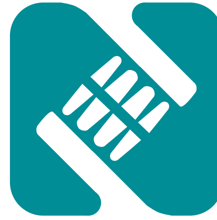
Welcome

Faith C. Drennon, DMD



Newport Pediatric Dentistry

Health History Form

Today's Date: ____________________

NOTE: The parent or guardian who accompanies the child is responsible for payment at the time of service.

1. Tell Us About Your Child

Child's Name ______________________________________
Last First MI

Goes by: ____________________ ❒ Male ❒ Female

Siblings that we treat ____________________________

Child's Birthdate ____ / ____ / _____ Child's Age _____

School ____________________________ Grade ______

Child's Home # (________) ____________________

SS# ______________________________________

Child's Home Address ____________________________

____
City State Zip

Email Address: ______________________________________

2. Who may we thank for referring you to our office:

____

3. Mother's Information:

Name ______________________________________

❒ Mother ❒ Stepmother ❒ Guardian Birthdate___/___/____

Employer ______________________________________

Work # ______________________________________

Home # ________________ Cell # ________________

SS # __________________ DL # ________________

4. Father's Information:

Name ______________________________________

❒ Father ❒ Stepfather ❒ Guardian Birthdate___/___/____

Employer ______________________________________

Work # ______________________________________

Home # ________________ Cell # ________________

SS # __________________ DL # ________________

5. Who is accompanying the child today?

Name ______________________________________

Relationship ______________________________________

Do you have legal custody of this child? ❒ Yes ❒ No

6. Person responsible for account

Name ______________________________________

Relationship ______________________________________

Billing Address ______________________________________

____
City State Zip

Home # ______________________________________

Work # ________________ Cell # ________________

E-mail ______________________________________

7. Primary Dental Insurance

Insurance Co. Name ______________________________________

Insurance Co. Address ______________________________________

____

Insurance Co. Phone # ______________________________________

Group # (Plan, Local or Policy #) ____________________

Policy Owner's Name ______________________________________

Relationship to Patient ______________________________________

Policy Owner's Birthdate ______/______/______

Social Security # ______________________________________

Policy Owner's Employer ______________________________________

8. Secondary Dental Insurance

Insurance Co. Name ______________________________________

Insurance Co. Address ______________________________________

____

Insurance Co. Phone # ______________________________________

Group # (Plan, Local or Policy #) ____________________

Policy Owner's Name ______________________________________

Relationship to Patient ______________________________________

Policy Owner's Birthdate ______/______/______

Social Security # ______________________________________

Policy Owner's Employer ______________________________________

9. Dental Health History

1. Please check reason(s) for seeking dental care
   ___ first examination ___ toothache or swelling ___ crowding of teeth
   ___ rou tine check-up ___ appearance of teeth or face ___ accident
   ___ other ____

2. If your child has been to a dentist previously, when was last visit?
   Previous dentist's name ______________________________
   Have x-rays been taken and when? ❒ Yes ❒ No Date ______________________
   How did your child react and describe his/her temperament ______________________
   ____

3. How do you think your child will react to dental treatment? ______________________
   ____

4. Has your child had fluoride in any of the following forms?

Fluoride tablets or in multiple vitamins	❒ Don't know	❒ Yes	❒ No
Drinking water (community fluoridation)	❒ Don't know	❒ Yes	❒ No
Topical application to teeth; last ______________	❒ Don't know	❒ Yes	❒ No
Toothpaste; brand ______________________			

5. Does your child have his/her own toothbrush? ❒ Yes ❒ No

6. Does your child brush his/her own teeth?
   How frequently and when? ___AM ___PM ___After Breakfast ___After Snacks ___Before Bed

7. Do you brush your child's teeth? ___AM ___PM ___After Breakfast ___After Snacks ___Before Bed

8. Do you or your child use dental floss in cleaning your child's teeth? ❒ Yes ❒ No
   How frequently and when? ___AM ___PM ___After Breakfast ___After Snacks ___Before Bed

9. Does your child have between meal snacks? ❒ Yes ❒ No

10. Have your child's teeth ever been injured? ❒ Yes ❒ No
    When? ______________________________
    Which Teeth? ______________________________
    Cause? ______________________________
    Were the teeth treated? ❒ Yes ❒ No
    Is so describe treatment ____

11. Does your child have any of the following habits? (Indicate ages when occurred)
    Bottle or breast feeding at night or nap ______________________________
    What was in bottle? ______________________________
    Sippy Cup: what is inside the sippy cup? ______________________________
    Thumb or finger sucking ______________________________
    Tongue thrusting ______________________________
    Lip sucking or biting ______________________________
    Mouth breathing ______________________________

12. Has your child received any unusual dental or surgical treatment? ❒ Yes ❒ No
    If so, what & when? ____

10. Medical History

1. Were there any difficulties during the pregnancy, delivery or first year of the child's life? ❒ Yes ❒ No
   If so, what? ______________________________

2. Was your child premature? ❒ Yes ❒ No

3. Has the child ever had any of the following conditions?

❒ Yes	❒ No	Abnormal bleeding
❒ Yes	❒ No	Allergies to any drugs
❒ Yes	❒ No	Any hospital stays
❒ Yes	❒ No	Any operations
❒ Yes	❒ No	Asthma
❒ Yes	❒ No	Cancer
❒ Yes	❒ No	Congenital birth defects
❒ Yes	❒ No	Convulsions/Epilepsy
❒ Yes	❒ No	Pregnancy
❒ Yes	❒ No	Tuberculosis
❒ Yes	❒ No	ADD/ADHD
❒ Yes	❒ No	Disabilities/Special needs
❒ Yes	❒ No	Hearing impairment
❒ Yes	❒ No	Heart disease/Murmur
❒ Yes	❒ No	Hemophilia/Blood disorders
❒ Yes	❒ No	Hepatitis
❒ Yes	❒ No	HIV + / AIDS
❒ Yes	❒ No	Kidney/Liver conditions
❒ Yes	❒ No	Rheumatic/Scarlet fever
❒ Yes	❒ No	Allergies to latex product
❒ Yes	❒ No	Diabetes
❒ Yes	❒ No	Autism
❒ Yes	❒ No	Seizures
❒ Yes	❒ No	Cerebral Palsy
❒ Yes	❒ No	Learning disabilities, type? ______________
❒ Yes	❒ No	Emotional disabilities, type? ______________
❒ Yes	❒ No	Speech difficulty, type? ______________

Please discuss any serious medical conditions the child has had ______________________________

____

Please list all drugs the child is currently taking ______________________________

____

Please list all allergies ______________________________

____

Child's Physician and address ______________________________

______________________________ Phone ______________

Is the child currently under the care of a physician? ❒ Yes ❒ No

Please describe the child's current physical health . . .

Good Fair Poor

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA the CDC, and the ADA.

11.

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.
I authorize the dental staff to perform the necessary dental services my child may need.

______________________________ ______________________________
Signature of Parent or Guardian Date Relationship to Patient

For Office Use Only

I verbally reviewed the medical/dental information above with the parent/guardian and patient named herein.

Initials__________ Date______________

Doctor's Comments ______________________________

____

____

____

Newport Pediatric Dentistry

Faith C. Drennon, DMD
15 Old Beach Road
Newport, Rhode Island 02840
Tel 401.849.4790 Fax 401.847.3020
www.newportpediatricdentistry.com

FINANCIAL POLICY

Thank you for choosing our office for your child's dental treatment. We are committed to their successful treatment! Please understand that *payment of your bill is considered a part of your child's treatment.*

- Please be aware that the parent bringing the child to Newport Pediatric Dentistry is *legally responsible for payment of all charges.* We cannot send statements to other persons.

- **Payment is expected in full for each appointment as services are rendered.** For the convenience of our patients, we accept cash, personal checks (which CANNOT be post-dated), MasterCard, VISA and AMEX.

DENTAL INSURANCE:
If we have received all of your insurance information on the day of the appointment, we will be happy to file your claim for you. You must be familiar with your insurance benefits, as we will collect from you the estimated amount insurance is not expected to pay. By law your insurance company is required to pay each claim within 30 days of receipt. We file insurance electronically, so your insurance company will receive each claim within days of the treatment. You are responsible for any balance on your account after 30 days, whether insurance has paid or not. If you have not paid your balance within 60 days your account will be turned over to a collection agency. We will be glad to send a refund to you if your insurance pays us.

PLEASE UNDERSTAND that we file dental insurance as a courtesy to our patients. We are not responsible for how your insurance company handles its claims or for what benefits they pay on a claim. We can only assist you in estimating your portion of the cost of treatment. We at no time guarantee what your insurance will or will not do with each claim. We also cannot be responsible for any errors in filing your insurance.

EMERGENCY TREATMENT:
All emergency treatment must be paid in full at the time the service is rendered.

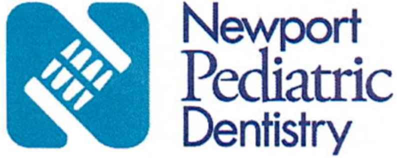
We recognize that under unusual circumstances an account balance may be incurred. Newport Pediatric Dentistry required that all outstanding balances *be paid in full within thirty (30) days* unless other arrangements have been made. Also note, if we have not received payment or you have not contacted us within thirty (30) days, further action may be taken. Thank you in advance for your understanding of our financial policy!

APPOINTMENT POLICY

- *We strive to see all patients on time* for their scheduled appointment. There are times when our schedule is delayed in order to accommodate an injured child or an emergency. Please accept our apology in advance should this occur during your appointment. We will do the exact same if your child is in need of emergency treatment.

- *Broken or missed appointments affect many people*. If two (2) broken/missed appointments occur or two (2) cancellations without 48-hour notice, our office reserves the right to NOT schedule any subsequent appointments and/or charge a $75.00 broken appointment fee. If a patient misses an appointment at Newport Hospital a $350.00 fee will be assessed. We require one week cancellation notice for appointments at Newport Hospital.

If at any time you have questions, please feel free to ask our staff or call our office. We are here to help in any way we can. We appreciate you entrusting your child's dental health to us. Thank you!



Faith C. Drennon, DMD
Board Certified Pediatric Dentist

15 Old Beach Road. Newport, Rhode Island * TELEPHONE: (401) 849.4790 FAX: (401) 847.3020

PATIENT NAME: ______________________________

DATE OF BIRTH: ______________________________

Privacy Practices (HIPAA)

By signing below I acknowledge that I was provided with Notice of Privacy Practices of Newport Pediatric Dentistry.

Please list any persons to whom your protected health information can be disclosed (e.g., spouse, parent, etc.).

This list should include your emergency contact person.

Name: ____________________ Relationship __________________ Phone number ___________________

Name: ____________________ Relationship __________________ Phone number ___________________

Name: ____________________ Relationship __________________ Phone number ___________________

Name: ____________________ Relationship __________________ Phone number ___________________

Signature:____________________________Date:________________Relationship:____________________

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(800) 243-4675

NOTICE OF PRIVACY PRACTICES

Effective Date: ______________________________

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 PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

CONTACT INFORMATION

For more information about our privacy practices, to discuss questions or concerns, or to get additional copies of this notice, please contact our Privacy Officer.

Title: Privacy Officer Telephone: (______) ______–____________ Fax: (______) ______–____________

Email: Address:

OUR LEGAL DUTY

We are required by law to protect the privacy of your protected health information ("medical information"). We are also required to send you this notice about our privacy practices, our legal duties, and your rights concerning your medical information.

We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect on the date set forth at the top of this page, and will remain in effect unless 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 any change in our privacy practices and the new terms of our notice applicable to all medical information we maintain, including medical information we created or received before we made the change.

We may amend the terms of this notice at any time. If we make a material change to our policy practices, we will provide to you the revised notice. Any revised notice will be effective for all health information that we maintain. The effective date of a revised notice will be noted. A copy of the current notice in effect will be available in our facility and on our website if applicable. You may request a copy of the current notice at any time.

We collect and maintain oral, written and electronic information to administer our business and to provide products, services and information of importance to our patients. We maintain physical, electronic and procedural security safeguards in the handling and maintenance of our patients' medical information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction or misuse.

USES AND DISCLOSURES OF YOUR MEDICAL INFORMATION

Treatment: We may disclose your medical information, without your prior approval, to another dentist, a physician or other health care provider working in our facility or otherwise providing you treatment for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, your health information may be disclosed to an oral surgeon to determine whether surgical intervention is needed.

Payment: We provide dental services. Your medical information may be used to seek payment from your insurance plan. For example, your insurance plan may request and receive information on dates that you received services at our facility in order to allow your employer to verify and process your insurance claim.

Health Care Operations: We may use and disclose your medical information, without your prior approval, for health care operations. Health care operations include:

- healthcare quality assessment and improvement activities;
- reviewing and evaluating dental care provider performance, qualifications and competence, health care training programs, provider accreditation, certification, licensing and credentialing activities;
- conducting or arranging for medical reviews, audits, and legal services, including fraud and abuse detection and prevention; and
- business planning, development, management, and general administration, including customer service, complaint resolutions and billing, de-identifying medical information, and creating limited data sets for health care operations, public health activities, and research.

We may disclose your medical information to another dental or medical provider or to your health plan subject to federal privacy protection laws, as long as the provider or plan has or had a relationship with you and the medical information is for that provider's or plan's health care quality assessment and improvement activities, competence and qualification evaluation and review activities, or fraud and abuse detection and prevention.

Your Authorization: You (or your legal personal representative) may give us written authorization to use your medical information or to disclose it to anyone for any purpose. Once you give us authorization to release your medical information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we will not use or disclose your medical information for any purpose other than those described in this notice. We will obtain your authorization prior to using your medical information for marketing, fundraising purposes or for commercial use. Once authorized, you may opt out of any of these communications.

Family, Friends, and Others Involved in Your Care or Payment for Care: We may disclose your medical information to a family member, friend or any other person you involve in your care or payment for your health care. We will disclose only the medical information that is relevant to the person's involvement.

We may use or disclose your name, location, and general condition to notify, or to assist an appropriate public or private agency to locate and notify, a person responsible for your care in appropriate situations, such as a medical emergency or during disaster relief efforts.

We will provide you with an opportunity to object to these disclosures, unless you are not present or are incapacitated or it is an emergency or disaster relief situation. In those situations, we will use our professional judgment to determine whether disclosing your medical information is in your best interest under the circumstances.

Health-Related Products and Services: We may use your medical information to communicate with you about health-related products, benefits, services, payment for those products and services, and treatment alternatives.

Reminders: We may use or disclose medical information to send you reminders about your dental care, such as appointment reminders.

Plan Sponsors: If your dental insurance coverage is through an employer's sponsored group dental plan, we may share summary health information with the plan sponsor.

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Public Health and Benefit Activities: We may use and disclose your medical information, without your permission, when required by law, and when authorized by law for the following kinds of public health and public benefit activities:

- for public health, including to report disease and vital statistics, child abuse, and adult abuse, neglect or domestic violence;
- to avert a serious and imminent threat to health or safety;
- for health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities, and fraud prevention agencies;
- for research;
- in response to court and administrative orders and other lawful process;
- to law enforcement officials with regard to crime victims and criminal activities;
- to coroners, medical examiners, funeral directors, and organ procurement organizations;
- to the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; and
- as authorized by state worker's compensation laws.

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Business Associates: We may disclose your medical information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Data Breach Notification Purposes: We may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your health information.

Additional Restrictions on Use and Disclosure: Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. "Highly confidential information" may include confidential information under Federal laws governing alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information:

1. HIV/AIDS;
2. Mental health;
3. Genetic tests;
4. Alcohol and drug abuse;
5. Sexually transmitted diseases and reproductive health information; and
6. Child or adult abuse or neglect, including sexual assault.

YOUR RIGHTS

Access: You have the right to examine and to receive a copy of your medical information, with limited exceptions. We will use the format you request unless we cannot practicably do so. You should submit your request in writing to our Privacy Officer.

We may charge you reasonable, cost-based fees for a copy of your medical information, for mailing the copy to you, and for preparing any summary or explanation of your medical information you request. Contact our Privacy Officer for information about our fees.

Disclosure Accounting: You have the right to a list of instances in which we disclose your medical information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities.

You should submit your request to our Privacy Officer. We will provide you with information about each accountable disclosure that we made during the period for which you request the accounting, except we are not obligated to account for a disclosure that occurred more than 6 years before the date of your request.

Amendment: You have the right to request that we amend your medical information. You should submit your request in writing to our Privacy Officer.

We may deny your request only for certain reasons. If we deny your request, we will provide you a written explanation. If we deny your request, you may have a statement of your disagreement added to your medical information. If we accept your request, we will make your amendment part of your medical information and use reasonable efforts to inform others of the amendment who we know may have and rely on the unamended information to your detriment, as well as persons you want to receive the amendment.

Restriction: You have the right to request that we restrict our use or disclosure of your medical information for treatment, payment or health care operations, or with family, friends or others you identify. Except in limited circumstances, we are not required to agree to your request. But if we do agree, we will abide by our agreement, except in a medical emergency or as required or authorized by law. You should submit your request to our Privacy Officer. Except as otherwise required by law, we must agree to a restriction request if:

1. except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and not for purposes of carrying out treatment); and

2. the medical information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full by the patient.

Confidential Communication: You have the right to request that we communicate with you about your medical information in confidence by means or to locations that you specify. You should submit your request in writing to our Privacy Officer.

Breach Notification: You have the right to receive notice of a breach of your unsecured medical information. Breach may be delayed or not provided if so required by a law enforcement official. You may request that notice be provided by electronic mail. If you are deceased and there is a breach of your medical information, the notice will be provided to your next of kin or personal representatives if we know the identity and address of such individual(s).

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. Please contact our Privacy Officer to obtain this notice in written form.

COMPLAINTS

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, about amending your medical information, about restricting our use or disclosure of your medical information, or about how we communicate with you about your medical information (including a breach notice communication), you may contact to our Privacy Officer.

You also may submit a written complaint to the Office for Civil Rights of the United States Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, Washington, D.C. 20201. You may contact the Office for Civil Rights' Hotline at 1-800-368-1019.

We support your right to the privacy of your medical 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.

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