ACQUAINTANCE FORM

Today's Date _____

Patient's Name _____ Circle One M F Nickname _____

Birthdate _____ Age _____ School _____ Grade _____

Patient's Brothers/Sisters and Ages _____

Patient's under age 10: favorite pet, friend or toy: _____

Father or Guardian's Name _____ Soc. Sec. No. _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

Name of Employment _____ Position _____ Years _____

Address of Employment _____

Work Phone _____ Extension _____

Insurance: Dental Care Yes _____ No _____ Group or Plan # _____

If Yes, Name of Insurance Co. _____ Father's Date of Birth _____

Address of Insurance Co. _____

Mother or Guardian's Name _____ Soc. Sec. No. _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

Name of Employment _____ Position _____ Years _____

Address of Employment _____

Work Phone _____ Extension _____

Insurance: Dental Care Yes _____ No _____ Group or Plan # _____

If Yes, Name of Insurance Co. _____ Mother's Date of Birth _____

If no telephone, please give a number where we can leave a message:

Name _____ Phone _____ Relationship _____

WHO REFERRED YOU TO OUR PRACTICE? _____

MEDICAL & DENTAL HISTORY

Physician _____ Last Visit _____

Address _____ Phone _____

Is your child taking any medication now? _____ What? _____

Has your child been hospitalized? _____ When? _____ Why? _____

_____

Does your child have any allergies? _____ What? _____

Has your child had any unusual reaction to any of these drugs?

YES	NO		YES	NO		YES	NO	
____	____	Tylenol	____	____	Penicillin	____	____	Codeine
____	____	Nitrous Oxide	____	____	Other Antibiotics	____	____	Local Dental Anesthesia
			____	____	Sulfa	____	____	Other _____

Has your child ever had any of the following conditions?

YES	NO		YES	NO		YES	NO	
____	____	Hepatitis	____	____	Tuberculosis	____	____	Autism
____	____	Heart Murmur	____	____	Epilepsy	____	____	ADD/ADHD
____	____	Heart Trouble	____	____	Pneumonia	____	____	Fragile X Syndrome
____	____	Rheumatic Fever	____	____	Arthritis	____	____	Mental Retardation
____	____	Liver Disease	____	____	Severe Infections	____	____	Downs Syndrome
____	____	Blood Pressure	____	____	Asthma	____	____	Tourette Syndrome
____	____	Anemia	____	____	Hemophilia	____	____	Hearing Impaired
____	____	Blood Transfusions	____	____	Aids	____	____	Other _____
____	____	Convulsions	____	____	Fainting			
____	____	Hyperactivity	____	____	Prolonged Bleeding			

Is your child adopted? ❑ Yes ❑ No

Does your child have any psychological or emotional problems that you feel should be brought to our attention?

_____

Has your child ever had experiences with other health professionals which have been unpleasant? _____

_____

Any other information which you consider important: _____

_____

1. Current Oral Conditions:
   - A. Does your child suck his/her thumb, fingers or blankets? _____
   - B. Has your child experienced any cold sores in or around his/her mouth? _____
   - C. Does your child have any speech problems? _____
   - D. Do you feel your child may have:
     1. Cavities? _____
     2. Gum disease? _____
     3. Crooked teeth (malocclusion)? _____
     4. Other _____
   - E. Do you desire complete dental care for your child? _____

     If not, with what specific problems would you like us to help? _____
2. Current Oral Habits:
   - A. Does your child receive fluoride in any of the following forms?

     Water _____ Toothpaste _____ Vitamin Drops _____ Tablets _____ Rinses _____ Other _____
   - B. Brushing:
     1. Toothbrush: soft _____ medium _____ hard _____ ; Frequency per day: _____
     2. Do you assist your child? _____ ; How Often? _____
     3. Does your child floss? _____ ; How Often? _____
   - C. Snack food? Please list _____
   - D. Has your child ever taken a bottle to bed? _____ Contents? _____
3. Previous Dental Experience: (If 1st visit to any dentist please check ❑) _____
   - A. Name of last dentist _____
   - B. Date of last visit _____ Was treatment completed? _____
   - C. Was the experience pleasant? _____
   - D. Were x-rays taken? _____ Date _____ Number _____
   - E. Has your child seen an orthodontist? _____
   - F. Has anyone in your family had orthodontic treatment? _____

METHOD OF TODAY'S PAYMENT

Please circle one: Cash Check - Driver's License Number _____ Visa/Mastercard/Discover

Form completed by _____

Relationship to Patient _____ Date _____

- I authorize release of information relating to a claim from Kids Dental Kare
- I understand that I am responsible for all costs of dental treatment.
- I hereby authorize payment directly to Dr. Jay Felsenstein from my group insurance benefits if applicable.
- I have received a copy of the office's Notice of Privacy Practices to read.

Signature _____

PATIENT PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW DENTAL AND MEDICAL INFORMATION ABOUT YOU AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your child's dental care as a patient at KIDS DENTAL KARE we may use or disclose personal and health related information about you in the following ways:

*Your child's personal dental health information, including of your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
*Your child's dental health records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.
*Your name, address, phone number, and your child's dental health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message will be left on your answering machine, and we will contact you via mail. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provide to you or the reimbursement avenues associated with your child's dental care.

Under federal law, we are also permitted or required to use or disclose your child's following circumstances:

*** If we are providing dental health care services to your child based on the orders of another dental health provider.**
***If we provide dental health care services to you in an emergency.**
***If there are substantial barriers to communicating with you, but in Professional judgment we believe that you intend for us to Provide care.**
***If we are ordered by the courts or another appropriate agency.**

Any use or disclosure of your child's protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your child's dental health to you in person at the same time you receive dental care for your child from us. We may also mail information regarding your child's dental health care or about the status of your account. If you would like to receive the information at an address other than your home, or if you would like any other information in a different form, all requests **must be in writing.**

You have the right to inspect and/or copy your child's dental health information for seven years from the date that record was created. This request **must be in writing.**

We are further required by the state and federal law to maintain the privacy of your child's patient file and the heath protected health information therein. We are also required to provide you with the notice of our privacy practices with respect to your child's dental health information.

We are further required by state and federal law to maintain the privacy of your child's patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your child's dental health information in our files,

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to:
Dr. Jay Felsenstein

This notice is effective January 1, 2008. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature on the **acquaintance form** acknowledges that I have read this notice.