Dear New Patient,

We appreciate your allowing us to provide dental care for your child. We value our relationship with you and believe that the best relationships are based on understanding and good communication; we offer these clarifications of our office policies.

Parent Information

One parent is welcome to accompany their child into the treatment area on their visit. For the safety and privacy of all patients, other children and family members who are not being treated must remain in the reception room with a supervising adult. If two parents are present for the visit, the Doctor will speak to both parents AFTER the examination in the private office. Everyone will make a great effort to ensure that your child feels comfortable in these new surroundings. Since this first visit will establish their initial attitudes towards dentistry, it is very important to make this appointment a positive encounter. If you choose to accompany your child for the dental visit we ask that you please remember to play the role of a silent and supportive observer. The assistant will explain everything we use to your child and allow him/her to touch and get comfortable with everything.

Scheduling Guidelines

If your child is under the age of six we request that you schedule a morning appointment. Younger children do better in the morning. Your scheduled appointment time has been reserved specifically for your child. We request 48 hours notice if you need to cancel an appointment. We are aware that unforeseen events sometimes require missing an appointment. However, if you do miss an appointment without notifying us 48 hours in advance, a cancellation fee may be applied to your account.

Treatment Guidelines

For routine cleanings and exams our office follows the guidelines set forth by the American Dental Association and the American Academy of Pediatric Dentists. These guidelines recommend children receive a cleaning, exam and fluoride treatment twice a year. We follow ADA and AAPD guidelines. In the event your insurance provides a benefit for less than twice a calendar year, you are responsible for payment. If you choose to not have fluoride dispensed to your child, please let us know before the treatment.

Infection Control

We utilize the most effective infection control measures and fully comply with all OSHA and CDC standards for sterilization. We maximize our use of disposable materials and sterilize all of our hand instruments.

Payment/Insurance Guidelines

Our office will make every effort to gather all relevant information regarding your insurance coverage before the visit. We will pre-register your child based on the information given to us at the time you made the appointment. If you have insurance to help pay for your services, our office will bill your insurance as a courtesy. Any estimated co-payment is expected at the time services are rendered. For patients without dental insurance, payment is expected at the time treatment is rendered.

Email Communication

Unencrypted email is not a secure form of communication. There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by unauthorized third parties. However, you may consent to receive email from us regarding your treatment. We will use the minimum necessary amount of protected health information in any communication. Our first email to you will verify the email address you provide.

☐ I consent to and accept the risk in receiving information via email. I understand I can withdraw my consent at any time. *Secure emails are sent through zixmessagecenter.com.*

My email address is: _____

☐ I consent only to receiving appointment reminders via email or text. I understand I can withdraw my consent at any time.
My email address is: _____

☐ I do not consent to receiving any information via email. I understand that I can change my mind and provide consent later.

I have read and understand the Office Guidelines and agree to abide by its contents:
Parent/Guardian: _____ Date:_____

Health History

Patient Name: _____ Birth Date: _____
Child's nickname: _____ ☐ Male ☐ Female
Person completing this form: _____ Relationship to patient: ☐ Parent ☐ Guardian ☐ Other
Whom may we thank for referring you? ☐ Family/Friend Referral:_____ ☐ Event: _____
☐ Doctor Referral:_____ ☐ Internet Search, Browser: _____
☐ Insurance Provider: _____ ☐ Other: _____

DENTAL HISTORY

Reason for visit/chief dental complaint: ☐ Routine exam ☐ Other: _____
Is this the child's first dental visit? ☐ Yes ☐ No, approximate date of last dental visit: _____
Is there something you would like to ask or tell the dentist **before** the child has x-rays or a cleaning? _____
Does the child Have any of the following habits?
☐ Thumb/Finger Sucking ☐ Use of Pacifier
☐ Clenching/Grinding Teeth ☐ Use of Bottle If so, Bottle in Bed? ☐ Yes ☐ No
Has the child ever had a reaction from local anesthetic? ☐ Yes ☐ No

MEDICAL HISTORY

Is your child in good health? ☐ No ☐ Yes
Are the child's immunizations up to date? ☐ No ☐ Yes
Is the child taking any medication? ☐ No ☐ Yes, please list all: _____
Has the child ever been premedicated with antibiotics for your dental treatment? ☐ No ☐ Yes
Has the child had any trouble associated with dental treatment? ☐ No ☐ Yes
Has the child ever had a serious illness or surgery or been in the hospital overnight? ☐ No ☐ Yes, date: _____
Has the child ever had a blood transfusion? ☐ No ☐ Yes, date: _____
Does the child have any tubes, shunts, prosthesis? ☐ No ☐ Yes, please explain: _____

Has the child ever been diagnosed with any of the following conditions?

Yes	No		
☐	☐	Allergies to:	☐ Latex ☐ Penicillin ☐ Tetracycline ☐ Aspirin ☐ Sulfa Drugs ☐ Other: _____
☐	☐	Asthma, medication:	_____
☐	☐	Diabetes, medication:	_____
☐	☐	Heart disease	☐ Murmur ☐ Congenital defect ☐ History of rhematic fever
☐	☐	Blood disorders	☐ Anemia ☐ Sickle cell anemia ☐ Hemophilia ☐ Other
☐	☐	Excessive bleeding after dental treatment	
☐	☐	Cancer or chemotherapy	
☐	☐	Radiation treatment of any kind	
☐	☐	Hepatitis or liver disease	
☐	☐	Hearing loss	
☐	☐	Kidney disease	
☐	☐	Respiratory disease	
☐	☐	Epilepsy or seizures	
☐	☐	Behavior problems/learning disability	
☐	☐	Cerebral Palsy	
☐	☐	Autism	
☐	☐	Developmental or constitutional delay, functional age level:	_____
☐	☐	Skin rash	

Is there any other medical condition or syndrome from which the child suffers? ☐ No ☐ Yes, please explain: _____
Comments: _____

I have filled out this questionnaire completely. I have advised you of all medical problems of which I am aware and I authorize and give full consent to perform dental services agreed upon between doctor and patient representative to be necessary or advisable, including examination, radiographs, prophylaxis (cleaning of teeth) and application of fluoride. I am responsible for payment on all work performed regardless of my insurance coverage. I acknowledge that my questions, if any, about the inquired set forth above have been answered to my satisfaction.

Patient Signature(guardian if minor) Date

Doctor Signature Date

Financial Information/Agreement

If the patient has dental insurance, the responsible party will pay the patient estimated portion and deductible at the time treatment is rendered. The insurance will be billed as a courtesy; however, please be aware if the insurance company does not pay within 60 days, payment in full is expected from the responsible party. If the patient does not have insurance, payment in full is due at the time treatment is rendered. Please be advised if payment is not made as agreed, your account may be sent to an outside collections agency.

I agree to be responsible for payment of all services rendered on behalf of my dependant(s), including any balance not paid by the dental insurance company within 60 days of the date of service. I understand that I am responsible for handling any disputes regarding amount of payment with the insurance company. I authorize and request my insurance company to pay directly to the dentist any insurance benefits otherwise payable to me. Please keep in mind that all insurance companies provide a disclaimer that states they are only giving general information when we call to check on your benefits. We will do everything we can to assist you in obtaining the maximum of your insurance benefits. However the insurance is a contract between you and your insurance carrier. Therefore you are ultimately responsible for payment in full of your account.

I understand that every 6 months my child will have a full exam, x-rays, and a prophylaxis/fluoride treatment. If my insurance does not cover it that often, it is my responsibility to let the staff know before my child goes back for their appointment.

48 Hour Cancellation Policy: There will be a $50 fee for all appointments not cancelled within 48 hrs of scheduled appointment.

Person Responsible for Account:

Name LAST: _____ FIRST: _____ Relationship: _____

DOB: _____ Social Security Number/Ins ID: _____

Street Address: _____ City: _____ Zip: _____

Please list 2 phone numbers where we can reach you in order of preference:

Primary phone #: ( ) _____ ☐ Home ☐ Cell ☐ Work

Alternate phone #: ( ) _____ ☐ Home ☐ Cell ☐ Work

Email address: _____

ACKNOWLEDGMENT OF RECIEPT AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION AND PATIENT ACKNOWLEDGEMENT OF RECIEPT OF DENTAL MATERIALS FACT SHEET

You May Refuse to Sign This Acknowledgement

To the Patient/Guardian— Please read the Following Statements Carefully

Purpose of Consent: By signing this form, you acknowledge the receipt of this dental office's Privacy Practices and you consent to our use and disclosure of your child's protected health information to carry out treatment, payment activities, and healthcare operations.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Office Manager of the location. Please understand that revocation of this consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent

Dental Materials Fact Sheet: This is information provided by the dental board of California to advise patients of the types of materials used in the dental office. By signing this form you acknowledge receipt of the fact sheet.

I have received a copy of this office's Notice of Privacy Practices (see below) and authorize their use and disclosure of my child's protected Health information for treatment, payment, and healthcare operations.

In addition, I have received a copy of the Dental Materials Fact Sheet dated May 2004 (click link to receive copy).

Signature of Parent/Guardian: _____

Printed Name: _____ Date: _____

Notice of Privacy Practices

(Revised March 10. 2013)

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. If you have any questions about this Notice of Privacy Practices please contact our HI PAA Officer:

Laura Dinsmore or Sarah Rodriguez

This Notice of Privacy Practices describes how this facility may use and disclose your protected health information (PHI) to carry out treatment, payment or healthcare operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. 'Protected Health Information" is information about you. including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related healthcare services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that is maintained at that time. Upon your request, this facility will provide you with any revised Notice of Privacy Practices by calling the practice and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment

1. Uses and Disclosures of Protected Health Information

Uses and disclosures of Protected Health Information are based upon your written consent. You will be asked by this facility to sign a consent form. Once you have consented to use and disclosure of your protected health information for treatment, payment and healthcare operations by signing the consent form, this facility will use or disclose your protected health information as described in this section. Your protected health information may be used and disclosed by this facility, the office staff and others outside of our office that are involved in your care and treatment for the purpose of providing medical care services to you. Your protected health information may also be used and disclosed to pay your medical care bills and to support the operation of this facility practice.

2.Treatment

We will use and disclose your protected health information to provide, coordinate or manage your medical care and any related services. This includes the coordination or management of your medical care with a third party that has already obtained your permission to have access to your protected health information. In addition, this facility may disclose your protected health information to another physician or healthcare provider (e.g., a specialist or laboratory) who, at the request of this facility becomes involved in your care by providing assistance with your medical care diagnosis or treatment to this facility.

3. Payment

Your protected health information will be used, as needed, to obtain payment for your medical care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the medical care services this facility recommends for you.

4. Healthcare Operations

We may use or disclose, as needed, your protected health information in order to support the business activities of this facility's practice. In addition, this facility may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when the staff is ready to see you. We may use or disclose your protected health information, as necessary, to contact you regarding appointments. We will share your protected health information with third party "business associates" that perform various activities for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, this facility will have a written contract that contains terms that will protect the privacy of your protected health information.

5. Uses and Disclosures of Protected Health Information Based Upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that this facility or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

6. Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization, or Opportunity to Object

We may use and disclose your protected health information in the following instances [see section 7 and 8]. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then this facility may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your medical care will be disclosed.

7. Others Involved in Your Healthcare

Unless you object, this facility may disclose to a member of your family, a relative, a close friend or any other person you identify your protected health information that directly relates to that person's involvement in your medical care. If you are unable to agree or object to such a disclosure, this facility may disclose such information as necessary if it determines that it is in your best interest based on its professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person responsible for your care of your location, general condition or death.

8. Emergencies

We may use or disclose your protected health information in an emergency treatment situation. If this happens, this facility will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If this facility is required by law to treat you and it has attempted to obtain your consent but is unable to obtain your consent, it may still use or disclose your protected health information to treat you.

9. Communication Barriers

We may use and disclose your protected health information if this facility attempts to obtain consent from you but is unable to do so due to substantial communication barriers and it determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization, or Opportunity to Object:

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

- **Required By Law:** We may use or disclose your protected health information to the extent that law requires the use or disclosure. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.
- **Public Health:** We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.
- **Communicable Diseases:** We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.
- **Health Oversight:** This facility may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the medical care system, government benefit programs, other government regulatory programs and civil rights laws.
- **Abuse or Neglect:** We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, this facility may disclose your protected health information if it believes that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.
- **Food and Drug Administration:** We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.
- **Legal Proceedings:** We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.
- **Law Enforcement:** We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. This law enforcement purposes include:
    - legal processes and otherwise required by law.
    - limited information requests for identification and location purposes.
    - pertaining to victims of a crime.
    - suspicion that death has occurred as a result of criminal conduct.
    - in the event that a crime occurs on the premises of the practice.
    - medical emergency (not on this facility practice's premises) and it is likely that a crime occurred.
- **Coroners:** This facility may disclose protected health information to a coroner medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law.
- **Criminal Activity:** Consistent with the applicable federal and state laws, this facility may disclose your protected health information, if it believes that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. This facility may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

- **Military Activity and National Security:** When the appropriate conditions apply, this facility may use or disclose protected health information of individuals who are Armed Forces personnel:
    - for activities deemed necessary by appropriate military command authorities.
    - for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits.
    - to foreign military authority if you are a member of that foreign military services. This facility may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.
- **Workers' Compensation**: This facility may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally established programs.
- **Required Uses and Disclosures:** Under the law, this facility must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of HIPAA Privacy Rule under§164.500 of the HIPAA Privacy Rule.

Your Rights

The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

- You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as this facility maintains the protected health information. A "designated record set" contains medical and billing records and any other records that this facility uses for making decisions about you. Under federal law, however, you may not inspect or copy the following records:
    - information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding.
    - protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our HIPAA Officer if you have questions about access to your medical record.
- You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. This facility is not required to agree to a restriction that you may request. If it believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If this facility does agree to the requested restriction, it may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with this facility. You may request a restriction by contact ins our HIPAA Officer.
- You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our HIPAA Officer.
- You may have the right to request this facility to amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as this facility maintains this information. In certain cases, it may deny your request for an amendment. If this facility denies your request for amendment; you have the right to file a statement of disagreement with us and it may prepare a rebuttal to your statement and it will provide you with a copy of any such rebuttal. Please contact our HIPAA Officer to determine if you have questions about amending your medical record.
- You have the right to receive an accounting of certain disclosures this facility has made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures this facility may have made to you, to family members or friends involved in your care or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14,2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.
- You have the right to the prohibition of the sale of your PHI.
- You have the right to opt-out of receiving fundraising communications.
- You have the right to be notified following a breach of unsecured PHI.
- You have the right to restrict disclosure of PHI to a health plan with respect to treatment for which the individual has paid fully out-of-pocket.
- You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Complaints

In the event you feel that there is cause for complaint we ask that you contact our office first and let us assist you in righting the matter.

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. Please contact our HIPAA Officer, for further information about the complaint process.

This notice became effective on April 14, 2003. Revised on March 10, 2013

Notice of Privacy Practices Acknowledgement Form

_____, (patient's name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. Bay Area Kids Dentist's Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information.

I understand that:

- I have the right to review this facility's Notice of Privacy Practices prior to signing this acknowledgement.
- This facility reserves the right to change their Notice of Privacy Practices and I may contact Bay Area Kids Dentist at any time to obtain a current copy of their Notice of Privacy Practice.

Signature of Individual or Legal Representative Witness: _____

Printed Name of Individual or Legal Representative: _____

Witness:_____ Date:_____

FOR OFFICE USE ONLY

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

- ☐ Individual refused to sign
- ☐ Communication barrier prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify) _____
  _____

HIPAA Officer: _____ Date:_____