HAPPY
PEDIATRIC DENTISTRY

APPOINTMENT AUTHORIZATION

Should a parent or guardian not be able to accompany the patient to his/her appointment, please list all persons authorized to bring your child/children to their dental appointment at our office. At your child's appointment, a six month medical/dental update form will be required; therefore, the person bringing your child will be responsible for providing information about any medical changes, current medications and dental concerns.

If your child is coming on her/his own, arrangements to have a parent complete the six month medical/dental update form will have to be made prior to the appointment. The person accompanying your child will have to be 18 years old or older in order to complete the medical/dental update form.

Child/Children's name(s) _____
_____
_____
_____

Authorized Adults

1. _____ Relationship _____
2. _____ Relationship _____
3. _____ Relationship _____

Mother's Name _____ Contact Number _____
Father's Name _____ Contact Number _____

Signature _____ Date _____

Patient's name _____ **DOB** _____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

As per Texas and Federal HIPAA[1] Privacy Rule[2], we are required to maintain the privacy of your child's dental and health information. By signing this Authorization, you agree to the release of your Protected Health Information[3] as described in this Authorization. If you have questions about this Authorization, please contact the Privacy Official at Happy Pediatric Dentistry, PC. This information can and will be used either orally or in writing to:

- Provide and coordinate your child's treatment among a number of healthcare providers who may be involved in your treatment directly (internal staff such as the dentist, hygienists, dental assistants, and front office personnel), and indirectly (e.g. your medical provider, your orthodontist, dental lab, other dentists for consultation reasons). All of our internal staff have read and agreed to this policy.
- Obtain payment from third-party payers (e.g. your insurance carrier, non-custodial parent, or any other person listed by you as the financially responsible party) for your child's dental care services.
- Conduct normal healthcare operations such as quality assessments and improvement activities.
- Send appointment reminders to you by voicemail, postcards, texts, or emails.
- Provide school excuses with only the date and time of appointments, upon your request.
- Report abuse and neglect to appropriate authorities if we reasonably believe that your child is a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We would disclose your child's health information to the extent necessary to protect your child from a serious threat or for his/her safety or the health or safety of others.
- When otherwise required by Law.

Any other uses and disclosures will be made with your written authorization only.

Expiration of this Authorization: This Authorization will automatically expire one year after the date that I sign it unless I (the patient, parent or guardian) indicate an earlier date or event here: _____.

---

1 "HIPAA" stands for the Health Insurance Portability and Accountability Act of 1996.

2 The "Privacy Rule" refers to regulations issued by the U.S. Department of Health and Human Services pursuant to HIPAA and Texas Health & Safety Code 181.001.

3 "Protected Health Information" is information (i) about your physical or mental health or condition, health care, or the payment for the health care; (ii) that identifies you directly or indirectly *(i.e.*, there is a reasonable basis to believe that the information could be used to identify you); and (iii) that is maintained or transmitted by the Health Plan.

In addition, I request that the Dental Practice release my Protected Health Information to:

Organization name:	
Person name or title:	
Mailing address, email or fax:	
Phone number:	

When your Protected Health Information is released as provided in this Authorization, the recipient may not have a legal obligation to protect its confidentiality and may re-disclose it.

Your rights with respect to this Authorization:

- **It is completely your decision whether or not to sign this Authorization**. We cannot refuse to treat your child if you choose not to sign this Authorization.
- **You can revoke this authorization prior to the expiration** date by sending a note in writing to the Dental Practice to the address or email address indicated on this Authorization. The revocation will not have any effect, however, on actions taken in reliance of this Authorization prior to your revocation.
- **The right to request restrictions on certain uses and disclosures** of protected health information to any person identified by you. We are not required to agree to a requested restriction. However, if we agree to a restriction, we must abide by it unless you agree in writing to remove it.
- T**he 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 past 6 years. 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.
- **The right to inspect and obtain copies** of your health information, with limited exceptions. You may request that we provide the information in a format other than photocopies. We will use the format you request unless we cannot practically do so. You must make such request in writing.
- **The right to request that we amend your protected health information**. You must do so in writing by explaining why the information should be amended. We may deny your request under certain circumstances.
- **If you feel that your privacy protection has been violated**, you have the right to file written complaint with our office, or with the Department of Health and Human Services, office of Civil Rights, regarding violations of the provisions of this notice or the policies and procedures of this office. We will not retaliate against you for filling a complaint.

BY MY SIGNATURE BELOW, I CERTIFY THAT I HAVE READ AND UNDERSTAND THIS AUTHORIZATION. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY PROTECTED HEALTH INFORMATION AS DESCRIBED IN THIS AUTHORIZATION.

_____ _____

Signature of Parent or Guardian Date

_____

Printed name of Parent or Guardian

Welcome

HAPPY PEDIATRIC DENTISTRY

PATIENT HISTORY

Tell us about your child

Patient's name _____ **DOB** _____
Preferred name _____ SS# _____ Male _____ Female _____
Physical address _____
Hobbies _____ Grade _____
Home phone (____) _____ School _____School's phone_____

Father's information ___ Married ___ Single ___ Guardian ___ Step-father ___ Foster parent
Name _____ Driver's license # _____State _____
Phones *Home* (____) _____ *Cell* (____) _____ *Work* (____) _____
Email _____

Mother's information ___ Married ___ Single ___ Guardian ___ Step-mother ___ Foster parent
Name _____ Driver's license # _____State _____
Phones *Home* (____) _____ *Cell* (____) _____ *Work* (____) _____
Email _____

Who is accompanying the child? _____ Relation _____
Do you have legal custody of the child? ____ YES ____ NO

In case of emergency, please call *(besides parent or guardian):*
Name _____ Relation _____ Phone (____) _____

Person responsible for account ____ Father ____ Mother ____ Other (*complete section below*)
Name _____ *Relation* _____
Driver's license # _____ *State* _____ *Expires* _____
Home phone (____) _____ *Cell phone (____)* _____

Insurance Information *Policy #*_____ *Group #* _____
Policy holder ____ *Father* ____ *Mother* ____ *Other*
Name _____ *DOB* _____ *SS#* _____ *Relation* _____
Insured's employer _____ Employer's phone (____) _____
Insurance co. name _____ Insurance co. phone (____) _____
Employer's address _____
Insurance co. address _____

May we request the release of your child's medical records for our references? ___Y ___N

Who may we thank for referring you? *(Optional)*
Name _____ Phone (____) _____

I give **permission for the use of my child's picture** whether alone or with others (family members and friends) for (*check your preferences*):
____HPD Website ____Brochures ____ Electronic Media ____Internal Print ____W/1st Name

Please verify that your Dental policy will cover treatment before you come in for your appointment. We will do our best to verify your benefits as well, and to calculate your portion of the payment prior to your appointment, should there be any. Payment of your portion is due in full at the time services are rendered. We will submit and file claims with all insurances. You may be responsible for any remaining amounts not covered by your insurance after your claim has been processed.

Welcome

HAPPY PEDIATRIC DENTISTRY

Reason for today's visit

DENTAL HISTORY
Is this your child's first visit to the dentist? __Y __N

If not, who was the previous dentist?
_____

Date of last dental visit _____

Were X-Rays taken in previous visits? __Y __N

Has your child ever had…
Problems associated w/dental treatment? __Y __N

Pain in his/her mouth? ___Y ___N

Any trauma to his/her head/neck? ___Y ___N

Is child nervous about dental treatment?
___Y ___ N ___ Maybe

Does your child brush teeth daily? ___Y ___N

_____ **Child's name**

_____

DIET HISTORY
Do you assist in brushing? ___Y ___N

Does your child floss daily? ___Y ___N

Do you assist in flossing? ___Y ___N

Does/did your child:
Breast-feed? ___Y ___N Age when stopped _____
Bottle-feed? ___Y ___N Age when stopped _____
Snack more than twice a day? ___Y ___N

What does your child drink with meals?_____
What does your child drink between meals? _____
_____

Does child have dietary restrictions?___Y ___N
Does child have an eating disorder? ___Y ___N
Does child take fluoride supplements? ___Y ___N
Water: ___City ___Well ___Bottled
Brand of bottled water _____

MEDICAL HISTORY
Child'sPediatrician_____Pediatrician's ph. _____

Please check any of the following that your child had or presently has: ____*Check here if N/A*

____ ADD/ADHD	____ Emotional Impairment	____ Premature Birth
____ Allergies	____ Hearing Impairment	____ Physical Impairment
____ Arthritis	____ Heart murmur	____ Seizure Disorder
____ Artificial Joint/Valve	____ Hepatitis/Liver Disorder	____ Sickle Cell/Anemia Trait
____ Asthma	____ High Blood Pressure	____ Speech Impairment
____ Autism	____ HIV+/AIDS	____ Surgery
____ Bleeding Disorder	____ Hospitalization	____ Tuberculosis
____ Cancer	____ Kidney Disorder	____ Vision Impairment
____ Cerebral Palsy	____ Latex Sensitivity	____ Other _____
____ Congenital Heart Defect	____ Mental Impairment	_____
____ Diabetes	____ Pregnancy	Hospitalizations ____ Y ____ N

Please explain any of the above checked conditions or any serious medical conditions not listed:
_____

Medications that your child has had a reaction to _____

Medications that the child is currently taking _____

I understand that the preceding information represents my child's health history and that it will be held in the strictest of confidence. It is my responsibility to inform Happy Pediatric Dentistry, PC of any changes in my child's medical status.

_____ _____
Signature of parent/guardian Date

_____
Printed name of parent/guardian

FOR STAFF USE ONLY: I have verbally reviewed the medical/dental information above with the parent/guardian. _____ _____
Staff's Initials Date