Northampton Pediatric Dentistry PC

TELL US ABOUT YOUR CHILD

Child's Name:_____

Goes by:_____ Gender: _____

Siblings that we treat:_____

_____

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

Child's Home Address:_____

City:_____ State:_____ Zip:_____

PARENT'S INFORMATION

Name:_____

Mother Father Grandparent Other_____

Parent's Address:_____

City:_____ State:_____ Zip:_____

Cell #:(____)_____Home #:(____)_____

Employer:_____

Occupation:_____ Birthdate: ___/___/____

Email Address:_____

PARENT'S INFORMATION

Name:_____

Mother Father Grandparent Other_____

Parent's Address:_____

City:_____ State:_____ Zip:_____

Cell #:(____)_____Home #:(____)_____

Employer:_____

Occupation:_____ Birthdate: ___/___/____

Email Address:_____

PRIMARY DENTAL INSURANCE

Insurance Co Name:_____

Insurance Co. Address:_____

_____

Insurance Co Phone #: (_____)_____

Group #:_____Policy #:_____

Subscriber's Name:_____

Relationship to Patient:_____

Employer:_____

Subscriber's Birthdate: _____/_____/_____

Subscriber's SSN:_____-_____-_____

SECONDARY DENTAL INSURANCE

Insurance Co Name:_____

Insurance Co. Address:_____

_____

Insurance Co Phone #: (_____)_____

Group #:_____Policy #:_____

Subscriber's Name:_____

Relationship to Patient:_____

Employer:_____

Subscriber's Birthdate: ____/____/____

Subscriber's SSN:_____-_____-_____

The parent or guardian who brings the child to the appointment is responsible for payment on the day service is rendered, unless prior arrangements have been made.

Please initial_____

264 Elm Street, Suite 5, Northampton, MA 01060 | 413-584-7773
23 Pray Street, Amherst, MA 01002 | 413-835-0310
mail@npdma.com | www.npdma.com

DENTAL HISTORY

Is this your child's first visit to the dentist? *YES NO*

If not, how long since the last visit?_____

Previous dentist's name:_____

Were any x-rays taken at previous dental visits? *YES NO*

Have there been any injuries to the teeth, face or mouth?_____

If yes, please explain:_____

_____

_____

Does the child have any of the following habits?

YES NO Lip Sucking/ Biting *YES NO* Nail Biting

YES NO Nursing/Bottle Habits *YES NO* Thumb/Finger Sucking

Has the child ever had a serious or difficult problem with previous dental work? *YES NO*

If yes, please explain:_____

_____

_____

Is the child's water fluoridated? *YES NO*

Is the child taking fluoride supplements? *YES NO*

Please describe any family history of dental treatment:_____

_____

_____

Is your child wearing Orthodontic Braces? *YES NO*

PHARMACY INFORMATION

Pharmacy Name:_____

Pharmacy Address:_____

_____

HEALTH HISTORY

Has the child ever had any of the following conditions?

Y N ADHD	Y N Anxiety Disorder
Y N Asthma	Y N Autism Spectrum
Y N Bleeding Disorder	Y N Cancer
Y N Developmental Delays	Y N Diabetes
Y N Digestive Issues	Y N Epilepsy or Seizures
Y N Hearing Impairment	Y N Heart Condition
Y N Hepatitis	Y N History of Surgery
Y N HIV Positive/AIDS	Y N Respiratory Disorder
Y N Rheumatic Fever	Y N Sensory Disorder
Y N Vision Impairment	Y N Other

If yes to any of the above questions, please provide additional details:_____

_____

_____

_____

Does your child have any allergies to food or medication?

YES NO

If yes, please specify:_____

_____

Please list all medications, over the counter and herbal supplements taken by your child: _____

_____

_____

Child's Physician:_____

Phone #: (_____)_____

Parent/Guardian Signature:_____ Relationship: _____

Northampton Pediatric Dentistry

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 you 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 January 1, 2007, 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.

Person 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 you 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 $1.00 for each page, $25.00 per hour for staff time to 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 Janaury 1, 2007. 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 uses 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 Website 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: Karyn Hibbard, Office Manager, Northampton Pediatric Dentistry

Telephone: (413)584-7773 Fax: (413) 586-0684

E-mail: mail@npdma.com

Address: 264 Elm Street, Northampton, MA 01060

INFORMED CONSENT FOR PEDIATRIC DENTISTRY

It is your right, as a parent, to understand the risks, benefits, and alternatives of your child's dental treatment, and to accept or refuse treatment offered to your child. Please read this form carefully and ask about anything you do not understand.

EXAMINATION

Every child is a unique individual and thus not every child will require the same treatment to obtain a comprehensive oral examination. Based upon your child's age, teeth present, and tooth position, Dr. Marie Tremblay and Dr. Europa Yang and staff will determine if radiographs (x-rays) are necessary. In general, the examination appointment also includes cleaning of the teeth and application of topical fluoride. If you have any questions or concerns about our examination procedure, please ask one of our staff.

TREATMENT

If your child should need any dental treatment after the dental examination has been completed, Dr. Marie Tremblay and Dr. Europa Yang will review the planned treatment with you. Please read the following information regarding dental treatment at our office.

It is our policy that all treatment options are explained to the parent(s), including treatment alternatives, advantages, and disadvantages of each. Although good results are expected, it is not possible to guarantee success due to the possibility of complications.

Risks that are occasionally associated with dental treatment procedures include: numbness, swelling, bleeding, soreness, tooth discoloration, nausea, vomiting, hyperventilation, fainting, allergic reactions and infection.

If my child requires dental treatment, I will be advised of the benefits, risks, and possible side effects of proposed treatment, and possible consequences of not receiving the treatment. Treatment alternatives, including no treatment, will be presented to me and all of my questions regarding my child's care will be answered satisfactorily. With my signature I authorize Northampton Pediatric Dentistry, PC to perform a dental exam of my child and agreed upon treatment. I acknowledge that I have reviewed the possible risks and complications associated with dental treatment.

Patient Name:_____DOB:_____

Parent/Guardian Signature:_____Date:_____

Witness Signature:_____Date:_____

Email: _____

Northampton Pediatric Dentistry, PC

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient giving consent

Patient's Name: _____

Section B: To the Patient – Please read the following statements carefully.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice is available to you upon request. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to: Europa Yang, DMD and Marie Tremblay, DMD. Please understand that revocation of this Consent will not affect any action we took in reliance on the Consent before we received your revocation, and we may decline to treat you or to treat you or to continue treating you if you revoke this Consent.

Patient Representative's Name: (Please Print Name)

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Relationship to Patient: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse to Sign This Acknowledgement**

I, _____, have read a copy of this office's Notice of Privacy Practices. (Please Print Name)

Signature: _____ Date: _____