CHILD/TEEN DENTAL & MEDICAL HEALTH HISTORY

NAME______________________________ MALE/FEMALE (circle one) BIRTHDATE__________
ADDRESS____ CITY/ZIP ____________________

Father's Information	**Mother's Information**
NAME ______________________________	NAME ______________________________
ADDRESS ___________________________	ADDRESS ___________________________
PHONE (h) ___________ (c) ____________	PHONE (h) ___________ (c) ____________

Do you have medical assistance? YES / NO
Ex: Medicare, Medicaid, Forward, BadgerCare, BadgerCare Plus (circle one)

Do you have dental insurance? YES / NO
Please provide receptionist with name of insurance company, employee, employer, group number, subscriber number (usually SSN) and date of birth of the subscriber.

DENTAL HISTORY

- DATE OF LAST VISIT TO A DENTIST______________ For what?______________________________

	Yes	No	
- HAS CHILD COMPLAINED ABOUT DENTAL PROBLEMS?...	❑	❑	If yes: ______________________
- ANY UNHAPPY DENTAL EXPERIENCES?........................	❑	❑	______________________
- ANY INJURIES TO HEAD, NECK OR TEETH?..................	❑	❑	______________________
- ANY MOUTH HABITS - THUMBSUCKING, NAIL BITING, MOUTH BREATHING, PACIFIER, BOTTLE HABITS.........	❑	❑	______________________
- ANY UNUSUAL SPEECH HABITS?................................	❑	❑	______________________
- ANY LOST TEETH?...	❑	❑	______________________
- HAVE MISSING TEETH BEEN REPLACED?.....................	❑	❑	______________________
- ORTHODONTICS APPLIANCES WORN OR ADVISED?.......	❑	❑	______________________
- DOES YOUR CHILD BRUSH TEETH DAILY?.....................	❑	❑	How often?__________________
- DO YOU ASSIST YOUR CHILD WITH BRUSHING?...........	❑	❑	______________________
- IS DENTAL FLOSS USED?...	❑	❑	______________________
- IS FLUORIDE TAKEN IN ANY FORM?............................	❑	❑	______________________
- IS YOUR WATER SUPPLY FLUORIDATED?.....................	❑	❑	______________________
- HAS CHILD EVER RECEIVED LOCAL ANESTHETIC?.........	❑	❑	______________________
- HAS ORTHODONTICS EVER BEEN RECOMMENDED OR PERFORMED?..	❑	❑	______________________
- DOES CHILD EAT BETWEEN MEALS?............................	❑	❑	______________________
- DOES CHILD EAT SWEETS SUCH AS CANDY, SODA POP, CHEWING GUM?..	❑	❑	How much? __________________

Child's attitude towards dentistry: ____

Do you have any other dental concerns you would like to discuss?
____
____

Please complete back of this questionnaire.

KAUKAUNA FAMILY DENTISTRY, S.C.

Child Medical History*

Patient Name: Birth Date: Date Created:

MEDICAL HISTORY

Is child under care of a physician? If so, for what?	◯ Yes ◯ No	If yes
Is child receiving medication? Please list:	◯ Yes ◯ No	If yes
Is there excessive bleeding when child is injured?	◯ Yes ◯ No	If yes
Has child ever been hospitalized? Please explain.	◯ Yes ◯ No	If yes
Has child ever had surgery? Please explain.	◯ Yes ◯ No	If yes
Are there any emotional problems?	◯ Yes ◯ No	If yes
Does child have good physical coordination?	◯ Yes ◯ No	If yes
Does child take vitamins?	◯ Yes ◯ No	If yes
Does child drink fluoridated water?	◯ Yes ◯ No	If yes
Does child snack between meals?	◯ Yes ◯ No	If yes
Does child drink soda or juice?	◯ Yes ◯ No	If yes
Does child have a Physician? Physician's name:	◯ Yes ◯ No	If yes

DRUG ALLERGIES

Has your child had allergies or adverse reactions to any of the following?

Latex	◯ Yes ◯ No	Local Anesthetic	◯ Yes ◯ No	Aspirin	◯ Yes ◯ No	Codeine	◯ Yes ◯ No
Nickel/metals	◯ Yes ◯ No	Penicillin	◯ Yes ◯ No	Sulfa drugs	◯ Yes ◯ No	Other	◯ Yes ◯ No

Please list any other allergies: ☐

CONDITIONS AND DISEASES

Has child had any history or difficulty with any of the following?

☐ Anemia	☐ Asthma	☐ Bladder	☐ Cerebral Palsy
☐ Chicken Pox	☐ Chronic Sinus/Ear Infections	☐ Convulsions	☐ Diabetes
☐ Epilepsy	☐ Fainting	☐ Hearing	☐ Heart
☐ Hepatitis	☐ HIV	☐ Kidney	☐ Liver
☐ Cancer	☐ Measles	☐ Mononucleosis	☐ Mumps
☐ Rheumatic Fever	☐ Thyroid	☐ Tonsilitis	☐ Tuberculosis
☐ Venereal Disease	☐ Other		

Do you have comments on items checked above: ◯ Yes ◯ No

____

____

____

Is there any other concern we should know about? ◯ Yes ◯ No

____

____

____

ALL INFORMATION WILL BE KEPT STRICTLY CONFIDENTIAL.

Signature of Patient, Parent or Guardian:

X ______________________________ Date:___________

Well Baby Dental Visit

Medical & Dental History

Name ______________________________ Male/Female __________ Birth date _____________

Address ____ State/Zip _____________

Father's Name ___________________________ Mother's Name ___________________________

Whom may we thank for referring you to our office? ____________________________________

Child's Physician ____________________________ Address _____________________________

Result of last exam ____

DENTAL HISTORY

1. Has your child been to a dentist previously? ____

   If so, for what? ____

2. Has your child complained of any dental problems? ____________________________________
3. Any injuries to head, neck or teeth? ____
4. Any mouth habits - thumbsucking, nail biting, mouth breathing, pacifier, nursing bottle habits?

   ____

5. How do you care for your child's teeth? ____

   ____

6. Does your child ingest fluoride in any form? ____
7. Is fluoridated water used to make infant formula? _____________________________________
8. Does your child go to bed with a bottle? ____

HEALTH HISTORY

1. Is child under care of a physician now? ____
2. Is child receiving medication? ____
3. Was any medication taken while the mother was pregnant with this child? _________________

   If so, what? ____

4. Does the child have any known allergies? ____
5. Is there any other health concern that you feel we should know about? _____________________

   ____

Signed ____ Date __________________

Relationship to child ____

Kaukauna Family Dentistry
Dr. Curtis R. Hebdon, DDS, SC
Notice of Privacy Practices

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.

The Health Insurance Portability and Accountability Act (HIPAA; "Act") of 1996, revised in 2013, requires us as your health care provider to maintain the privacy of your protected health information, to provide you with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We are required to maintain these records of your health care and to maintain confidentiality of these records.

The Act also allows us to use your information for treatment, payment, and certain health operations unless otherwise prohibited by law and without your authorization.

- Treatment: We may disclose your protected health information to you and to our staff or to other healthcare providers in order to get you the care you need. This includes information that may go to the pharmacy to get your prescription filled, to a diagnostic center to assist with your diagnosis, or to the hospital should you need to be admitted. If necessary to ensure that you get this care, we may also discuss the minimum necessary with friends or family members involved in your care unless you request otherwise.
- Payment: We may send information to you or to your health plan in order to receive payment for the service or item we delivered. We may discuss the minimum necessary with friends or family members involved in your payment unless you request otherwise.
- Health operations: We are allowed to use or disclose your protected health information to train new health care workers, to evaluate the healthcare delivered, to improve our business development, or for other internal needs.
- We are required to disclose information required by law, such as public health regulations, health care oversight activities, certain law suits, and law enforcement.

Certain ways that your protected health information could be used disclosed require an authorization from you: disclosure of psychotherapy notes, use or disclosure of your information for marketing, disclosures or uses that constitute a sale of protected health information, and any uses or disclosures not described in this NPP. We cannot disclose your protected health information to your employer or to your school without your authorization unless required by law. You will receive a copy of your authorization and may revoke the authorization in writing. We will honor that revocation beginning the date we receive the written signed revocation.

You have several rights concerning your protected health information. When you wish to use one of these rights, please inform our office so that we may give you the correct form for documenting your request.

- You have the right to access your records and/or to receive a copy of your records, with the exception of psychotherapy notes. Your request must be in writing, and we must verify your identity before allowing the requested access. We are required to allow the access or provide the copy within 30 days of your request. We may provide the copy to you or to your designee in an electronic format acceptable to you or as a hard copy. We may charge you our cost for making and providing the copy. If your request is denied, you may request a review of this denial by a licensed health care provider.

- You have the right to request restrictions on how your protected health information is used for treatment, payment, and health operations. For example, you may request that a certain friend or family member not have access to this information. We are not required to agree to this request, but if we agree to your request, we are obligated to fulfill the request, except in an emergency where this restriction might interfere with your care. We may terminate these restrictions if necessary to fulfill treatment and payment.
- We are required to grant your request for restriction if the requested restriction applies only to information that would be submitted to a health plan for payment for a health care service or item for which you have paid in full out-of-pocket, and if the restriction is not otherwise forbidden by law. For example, we are required to submit information to federal health plans and managed care organizations even if you request a restriction. We must have your restriction documented prior to initiating the service. Some exceptions may apply, so ask for a form to request the restriction and to get additional information. We are not required to inform other covered entities of this request, but we are not allowed to use or disclose information that has been restricted to business associates that may disclose the information to the health plan.
- You may have the right to request confidential communications. For example, you may prefer that we call your cell phone number rather than your home phone. These requests must be in writing, may be revoked in writing, and must give us an effective means of communication for us comply. If the alternate means of communication incurs additional cost, that cost will be passed on to you.
- Your medical records are legal documents that provide crucial information regarding your care. You have the right to request an amendment to your medical records, but you must make this request in writing and understand that we are not required to grant this request.
- You have a right to an accounting of disclosures. This will tell you how we have used or disclosed your protected health information.
- You have the right to receive a copy of this notice, either electronic or paper or both.
- You have the right to opt out of fund raising communications.

If you have any questions about our privacy practices, or would like to file a complaint with us, please contact our Privacy Officer at the phone number below.

You have the right to file a complaint with us or with the Office for Civil Rights. We will not discriminate or retaliate in any way for this action. To file a complaint, please contact the applicable party:

Privacy Officer: Curtis R. Hebdon, DDS, SC

Phone number: 920-766-9542

Fax number: 920-759-4439

Office for Civil Rights

http://www.hhs.gov/ocr/privacey/hipaa/complaints/index.html

We are required to abide by the policies stated in this Notice of Privacy Practices, which became effective March 26, 2013.

Kaukauna Family Dentistry
Dr. Curtis R. Hebdon, DDS, SC

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the *Health Insurance Portability & Accountability Act of 1996 (HIPAA),* I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly or indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my PHI. I understand that this organization (Kaukauna Family Dentistry) has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a copy of the current *Notice of Privacy Practices*.

HIPAA AUTHORIZATION

The notice above lists examples of who we may share your PHI (other doctors, insurance carriers, etc). In addition you may authorize a family member or friend to whom we may disclose your protected health information (PHI); this may include appointment dates, recommended treatment, treatment performed, and/or account information.

Names of person(s) authorized to receive your PHI: ______________________________________

____

I understand that I have the right to revoke this authorization, in writing, at any time by providing notification to the Privacy Officer at Kaukauna Family Dentistry, 233 Dodge Street, Kaukauna, WI 54130.

I also understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. The use and disclosure requested under this authorization may result in direct or indirect remuneration to the physician from a third party.

HIPAA Acknowledgement and Authorization for: ____________________________________

Please print patient name

____

Patient or Guardian signature

____

Date

PRACTICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

____

____

__________________________ ______________________ _________

Staff member *Staff Signature* *Date*

OUR FINANCIAL POLICY

- We encourage you to take advantage of our **5% cash discount** by paying in full the day treatment is performed. *At this time, we only offer this for cash or checks, not with insurance or CareCredit payments.*

- Your account is **due in full within 30 days** unless other arrangements were made.

- For your convenience **Mastercard, Discover and VISA are accepted**. Our primary concern is providing high quality dental care, and since we are not a financial institution, we cannot extend credit over long periods of time. We encourage you to use your bank cards or see your local bank for this service.

- We also accept **CareCredit** financing as a way to help make necessary dentistry available for everyone. We can give you the information and help you with the application process.

- **Past-due accounts are charged a billing fee of 1.5% (18% yearly) of the balance due**. Delinquent accounts, (those over 90days past due) are referred to a collection agency or our attorney.

- Dental treatment requiring **laboratory procedures** from a source outside the office (ex. crowns, bridges, dentures) require the fee must be paid in full before the case is completed, with **at least half paid when the case is prepared and the balance due upon completion.**

- **Orthodontic cases require a down payment** of at least 1/4 the total fee, with monthly payments during the estimated treatment time span.

- **Accidental Injury** - In cases where dental services are required because of car accident, on the job injury or other trauma which will result in claims being submitted to a carrier other than your dental insurance, we will set up a separate accident account and payment is due in full within 90 days whether or not any accident or Workman's Compensation claim has been settled.

Additional Information for patients with dental insurance:

- Please bring your insurance card or information with you the day of your first appointment. Your signature on the attached financial acknowledgement authorizes us to submit your insurance claims and allows your insurance company to pay us directly. It is your responsibility to notify us of any changes regarding your insurance coverage.

- **Any deductibles, co-payment and/or known uncovered charges are due at the time of treatment**. All charges are due within 30 days of treatment, regardless of whether your insurance has paid its benefit or not.

- We will file insurance claims relative to your dental treatment. However, **our professional services are rendered to you and not your insurance company**. Our fees are the same for all of our patients and your treatment is determined by your dental needs and not what your insurance policy will pay.

- A pre-treatment estimate will be sent to your insurance company for extensive dental treatment. Once this is known, we can proceed with the recommended treatment, payment for uncovered treatment, co-payments and deductibles are due at the time of treatment. If you choose to start your dental treatment without the benefit of this estimate, your payment is due at the time of treatment, and we will have the insurance company send their payment to you.

- We will be happy to assist you with your insurance and will answer any questions we are able to, but any dispute in the coverage is between you and your employer or insurance company, we are not responsible for the structure of your plan. ***Please remember dental insurance is not a 'pay all' ....but rather an aid to attaining dental health.***

Kaukauna Family Dentistry
Curtis R. Hebdon, DDS, SC
233 Dodge Street
Kaukauna, WI 54130
920-766-9542

PATIENT COPY

FINANCIAL POLICY ACKNOWLEDGEMENT AND INSURANCE SIGNATURE ON FILE AGREEMENT

- Cash Discount of 5% for payment in full the day of service. (cash, check, MasterCard, Discover or VISA) with I.D.
- Payment is due the day of tooth preparation for dental services (ex. Crowns) that require outside laboratory fees.
- CareCredit financing available (Ineligible for Cash Discount)
- 5% Senior Citizens Discount-For patients **62** years of age or older.
- Open Account-Statements will be sent with payment in full due within 30 days for all established patients.
- Orthodontic Treatment will require a start fee of at least ¼ of the total fee.
- As a courtesy to our patients we will file claims with dental, medical or accident insurance companies. Any unpaid portion is due 60 days from the date of service. **(We reserve the right to decline assignment of benefits from any company)**

SIGNATURE ON FILE

- I authorize use of this form on all my insurance submissions.
- I authorize release of information to all my insurance companies.
- I authorize my dentist or his assigned staff member to act as my agent in helping me obtain payment from my insurance company.
- I authorize payment directly to my dental office.
- I permit a copy of this authorization to be used in place of the original.
- My signature also applies to **all dependents covered** by my policy.

My signature indicates that I have read the attached financial policy and understand the payment options available and that I agree to the above "Signature on File" items. I am aware that I, not my insurance company, am responsible for the entire account.

_______________________________________ ___/___/___

Patient or guardian signature Date

KAUKAUNA FAMILY DENTISTRY

Curtis R. Hebdon, DDS, S.C.

233 Dodge Street

Kaukauna, WI 54130

(920) 766-9542