

Welcome

Patient ID # _____ Today's Date _____

to our practice! We strive to make each of your child's visits pleasant and comfortable. Please fill out this form completely in ink.

Your Child

Child's Name _____
Nickname _____ Sex _____
Birthdate _____ Age _____
SS#/SIN _____
School _____ Grade _____
Child's Home Address _____
City _____ State/Prov. _____ Zip/P.C. _____
Phone _____

Responsible Party

Name _____
Relationship _____
Address _____
City _____ State/Prov. _____ Zip/P.C. _____
Email _____
SS#/SIN _____
DL # _____

Who is responsible for making appointments?

Name _____
Home Phone _____ Cell Phone _____
Work Phone _____ Ext. _____

Best time to call _____
Time _____ Days _____

Mother

Stepmother Guardian

Name _____
Home Phone _____ Cell Phone _____
Work Phone _____ Ext. _____
Email _____
Employer _____
Occupation _____
SS#/SIN _____
DL # _____

Father

Stepfather Guardian

Name _____
Home Phone _____ Cell Phone _____
Work Phone _____ Ext. _____
Email _____
Employer _____
Occupation _____
SS#/SIN _____
DL # _____

Marital Status Single Married Divorced
 Widowed Separated

Marital Status Single Married Divorced
 Widowed Separated

Primary Insurance

Insured's Name _____
Relationship _____
Birthdate _____ SS#/SIN _____
Employer _____ Date Employed _____
Occupation _____
Insurance Company _____
Group # _____ Employee # _____
Ins. Co. address _____
City _____ State/Prov. _____ Zip/P.C. _____
Deductible _____ Copay _____
Amount already used _____
Max. annual benefit _____

Additional Insurance

Insured's Name _____
Relationship _____
Birthdate _____ SS#/SIN _____
Employer _____ Date Employed _____
Occupation _____
Insurance Company _____
Group # _____ Employee # _____
Ins. Co. address _____
City _____ State/Prov. _____ Zip/P.C. _____
Deductible _____ Copay _____
Amount already used _____
Max. annual benefit _____

Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer.

Payment in full at each appointment. Cash Personal Check
 Credit Card Visa MC I wish to discuss the office's payment policy.

Dental & Health History

CONFIDENTIAL

Patient ID # _____

Your child's overall health as well as any medications which your child takes could have an important inter-relationship with the dental care your child receives. Please answer each of the following questions completely.

How often does your child brush? _____ How often does your child floss? _____

Is your child's water fluoridated?..... Yes No Does your child take fluoride supplements?..... Yes No

Does your child:

Suck thumb/finger Yes No Chew hard objects (pencils, etc.) Yes No

Suck/Bite lip Yes No Grind teeth Yes No

Bite/Chew nails?..... Yes No Clench jaws Yes No

Previous dentist _____ Address _____

Date of last dental visit? _____

Has your child had difficulty with previous dental visits? Yes No

Child's physician _____ Address _____

Phone # _____

Previous Hospitalizations/Surgeries/Serious Illnesses? _____ When? _____

Is your child currently taking medications? Yes No (if yes, please list)

Has your child ever taken Fen-Phen/Redux? Yes No

Does your child have a history of allergies/sensitivities/adverse reactions to any drugs or medications (penicillin, Novocain, etc.)? Yes No (if yes, please describe) _____

Does your child have a history of allergies to any other substances (latex, environmental, etc.)? _____

Has your child ever had any of the following:

Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach, liver or kidney problems <input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	Handicaps/Disabilities..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No
HIV/AIDS <input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Hemophilia <input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No
A persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Congenital Heart Defect <input type="checkbox"/> Yes <input type="checkbox"/> No
Abnormal Bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No
	Convulsions/Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No

Please explain any medical problems that your child has: _____

Authorization & Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need.

I also authorize the Dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the Dentist or Dentist's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient (or parent/guardian if minor) _____ Date _____

Dentist Review: _____

Signature of Dentist _____ Date _____



Brad Mc Connell, DDS
Harris Parkway Dental Care
6029 Harris Parkway
Fort Worth, TX 76132
(817) 423-2223

Advance Consent To Treat Minor Child

I, _____, the parent or legal guardian of my child, _____, hereby authorize and consent to the rendition of routine and emergency dental treatment for my child when deemed necessary by licensed dentist(s) and qualified dental personnel of Harris Parkway Dental Care. This authorization will remain in effect until revoked in writing by me and this authorization shall remain a permanent part of my child's Harris Parkway Dental Care treatment record.

Dated this ____ day of _____, 200__.

Signature of parent/legal guardian

Important Please Read

This document will not be accepted as authorization by Harris Parkway Dental Care and its licensed dentist(s) and qualified dental personnel prior to the rendition of an initial comprehensive or emergency dental examination and other diagnostic tests and radiographs. The parent or legal guardian must be present at the initial comprehensive or emergency dental visit. Harris Parkway Dental Care reserves the right to require the presence of the parent or legal guardian at any or all future dental visits at the election of its licensed dentist(s) and qualified dental personnel.

NOTE: PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, THIS IS A PROPRIETARY DOCUMENT THAT CONTAINS PROTECTED HEALTH INFORMATION. THIS DOCUMENT MAY NOT BE VIEWED BY PERSONS FOR WHICH THE INFORMATION APPEARING HEREIN IS NOT THE LEGITIMATE JOB RELATED INFORMATION ASSOCIATED WITH RENDERING HEALTH TREATMENT OR APPROPRIATE ADMINISTRATIVE SUPPORT TO THE PATIENT

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 4/13/03, 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 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 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: Brad A. McConnell, DDS

Telephone: (817) 423-2223 **Fax:** (817) 423-2238

Address: 6029 Harris Parkway, Fort Worth, TEXAS 76132

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(This Form is educational only, does not constitute legal advice, and covers only federal, not state, law in effect or proposed as of March 27, 2002. Subsequent law changes may require Form revision.)

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)

