____ **Date:**_____

(Patient signs, if patient is 18 or older / if patient is under 18 years old, parent signs)

- If you wish to grant someone permission to the Patient Information (PHI), please complete the following:
  I, _____ (Parent) hereby, grant permission to release information about _____'s (Patient) treatment, financial and payment records to the following:

  _____ _____

  _____ _____

Signed: _____ Date: _____

Child's Name: _____
Date of birth: _____
Date: _____

Medical and Dental History

Your child's overall health, as well as any medications that he/she takes, may have an important inter-relationship with the dental care your child receives. Please answer each of the following questions completely.

Medical History

Child's Physician: _____
Physician's Address:_____
_____
Date of last physical: _____

Has your child ever had any of the following?

Asthma	☐yes	☐no
Cancer/Tumors	☐yes	☐no
Hepatitis	☐yes	☐no
HIV/AIDS	☐yes	☐no
Hemophilia	☐yes	☐no
Diabetes	☐yes	☐no
Kidney problems	☐yes	☐no
Liver/GI problems	☐yes	☐no
Endocrine abnormalities	☐yes	☐no
Allergies(seasonal)	☐yes	☐no
Allergies(food,drug)	☐yes	☐no
Explain _____		
Hearing problems	☐yes	☐no
Eye disorders	☐yes	☐no
Breathing/lung problems	☐yes	☐no
Blood disorders	☐yes	☐no
Adverse drug reaction	☐yes	☐no
Rheumatic fever	☐yes	☐no
Congenital heart defect	☐yes	☐no
Congenital birth defect	☐yes	☐no
Mental/Physical developmental delays	☐yes	☐no
Behavioral/learning problems	☐yes	☐no
Seizures/Epilepsy	☐yes	☐no
Social development delays	☐yes	☐no
Recurrent /frequent headaches	☐yes	☐no
Tuberculosis	☐yes	☐no
Frequent infections	☐yes	☐no
Significant injuries	☐yes	☐no
Explain _____		
Hospitalizations	☐yes	☐no
When _____		
Abnormal bleeding	☐yes	☐no
History of blood transfusion	☐yes	☐no
Date _____		
Heart ailments	☐yes	☐no
Heart murmur	☐yes	☐no
Type _____		
Premed Needed	☐yes	☐no

Please explain any other medical problems that your child has_____
_____
_____
_____
_____

Child's Medications

Please list your child's medications and dosages.
_____
_____
_____

Dental History

What are your main concerns about your child's dental health?_____
_____
How frequently are your child's teeth brushed?____
How frequently are your child's teeth flossed? ____
Do you help your child with brushing and flossing? ☐yes ☐no
Date of last dental visit_____Xrays_____
Previous dentist _____
How would you describe your last dental experience?
_____
Does your child have a healthy diet?_____
Does your child's family have a history of dental decay or gum disease? ☐yes ☐no
Is your child's drinking water fluoridated? ☐yes ☐no
Does your child take a fluoride supplement?
Dosage _____ ☐yes ☐no
Does your child:

Suck thumb/finger/lips/pacifier	☐yes	☐no
Bite/chew nails or hard objects (pencils, etc)	☐yes	☐no
Grind teeth/clench jaws	☐yes	☐no
Use a bottle/sippy cup	☐yes	☐no
Breast feed/how long?_____	☐yes	☐no
Eat/drink after brushing	☐yes	☐no
Brush before bed	☐yes	☐no
Drink more than 1 glass of juice, tea, soda or sports drink per day	☐yes	☐no
Have a history of dental trauma?	☐yes	☐no

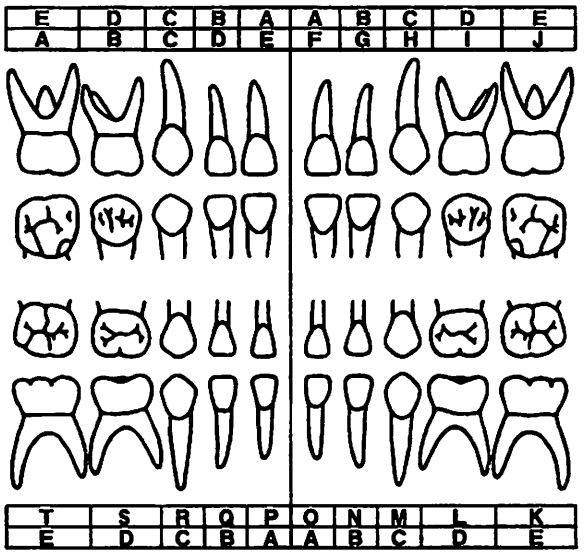
Authorization and Release

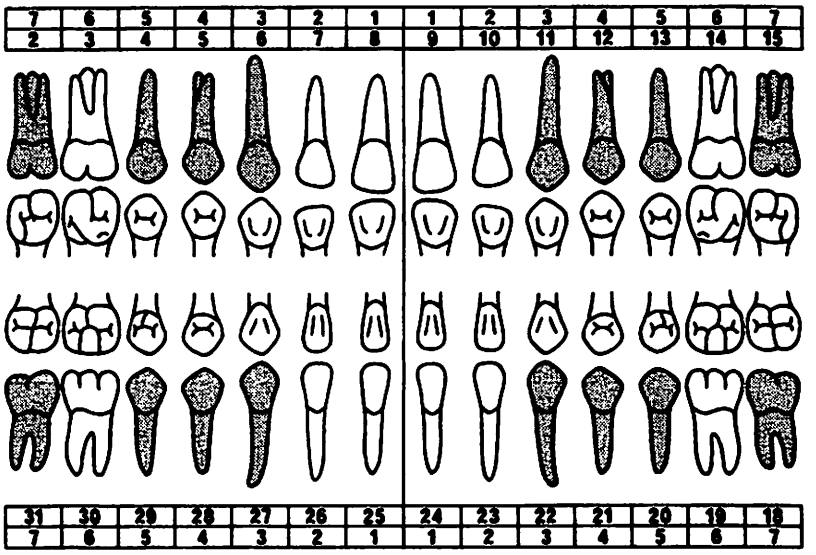
To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examinations rendered to my child during the period of such dental care to third party payers and/or health practitioners. I also consent to any necessary radiographs (x-rays) needed for proper diagnosis.

X_____
Signature of parent/guardian date

MEDICAL ALERT →

NAME _____ DATE _____ AGE _____





MEDICAL HISTORY SUMMARY

1. Existing illnesses _____
2. Current medications _____
3. Allergies _____
4. Nutritional eval. _____

DENTAL HISTORY SUMMARY

1. Chief concern _____
2. Oral habits _____
3. Oral hygiene _____
4. Caries risk _____
5. Preventive Recare 3 4 6 months

DENTAL *ORO-FACIAL* EXAM

(Circle Abnormalities and Explain)

I. Dentition

Hypoplasia	Ankylosis	Supernumerary
Hypocalcification	Eruption Sequence	Over-retention
Fluorosis	Eruption Status	Congenitally Missing
Discoloration/Staining	Normal/Adv/Delayed	Size and shape

Other _____

II. Occlusion and Functional Relations

ANGLE'S BITE CLASSIFICATION 6's/E's 3's/C's

Overbite _____%	Open Bite _____mm	Crowding/Spacing	Facial profile_____
Overjet _____mm	Midline deviation	Rotations	Arch length deficiency
Crossbite _____	Other _____		

III. Gingiva and Periodontium

Plaque: light/moderate /heavy	Calculus	Bleeding: localized/ generalized	Probing depths _____ PSR _____

IV. Soft and Hard Tissue

Face	Oro-pharynx	Salivary glands	Lymph nodes
Lips	Palate	Tongue	T.M.J.
Floor of mouth	Cheeks	Frenum	Other _____

Other Notes:

_____

_____

CHILD'S REGISTRATION AND HISTORY
(PLEASE COMPLETE BOTH SIDES)

CHILD'S NAME_____
FIRST MIDDLE LAST

ADDRESS_____

CITY:_____STATE:_____ZIP_____

HOME PHONE NUMBER (INCLUDING AREA CODE)_____

EMAIL ADDRESS (PLEASE PRINT)_____

PRIMARY DENTAL INSURANCE_____POLICY HOLDER:_____

POLICY NUMBER:_____GROUP NUMBER:_____

SECONDARY DENTAL INSURANCE_____POLICY HOLDER:_____

POLICY NUMBER:_____GROUP NUMBER:_____

PRIMARY GUARANTOR'S FULL NAME:_____
FIRST MIDDLE LAST

GUARANTOR'S SS#:_____GUARANTOR'S BIRTHDATE:____/____/____BUSINESS PHONE:_____

GUARANTOR'S CELL PHONE #:_____

GUARANTOR'S EMPLOYER:_____HOW LONG?_____

GUARANTOR'S DRIVER'S LICENSE#:_____STATE:_____

ADDRESS:_____
(IF OTHER THAN CHILD'S)

SECONDARY GUARANTOR'S FULL NAME:_____
FIRST MIDDLE LAST

SECONDARY GUARANTOR'S SS#:_____SECONDARY GUARANTOR'S BIRTHDATE:____/____/____BUSINESS PHONE:_____

SECONDARY GUARANTOR'S CELL PHONE #:_____

SECONDARY GUARANTOR'S EMPLOYER:_____HOW LONG?_____

SECONDARY GUARANTOR'S DRIVER'S LICENSE#:_____STATE:_____

ADDRESS:_____
(IF OTHER THAN CHILD'S)

PERSON FINANCIALLY RESPONSIBLE IF OTHER THAN PARENT:_____

RELATIONSHIP TO CHILD:_____

ADDRESS:

HOME PHONE #:_____BUSINESS PHONE #:_____

EMPLOYER:_____SS#_____

DRIVER'S LICENSE #:_____STATE_____

THANK YOU FOR TRUSTING US AS YOUR CHILD'S DENTAL HEALTH CARE PROVIDER. WE APPRECIATE YOUR TRUST AND THE OPPORTUNITY TO SERVE YOU. IT IS OUR GOAL TO PROVIDE THE BEST POSSIBLE CARE FOR YOUR CHILD. IN ORDER FOR US TO MEET THIS GOAL, WE MUST HAVE YOUR HELP. PLEASE CAREFULLY READ THE FOLLOWING GUIDELINES FOR OUR OFFICE.

APPOINTMENTS: ONCE AN APPOINTMENT IS MADE PLEASE REMEMBER THAT THIS TIME HAS BEEN RESERVED ESPECIALLY FOR YOUR CHILD. WE EXPECT AT LEAST 48 HOURS NOTICE PRIOR TO CHANGING OR CANCELING AN APPOINTMENT SO THAT WE MAY ACCOMMODATE OTHER PATIENTS AWAITING TREATMENT. THE MORE ADVANCE NOTICE YOU GIVE US, THE MORE CAPABLE WE ARE OF FINDING A MORE APPROPRIATE APPOINTMENT TIME FOR YOU. APPOINTMENTS BROKEN OR CANCELED ON SHORT NOTICE MAY NOT BE ABLE TO BE RESCHEDULED FOR SEVERAL WEEKS. PLEASE UNDERSTAND THAT AFTER 3 MISSED APPOINTMENTS WE MAY ASK YOU TO FIND ANOTHER DENTAL OFFICE THAT BETTER MEETS YOUR SCHEDULE NEEDS.

ALSO, WE CANNOT EXPECT PATIENTS WHO HAVE ARRIVED ON TIME FOR THEIR APPOINTMENTS TO WAIT WHILE WE "WORK IN" PATIENTS WHO ARRIVED LATE WHEN YOU ARE UNAVOIDABLY LATE FOR YOUR CHILD'S APPOINTMENT. WE MAY BE ABLE TO OFFER A LATER APPOINTMENT TO YOU, OR WE MAY NEED TO RESCHEDULE YOUR CHILD'S APPOINTMENT. PLEASE UNDERSTAND THAT WE MAKE EVERY EFFORT TO BE ON TIME FOR YOUR CHILD'S APPOINTMENT, HOWEVER, EMERGENCIES DO ARISE, ESPECIALLY WHEN WE ARE DEALING WITH CHILDREN. WE HOPE THAT YOU WILL UNDERSTAND ANY DELAYS THAT MAY OCCUR, SINCE WE WOULD DO THE SAME IF YOUR CHILD WERE THE ONE WITH THE EMERGENCY.

PAYMENT. TO AVOID MISUNDERSTANDING, WE WISH THE PERSONS RESPONSIBLE FOR THE PATIENT'S ACCOUNT BE AWARE THAT ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED DIRECTLY TO THEM AND THAT THEY ARE PERSONALLY RESPONSIBLE FOR PAYMENT OF FEES AT THE TIME OF SERVICE. FOR THOSE THAT DO HAVE DENTAL INSURANCE, IF YOU PROVIDE OUR OFFICE WITH COMPLETED DENTAL CLAIM FORMS, WE WILL BE HAPPY TO KEEP THESE IN YOUR CHILD'S CHART AND HAVE THEM READY FOR FILING FOR DIRECT REIMBURSEMENT TO THE SUBSCRIBER. PLEASE UNDERSTAND THAT OUR OFFICE DOES NOT PARTICIPATE WITH ANY INSURANCE COMPANY. DENTAL INSURANCE IS AN AGREEMENT BETWEEN YOU AND YOUR INSURANCE COMPANY. WE DO NOT RENDER OUR SERVICES ON THE BASIS THAT INSURANCE COMPANIES WILL PAY OUR FEES. HOWEVER, IN THE EVENT THAT AN EXTENSIVE TREATMENT PLAN HAS BEEN DETERMINED NECESSARY FOR YOUR CHILD, OUR OFFICE WILL GLADLY WORK WITH YOU TO MAKE FINANCIAL ARRANGEMENTS.

I (WE) HAVE READ AND UNDERSTAND THE ABOVE OFFICE POLICIES CONCERNING APPOINTMENTS AND PAYMENT: I (WE) AGREE TO ABIDE BY THESE POLICIES.

GUARANTOR'S SIGNATURE_____

DATE

SECONDARY GUARANTOR'S SIGNATURE_____

DATE

RELEASE OF INFORMATION: I HEREBY AUTHORIZE THE RELEASE OF ANY INFORMATION ACQUIRED DURING THE EXAMINATION OR TREATMENT TO INSURANCE COMPANY (IES), AND TO ANY OTHER PHYSICIAN(S) OR DENTIST(S) INVOLVED IN THE PATIENT'S CARE.

PATIENT OR GUARDIAN SIGNATURE:_____

DATE