Child's Medical History and HIPAA

Patient Name _____ Patient's Date of Birth _____

Custodial Parent/Guardian Name(s) _____

Approximate date of last dental visit _____

Any mouth habits (thumbsucking, grinding teeth, etc.) _____

Is Fluoride used in daily hygiene _____

Has the child complained of any dental problems _____

Any Orthodontic treatment _____

Please check "Yes" if your child has/had any of the following:

	Yes
Diabetes	o
Hepatitis	o
Allergies	o
Allergies to any drugs	o
Any heart conditions	o
Heart murmur	o
Rheumatic Fever	o
Prolonged bleeding	o

List any medications your child is taking _____

Name of Child's physician _____

Custodial Parent/Guardian Signature _____ Date _____

Under the Health Insurance Portability and Accountability Act (known as HIPAA), I recognize my child's right to privacy regarding health information. The information may be used to:

1. Obtain payment from insurance companies.
2. Consult with or refer to other healthcare providers regarding your child's treatment.
3. Execute required health care certifications and quality reviews by state agencies.

I recognize that I may restrict how my child's health information is disclosed in writing. With my signature below, I acknowledge that I can review the *Notice of Privacy Practices* which provides greater detail of the uses of my child's private health information.

I give permission to the office of Bruce Merry DDS to share medical information with a family member or friend who assists in my child's care, either financially or medically. (We will only give out necessary information to the following individuals as it pertains to your child's dental care.)

Custodial Parent/Guardian Signature _____ Date _____

I only want to release information to the following individual(s): _____

Child Registration

Patient Name _____ Patient's Date of Birth _____

Custodial Parent/Guardian Name(s) _____

Address _____ City _____

State _____ Zip _____ Home Phone # _(____)_____

Cell Phone # _(____)_____ Work Phone # _(____)_____

Responsible Party (Who is responsible for payment of child's dental services?)

o Custodial Parent o Other Parent o Other

Name of Responsible Party (if other than Custodial Parent/Guardian listed above) _____

Address (if different than child) _____

City _____ State _____ Zip _____

Responsible Party's (if different than child) Home Phone # _(____)_____

Cell Phone # _(____)_____ Work Phone # _(____)_____

Responsible Party's Employer _____

Dental Insurance Information

Note: Please be careful to submit a DENTAL insurance card, NOT your health/medical insurance card.
Also note, we CANNOT process your dental insurance without the following information:

Who is the Primary <u>Dental</u> Insurance Policyholder?

o Custodial Parent o Other Parent o Other

Policyholder's name (If other than Custodial Parent/Guardian) _____

Policyholder's Address (if different than child) _____

City _____ State _____ Zip _____

Policyholder's Employer _____ Work Phone # _(____)_____

Home Phone # _(____)_____ Cell Phone # _(____)_____

Policyholder's Birth Date _____/_____/_____ (very important!)

Dental Insurance Policy/Subscriber/Member ID # _____

If above ID # is unknown, please give Policyholder's SS # _____ (very important!)

Name of Dental Insurance company _____ Group/Plan # _____