Date_____ **Confidential Patient Information** + A B C -

Patient's Name_____
Last First Middle Nickname Gender

Address_____
Street City State Zip

Home Phone_____ Birthdate_____ Social Security #_____

If patient is a minor, give parent's or guardian's name_____

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

## Confidential Responsible Party Information

Name_____ Marital Status_____
Last First Middle

Residence_____
Street City State Zip

Mailing Address_____
Street City State Zip

How long at this address_____ Home Phone_____ Work Phone_____

Cell Phone _____ Email _____

Previous Address (if less than 3 yrs.)_____
Street City State Zip

Social Security #_____ Birthdate_____ Relationship to Patient_____

Employer_____ Occupation_____ No. Years Employed_____

**Spouse's** Name_____ Rel. to Patient_____
Last First Middle

Employer_____ Occupation_____ No. Years Employed_____

Social Security #_____ Birthdate_____ Work Phone_____

## Insurance Information

Policy Holder's Name_____ and Soc.Sec. #_____

Insurance Company_____ Group No._____ Birthdate_____

Insurance Co. Address_____ Insurance Co. Phone_____

Policy Holder's Employer_____

Do you have dual coverage? No ☐ Yes ☐ If yes:

Policy Holder's Name_____ and Soc. Sec. #_____

Insurance Company_____ Group No._____ Birthdate_____

Insurance Co. Address_____ Insurance Co. Phone_____

Policy Holder's Employer_____

## Emergency Information

Name of nearest relative not living with you_____

Complete Address_____

Phone_____ Relationship:_____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor)_____

Updates (date & initial)_____

CONFIDENTIAL (for record and pretreatment evaluation)

Patient _____ Date of Birth_____

# My Kids Smile Confidential Patient Medical and Dental History

Physician's Name_____Phone_____Last Visit_____

Has patient ever been under the extended care of a physician or had any surgeries? Yes ☐ No ☐
If yes, Please explain:

CHECK ANY OF THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN TREATED

| | | |
|---|---|---|
| ☐ Heart Conditions (murmur, etc) | ☐ HIV Positive | ☐ Hepatitis |
| ☐ Excessive Bleeding | ☐ Tuberculosis | ☐ Frequent Headaches |
| ☐ Diabetes | ☐ Asthma | ☐ Kidney Infections |
| ☐ Rheumatic Fever | ☐ Epilepsy | ☐ Cerebral Palsy |
| ☐ Liver Problems | ☐ Birth Defects | ☐ Eyesight Problems |
| ☐ Cancer | ☐ Infections | ☐ Speech Impairments |
| ☐ Nervous Disorders | ☐ Other _____ | |

Is the patient currently on any medications? Yes ☐ No ☐ If yes list_____
Is the patient allergic to any foods or medicines? Yes ☐ No ☐ If yes list_____

Last Dentist Name_____Phone_____Last Visit_____

DENTISTRY

| | | |
|---|---|---|
| Were any x-rays taken at patient's last dental visit? | Yes ☐ | No ☐_____ |
| Has patient had any problems with dental exams or treatment in the past? | Yes ☐ | No ☐_____ |
| Has patient had any cavities in the past? | Yes ☐ | No ☐_____ |
| Does patient brush their teeth daily? | Yes ☐ | No ☐ _____ |
| Does patient currently take a fluoride supplement (tablets,gels,rinses,etc)? | Yes ☐ | No ☐ _____ |
| Does patient floss their teeth daily? | Yes ☐ | No ☐_____ |
| Has patient ever received local anesthetic? | Yes ☐ | No ☐_____ |
| Has patient ever had occlusal sealants placed? | Yes ☐ | No ☐_____ |
| If applicable: Has parent been diagnosed with tooth decay in past 2 year? | Yes ☐ | No ☐_____ |
| Has patient experienced any trauma to the teeth? (falls, blows, chips, etc) | Yes ☐ | No ☐_____ |

If yes, Please Explain: _____
Please describe patient's diet (regular/favorite foods):

ORTHODONTICS

| | | |
|---|---|---|
| Has patient ever sucked thumbs or fingers? | Yes ☐ | No ☐_____ |
| Does patient have any speech problems? | Yes ☐ | No ☐_____ |
| Has patient ever been informed of any extra or missing teeth? | Yes ☐ | No ☐_____ |
| Has patient ever had a previous orthodontic exam? | Yes ☐ | No ☐_____ |
| Has any family members ever needed orthodontics in the past? | Yes ☐ | No ☐_____ |
| Does patient have any pain in their jaw? | Yes ☐ | No ☐_____ |
| Does patient have any popping or cracking of the jaw joint? | Yes ☐ | No ☐_____ |
| Does patient clench or grind? | Yes ☐ | No ☐_____ |

Chief Orthodontic Concern? _____

*******Please tell us about the patients interest (favorite sports, hobbies, TV shows, travel, movies, etc******:
_____

*Thank You for taking the time to fill out!*

**I certify that the above information is complete and accurate.**
Parent/Guardian Signature_____ Date_____
Dentist Signature_____ Date_____

# My Kid's Smile: Dentistry and Orthodontics

**Our Mission: "Quality Care and a Positive Patient Experience"**

*The Doctors and staff at My Kid's Smiles have an unwavering commitment to your child's superior oral health. We use sound scientific and ethical principles in order to provide your child with the highest standard of pediatric dental care available in our area. We also recognize that creating a fun, friendly, and comfortable environment is critical to the child's long-term oral health. We know you have a choice in dental providers and we hope that these goals are the primary reasons you have chosen our practice. Please keep in mind that all of the following policies center on accomplishing these two core philosophies.*

**Late Appointment Policy**

We ask that parents make a special effort to be on time to your child's appointments in order to minimize the impact on their child's care as well as those children scheduled later in the day. If a patient is more than 5 minutes late to a 30 minute appointment or 15 minutes late to a 60 minute appointment they may be required to reschedule or wait while we care for those patients who were on time to their appointments. Regular tardiness will lead to the end of the doctor patient relationship.

INITIAL_____

**Missed or Cancelled Appointment Policy**

Due to the busy nature of our practice and as a common courtesy to the doctors and staff who are providing important care to your child we ask that you please make your child's appointment a top priority. If you are unable to make your appointment please give us sufficient time to fill your child's appointment with another child waiting to see the doctor. An appointment cancelled in less than 24 hours, or an appointment missed completely without notice may be subject to a $25 no show fee. This fee will be assessed to your account and must be paid prior to rescheduling your child. A 2nd last minute cancellation or no-show will lead to the end of the doctor patient relationship.

INITIAL _____

**Insurance and Financial Policy**

In most cases insurance companies do not pay for 100% of the care needed by our patients. Should there be a difference between the costs of the quality dental care provided to your child by My Kid's Smile and the amount your insurance company reimburses the difference will be your responsibility. At your request, we will do all we can to help you understand and maximize the benefits available to you through your insurance provider but ultimately it is your responsibility to understand the coverage's of your policy prior to care being provided and charges incurred.

INITIAL _____

**Communication**

Our top priority is to give you all the information needed to make informed decisions in regards to your child's oral health. This includes providing you with the nature of recommended procedures, the risks of those procedures, any alternatives to the procedures recommended, and an estimate of the costs involved to perform those procedures.

We hope that open communication is important to you as well and that any concerns you have about treatment or our policies will be brought immediately to our attention with the same courtesy and respect. We will sincerely do all we can to develop a long-term relationship where your child's oral health and dental experience is number one for both of us.

I have read, understand, and agree to My Kids Smile key practice policies.

_____ _____

Parent/Guardians Signature Date

_____ _____

Printed Name Relationship to Patient

NORTHERN NEVADA DENTAL SPECIALTIES GROUP
dba

# MY KIDS SMILE

## 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.

We are required by law to maintain the privacy of protected health information, to provide individuals 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 must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 08/21/2014, 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

**HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU**

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

**Treatment.** We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

**Payment.** We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

**Healthcare Operations.** We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

**Individuals Involved in Your Care or Payment for Your Care.** We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

**Disaster Relief.** We may use or disclose your health information to assist in disaster relief efforts.

**Required by Law.** We may use or disclose your health information when we are required to do so by law.

**Public Health Activities.** We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

**National Security.** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized 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 the protected health information of an inmate or patient.

**Secretary of HHS.** We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

**Worker's Compensation.** We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

**Law Enforcement.** We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

**Health Oversight Activities.** We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Judicial and Administrative Proceedings.** If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

**Research.** We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

**Coroners, Medical Examiners, and Funeral Directors.** We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

**Fundraising.** We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

**Other Uses and Disclosures of PHI**

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

**Your Health Information Rights**

**Access.** You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

**Disclosure Accounting.** With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

**Right to Request a Restriction.** You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

**Alternative Communication.** You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

**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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

**Right to Notification of a Breach**. You will receive notifications of breaches of your unsecured protected health information as required by law.

**Electronic Notice.** You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

**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 if 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.

Our Privacy Official: Marcy Morris

Telephone: 775-852-6164x202 Fax: 775-284-7352
Address: 10645 Double R Blvd., Reno, NV 89521
E-mail: marcym@mykidssmilereno.com

My Kid's Smile
Dentistry & Orthodontics

**Your Name:** _____ **Today's Date:** _____

**Relationship to Patient(s):**_____ **Patient(s) Name:** _____

_____

_____

**How would you like us to communicate with you?**

*Our dental/orthodontic office sends appointment reminders, information about treatment, payment and insurance, and other communications including but not limited to newsletters, events, etc. Please tell us how you would like us to communicate with you.*

***Check or complete all that apply (please print clearly):***

☐ Contact me by U.S. Mail at the following address: _____

☐ Contact me by email at the following email address: _____

**For Phone and Text Communications:**

***This form is optional. You are not required to sign this form, and you do not need to sign it to receive care in our dental/orthodontic office.***

Phone Number: _____

☐ **By checking this box, I consent to the following:** The dental/orthodontic practice or its service provider may contact me to provide health care information such as appointment reminders and information about treatment, payment, my account or insurance, using artificial or prerecorded voice or telephone equipment that may be capable of automatic dialing. The dental/orthodontic practice may:

- ☐ Call me
- ☐ Text me
- ☐ Call me and text me

Signature: _____ Date: _____

***Please call My Kid's Smile right away if you get a new telephone number!***

---

*For Office Use Only:*

☐ Consent revoked. Date/Initials: _____/_____

☐ Possible reassigned number. Date/Initials: _____/_____

☐ Confirmed accurate.

Date/Initials: _____/_____ Date/Initials: _____/_____

Date/Initials: _____/_____ Date/Initials: _____/_____

Date/Initials: _____/_____ Date/Initials: _____/_____