ABOUT YOUR CHILD

Child's Name _____ Age_____ Birthday _____

Prefers to be called _____ ☐ Male ☐ Female

Reason for visit _____

Referred to this office by (We wish to thank them) _____

DENTAL HISTORY

Child's First Dental Visit? . . . . . ☐ Yes ☐ No

You child's previous dentist _____
Name City Date of last visit

Date of last dental x-rays _____

Any injuries to you child's teeth or mouth? . . . . . ☐ Yes ☐ No

If yes, please explain _____

Has your child had a history of:

Breast feeding after 1 yr old. . . . . ☐ Yes ☐ No
Bottle habits . . . . . ☐ Yes ☐ No
Thumb sucking/finger sucking . . . . . ☐ Yes ☐ No
Pacifier . . . . . ☐ Yes ☐ No
Dental grinding or clenching . . . . . ☐ Yes ☐ No

Has your child had recent dental pain? . . . . . ☐ Yes ☐ No

If yes, please explain _____

Has your child had any unfavorable dental experiences? . . . . . ☐ Yes ☐ No

If yes, please explain_____

MEDICAL HISTORY

Is your child presently under the care of a physician for any medical reason? . . . ☐ Yes ☐ No

If yes, please explain _____

Is your child presently taking any medications? . . . . . ☐ Yes ☐ No

If yes, what and how much? _____

Does your child have any drug, food, or environmental allergies? . . . . . ☐ Yes ☐ No

If yes, what? _____

Has your child ever been hospitalized or had surgery? . . . . . ☐ Yes ☐ No

If yes, please explain _____

Has your child had any history or difficulty with the following? If so, please check ☑

☐ Heart	☐ HIV	☐ Anemia	☐ Mononucleosis	☐ other _____
☐ Lungs	☐ Asthma	☐ Hepatitis	☐ Cerebral Palsy	
☐ Liver	☐ Fainting	☐ Epilepsy	☐ Rheumatic Fever	
☐ Kidney	☐ Diabetes	☐ Convulsions	☐ Speech problems	
☐ Bladder	☐ Mumps	☐ Tuberculosis	☐ Chronic Sinusitis	
☐ Hearing	☐ Measles	☐ Malignancy	☐ Cleft lip or Palate	

Please Explain _____

I certify that the above information is true and correct to the best of my knowledge.

Signature _____Relationship to Child _____ Date _____

PATIENT HISTORY FORM

Patient's Name _____ Phone No. _____

Patient's Date of Birth _____ Patient's Social Securtiy # _____

Patient's Address _____
Street # City, State Zip Code

Other Children in the family: (Are any of them patients of this practice ☐ Yes ☐ No)

Name _____ Age_____ Birthday _____

_____ Age_____ Birthday _____

Patient's Pediatrician _____ Pediatrician's Phone Number_____

Parent's Dentist _____

Is Patient covered by dental insurance? ☐ **No** ☐ **Yes** **or** ☐ **Medicaid** **Patient's Medicaid #**_____

Child's Primary Insurance	**Child's Secondary Insurance**
Subscriber's Name _____	Subscriber's Name _____
Subscriber's Relation to Patient _____	Subscriber's Relation to Patient _____
Subscriber # _____ DOB _____	Subscriber # _____ DOB _____
Employer _____	Employer _____
Insurance Co:_____	Insurance Co:_____
_____ (Street #) Ins. Phone #	_____ (Street #) Ins. Phone #
_____ (City, State) (Zip Code)	_____ (City, State) (Zip Code)
Insurance ID#:_____ Group#:_____	Insurance ID#_____ Group#:_____

Mother / Guardian	**Father / Guardian**
Name_____	Name_____
S.S.# _____ DOB _____	S.S.# _____ DOB _____
Occupation _____	Occupation _____
Business Name _____	Business Name _____
Business Location _____	Business Location _____
If different from patient: Home address_____ (Street #) _____ (City, State) (Zip Code)	If different from patient: Home address_____ (Street #) _____ (City, State) (Zip Code)
Home Phone ( ) _____	Home Phone ( ) _____

I understand that I am responsible for all charges incurred by me or my family regardless of insurance coverage and that **PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED**. If my account requires servicing by a collection agency or by an attorney I understand that I will be liable for the collection fees, attorney fees and applicable court costs, in addition to my outstanding balance. I also request that payment under my dental insurance program be made directly to The Smile Spot on any unpaid bills for services furnished me or my family. I authorize the release of any dental information necessary to process this claim and all future claims.

CERTIFICATION AND CONSENT FOR TREATMENT OF A MINOR

I certify that the above information is correct and I hereby authorize the doctors to use such measures as deemed necessary in their professional judgment to render a diagnosis for my child. This would include an oral examination including any necessary X-rays and after an explanation, all forms of treatment, medication, and therapy indicated for the dental care of the above named child. This consent shall remain in full force and effect until canceled by either party.

Signature _____ **Relationship to child**_____ **Date**_____

Consent for Dental Procedure and Acknowledgement of Receipt of Information

Informed consent indicates your awareness of sufficient information to allow you to make an informed personal choice concerning your child's dental treatment after considering the risks, benefits and alternatives. Please read this form carefully and ask about anything you do not understand. We will be pleased to explain it.

I hereby authorize and direct Dr. Michael Webb, and/or Dr. Matthew Anderson, assisted by other dentists and/or auxiliaries of their choice, to perform upon my child (or legal ward) the following dental treatment or oral surgery procedure(s), including the use of any necessary or advisable radiographs (x-rays) or diagnostic aids.

In general terms the dental procedure(s) may include:

Cleaning

Fluoride

Sealants
(protective resin application to the grooves of molar teeth)

Nitrous oxide and oxygen
(this gas is utilized to help the child become relaxed during the procedure. The child does not become unconscious)

Treatment of decayed or injured teeth may include:

Local Anesthesia

Silver Fillings

Tooth-Colored Fillings

Stainless Steel Crowns

Tooth-Colored Crowns
(For front teeth only)

Extraction
(removal of 1 or more teeth)

Nerve Treatment

Space Maintainer
(replacement of missing teeth with a "space holder")

This treatment has been explained to me. Alternate methods of treatment, if any, have also been explained to me, as have the advantages and disadvantages of each. I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee as expressed or implied either as to the results of the treatment or as to cure. I further authorize the doctor to perform other dental sevice(s) that in his judgement are advisable for my child or legal ward, with the exception of (if none so state):

☐ None ☐ Exception _____

Although their occurrence is extremely remote, some risks are known to be associated with dental or oral surgery procedures including anesthesia or sedation. State Law requires us to mention the risks of numbness, infection, swelling, bleeding, discoloraton, nausea, vomiting, allergic reactions, brain damage, quadriplegia, the loss or loss of function of any organ or limb, or disfiguring scars associated with such procedure or procedures. I further understand and accept that complicaitons may require hospitalizaiton and may even result in death.

I authorize the use of photographs, radiographs, other diagnostic materials and treatment records for the purposes of teaching, research and scientific publications.

I have read and understand this consent, and all my questions about the procedure(s) have been answered to my satisfaction. I understand that I have the right to be provided with answers to questions which may arise during the course of my child's treatment.

Child's Name _____ **Date** _____ **Time** _____**am/pm**

Signature of Parent or Guardian _____ **Relationship to Patient** _____

Witness or Interpreter _____

I have explained the above to the parent or legal guardian _____

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 CARFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

OUR LEGAL DUTY

We are required by applicable and state law to maintain the privacy of your health information. We are also required to give you this Notice about your 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 Jan 1st, 2016, and will remain in effect until we replace it.

We reserve the right to change our privacy policies and the terms of this Noticeat any time, provided such changes are permitted by the applicable law. We reserve the right to make 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 act 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 health care provider providing treatment to you.

Payment: We may use and disclose your health information to obtainpayment 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 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 familymember, 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 opportunityto object to such disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing any health information that is directly relevant to theperson's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences in your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, and other similar forms of health information.

Marketing Health-Related Services: 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 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, counter intelligence and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate of 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 may 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 there will be a fee as determined by location. If you request an alternative format we will charge you a cost-based fee for providing you health information in that format. If you prefer, we will prepare a summary or an explanation of you 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 business associates, disclose your health information for purposes, other than treatment, payment, healthcare operation and certain other activities, for the last 6 years, but not before Jan 1st, 2016 If you request this accounting more than once in a 12-moth 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 your 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 your alternative means and location, and provide satisfactory explanation how payments will be handles 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 website or by electronic mail (e-mail) you are entitled to receive his Notice in written form.

QUESTIONS AND COMPLAINTS

If you want anymore information about our privacy practices or haveany questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision 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 alternative locations, you may complain to us by using the contact information listed at the end of this Notice. You may also submit a written complaint with 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 you 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.

Connie Moore: Compliance Officer

Telephone: 816-214-5409 E-mail: cmoore@compassdentalservices.com

8043 Wornall Road Suite 103 Kansas City, MO 64114

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 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) _____

_____

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