PATIENT INFORMATION

Child's name: _____ Nickname: _____

Age: _____ Birth date: _____ Male/ Female

Names and ages of siblings: _____

Home address: _____City/State/Zip: _____

Telephone: _____ Child's School: _____

Child's Physician: _____ Address & Phone Number:_____

How did you find out about our practice? __ Other patient _____

(Please check category and list publication __ Physician _____

or person referring you so that we may thank them) __ Dentist _____

__ Other source _____

PARENT / GUARDIAN INFORMATION

Mother's Name: _____SSN: _____ Birth date: _____

Home Address: _____ City/State/Zip: _____

Home Phone: _____ Mobile Phone: _____

E-mail Address:_____

Occupation: _____Work Phone:_____

Employer & Address: _____

Father's Name: _____SSN: _____Birth date: _____

Home Address: _____ City/State/Zip: _____

Home Phone: _____ Mobile Phone: _____

E-mail Address:_____

Occupation: _____Work Phone:_____

Employer & Address: _____

Parent's Marital Status: _____ Preferred Salutation: Mr. Mrs. Ms. Dr. Mr. & Mrs.

Emergency Contact (not living with you): _____ Phone: _____

Completed Date: _____

CONSENT

Because your child is a minor, it is necessary that signed permission is obtained from a parent or legal guardian before Dr. Jennifer Bryk Hechko or her staff can begin any dental treatment.

Your child's specific treatment concerns will be explained to you after the examination and prior to any treatment. We will also review the treatment performed after each visit.

Our examination may include dental radiographs ("x-rays") depending on your child's specific needs. Photographs may be taken for diagnosis and treatment.

Local anesthesia and nitrous oxide/oxygen analgesia ("laughing gas") can be used to facilitate your child's comfort during dental treatment. The use of these medications will be explained to you prior to beginning treatment.

No sedative drugs are used by Dr. Hechko. However, Dr. Hechko performs sedation and general anesthesia procedures with a licensed anesthesiologist at Fairview Hospital, Medina Surgery Center, Nationwide Children's Hospital Of Columbus and in her office. Should sedation or general anesthesia be deemed necessary to treat your child, you will be consulted. The procedure will be explained and a separate consent and appointment time will be necessary. Physical restraint is not used without parental consent, and it is only used to prevent your child from causing self-injury.

Consent is hereby given for diagnostic, restorative, and surgical treatment for my child. Restorative treatment may include fillings, crowns, sealants, root canal therapy, or space maintainers. Restorative materials may include composite resin, amalgam, and stainless steel. Surgical treatment may include tooth removal and minor soft tissue treatment.

I have read this form and understand it contents.

_____

Patient's Name

_____

Parent / Guardian Signature

_____

Date

Medical History

1.) Is your child currently being seen by a physician? θ No θ Yes. Doctor's name is: _____

2.) Has your child had any of the following?

YES	NO		COMMENTS
_____	_____	Heart Murmur	
_____	_____	Congenital Heart Disease	
_____	_____	Asthma, Cystic Fibrosis, Respiratory Disease	
_____	_____	Jaundice, Hepatitis, Liver Disease	
_____	_____	Diabetes, Thyroid, or Endocrine Disease	
_____	_____	Kidney Disease	
_____	_____	Seizures, Cerebral Palsy, Neurologic Disease	
_____	_____	HIV or Sexually Transmitted Diseases	
_____	_____	Anemia, Hemophilia, Bleeding Disorder	
_____	_____	Sickle Cell Disease or Traits	
_____	_____	Cancer	
_____	_____	Speech or Hearing Disorder	
_____	_____	Sight or Eye Disorder	
_____	_____	Received Blood or Blood products	
_____	_____	Has your child ever been seriously ill?	
_____	_____	Has your child ever been hospitalized?	
_____	_____	Has your child ever had surgery?	
_____	_____	Does your child take any medicine?	
_____	_____	Developmental or Behavioral problems?	

3.) Is your child allergic to any of the following?

YES	NO	
_____	_____	Penicillin or other antibiotics
_____	_____	Codeine or other narcotics
_____	_____	Local Anesthesia
	Other	_____

4.) Is there any medical condition that we should know about in order to treat your child? _____

_____

Dental History

1.) Please tell us what brought you here today: _____
_____

2.) Please describe previous dental care: _____
_____
_____

3.) Please describe behavioral response to past medical & dental care: _____
_____
_____

4.) Please describe any history of headaches, grinding, TMJ problems: _____
_____

5.) Please describe any history of dental trauma: _____
_____
_____

6.) Please identify any oral habits: θThumb θ Pacifier θ Other
Comments:_____
_____

7.) Oral hygiene practices: Who brushes? θ Child θ Mom θ Dad θ Other
How often? θ 1-2 times/day θ 2-3 times/day θ Other
Comments:_____
_____

8.) Is your water fluoridated? θ No θ Yes θ Unsure
Comments:_____
_____

9.) Are supplemental fluorides used at home? θ Rinses θ Gels Names:_____
Comments:_____

10.) How do you anticipate your child will respond to dental treatment?_____
_____

_____ _____
Parent / Guardian Signature Date

_____ _____
Reviewed By Date

*Dr. Notes: _____

_____

8801 Brecksville Rd. Brecksville, OH 44141 **p. 440.838.5445 f.440.838.5325**

form if you have completed it for another child in your family with the **same information.** We require only one copy of this form. Thank you.

IF YOU HAVE DENTAL INSURANCE

___ My child is not covered by dental insurance. Please check this line and disregard this form.

___ My child is covered by dental insurance. Please check this line; read and complete this form.

If your child is covered by dental insurance, we ask that you complete the following items prior to your visit with us so that we may: (1) utilize your insurance as partial/complete payment to us, (2) maximize your benefits, and (3) ensure timely reimbursement.

Please ensure you have dental insurance coverage. Periodically, patients bring medical-only insurance information to our office. Dental insurance is nearly always separate from medical insurance and frequently medical and dental policies are administrated by different insurance companies.

Please ensure your child is eligible (i.e., covered by your dental insurance policy). If you are unsure if your child is covered by your dental insurance policy, please call your insurance company to verify they are included on the policy.

Please bring all of your insurance information with you to your initial visit. We ask that when you visit our office, you bring along your insurance card. If you do not have a dental insurance card, you may be able to visit the website of your insurance company to print one or print the information normally included on a card.

Please complete <u>ALL</u> of the following fields. Without <u>ALL</u> of the information requested here, we will not be able to properly bill your dental insurance company. If this occurs, we will be not be able to accept your dental insurance as partial/complete payment for services rendered and, as a result, you will be asked to pay in-full for your child's initial visit.

Dental Insurance Company Name:_____

Dental Insurance Company Claims Address:_____

Dental Insurance Company Phone Number:_____

Group Number:_____

Policyholder's ID Number (can be SSN):_____

*Policyholder's Name:_____

*Policyholder's Social Security Number:_____

*Policyholder's Date Of Birth:_____

*Policyholder's Employer & Address:_____

*Policyholder's Home Address & Phone #:_____

*write "SEE PIF" if information requested is listed on Patient/Parent Information Form

FINANCIAL AGREEMENT

We are committed to taking the very best care of your child. Part of the process of providing this care involves a financial relationship between you, the parents and guardians of your child, and us, your dental health care provider. We will make every effort to provide you with an accurate description of the services your child may need and your financial obligation for those services. Please read and sign the following Financial Agreement.

Full payment is due at the time of service. We accept payment by cash, check, Visa, MasterCard, Discover, and Care Credit. The adult accompanying your child is responsible for payment on the day of service. We will not bill any third parties, including situations involving divorce.

If you have Dental Insurance: As a courtesy, we will accept most insurance plans and will gladly process your claim. However, any estimated deductibles and co-payments will be due at the time of service. Please understand that your particular insurance policy is an agreement between you, your employer, and your dental insurance company. We strongly suggest contacting your insurance company so that you thoroughly understand your level of benefits.

Finance Charge: Any account balance will be accrue a monthly finance charge of 1.5% monthly (18% annually) beginning zero (0) days after the account balance occurs. Balances pending insurance payment will not accumulate fees until the insurance company pays our office.

Additional Fees: We require a minimum of 24 hours notice for an appointment cancellation. A $50.00 fee will be assessed on your account for any appointment missed without adequate notice.

Returned Checks/CollectionFees: A $45.00 fee will be assessed for any returned check. Any account balance exceeding sixty (60) days in age may be forwarded to our attorneys or a collection service. All costs incurred in collecting unpaid fees will be charged to your account.

If you have any questions or concerns regarding these financial policies—please do not hesitate to speak to our office personnel. We are here to help you in every possible way.

I UNDERSTAND THE ABOVE POLICIES AND WILL BE RESPONSIBLE FOR THE PAYMENT OF ANY FEES INCURRED DURING MY CHILD'S DENTAL TREATMENT.

Parent/Guardian_____ Date_____

Child's Name_____

Staff Witness_____ Date_____

MINOR CONSENT FORM

As the parent/legal guardian of:

_____ _____

Name of Minor Minor's Date of Birth

I authorize, in my absence, the following person(s), to bring my child to their dental appointments and sign consent for their treatment.

_____

Name and relationship to child

_____

Name and relationship to child

_____

Name and relationship to child

_____

Name and relationship to child

_____

Printed Name of Parent/Legal Guardian

_____

Signature of Parent/Legal Guardian Date

BRECKSVILLE KIDS DENTISTRY

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 described in this Notice while it is in effect. This Notice takes effect (MM/DD/YR), 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you 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 you.

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 disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use 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.

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

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.___ for each page, $___ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

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).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

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 or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, 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 any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Rae Sullivan Telephone: 440-838-5445

Fax: 440-838-5325 Address: 8801 Brecksville Rd. Brecksville, OH 44141

BRECKSVILLE KIDS DENTISTRY
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____

{Please Print Patient's Name}

_____

{Signature}

_____

{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)