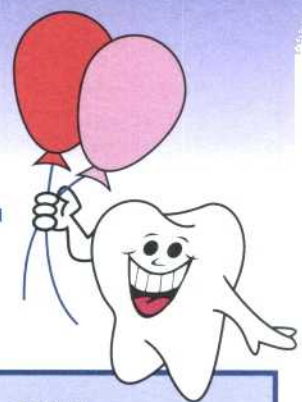


# Welcome!

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.



## PATIENT INFORMATION

Date \_\_\_\_\_ Name of Minor/Child \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Last Name First Name MI  
 Account # \_\_\_\_\_ Nickname \_\_\_\_\_ Sex M \_\_\_ F \_\_\_  
 Home Address \_\_\_\_\_  
 Street City State Zip  
 Mailing Address (if different) \_\_\_\_\_  
 Street City State Zip  
 Person financially responsible \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phne (\_\_\_\_) \_\_\_\_\_  
 Whom may we thank for referring you? \_\_\_\_\_  
 Has any other member been seen here? \_\_\_\_\_

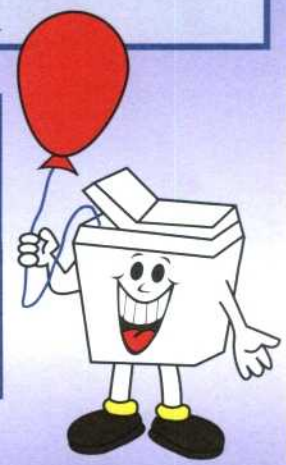
## INSURANCE

Father's/Guardian's Name _____ Address (if different from patient's) _____ Home Phone (____) _____ Work Phone (____) _____ <small>if different from above if different from above</small> Email _____ Cell (____) _____ Employer _____ Soc. Sec. # _____ - _____ - _____ Birthdate ____/____/____ Do you have dental insurance coverage for minor/child? <input type="checkbox"/> Yes <input type="checkbox"/> No Plan Name _____ Phone (____) _____ Address _____ Group # _____ Policy# _____ Is your child eligible for treatment under Medical Assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Please provide information about any additional dental coverage:</b> _____	Mother's/Guardian's Name _____ Address (if different from patient's) _____ Home Phone (____) _____ Work Phone (____) _____ <small>if different from above if different from above</small> Email _____ Cell (____) _____ Employer _____ Soc. Sec. # _____ - _____ - _____ Birthdate ____/____/____ Do you have dental insurance coverage for minor/child? <input type="checkbox"/> Yes <input type="checkbox"/> No Plan Name _____ Phone (____) _____ Address _____ Group # _____ Policy# _____ Child's Medical Assistance I.D. # _____
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## DENTAL HISTORY

Date of last visit to a dentist \_\_\_\_\_ For what service? \_\_\_\_\_

Has child complained about dental problems? .....	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Is fluoride taken in any form? .....	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Does child brush daily? .....	<input type="checkbox"/>	<input type="checkbox"/>	Any injuries to mouth, teeth head? .....	<input type="checkbox"/>	<input type="checkbox"/>
Does child use floss every day? .....	<input type="checkbox"/>	<input type="checkbox"/>	Any unhappy dental experiences? .....	<input type="checkbox"/>	<input type="checkbox"/>
Any mouth habits - thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc? .....	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>



Please Complete Both Sides

# MEDICAL HISTORY

Minor/Child's Physician \_\_\_\_\_ City/State \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Date of last physical examination \_\_\_\_\_ Results \_\_\_\_\_

Is Minor/Child under care of physician now? .....  YES  NO Medications \_\_\_\_\_

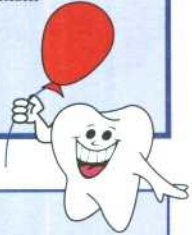
Receiving any medication or drugs? .....   \_\_\_\_\_

Ever been hospitalized? .....   Allergies \_\_\_\_\_

Is there excessive bleeding when cut? .....   \_\_\_\_\_

Has minor/child had any history of or difficulty with any of the following? If yes, please check (✓).

- |  |   |  |   |  |                                   |
|--|---|--|---|--|-----------------------------------|
| <input type="checkbox"/> A.I.D.S./H.I.V. | <input type="checkbox"/> Cerebral Palsy     | <input type="checkbox"/> Epilepsy        | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> A.D.H.D. |
| <input type="checkbox"/> Anemia          | <input type="checkbox"/> Chicken Pox        | <input type="checkbox"/> Fainting        | <input type="checkbox"/> Liver Disease  | <input type="checkbox"/> Sinus Problems  | <input type="checkbox"/> Autism   |
| <input type="checkbox"/> Asthma          | <input type="checkbox"/> Convulsions        | <input type="checkbox"/> Hearing Problem | <input type="checkbox"/> Measles        | <input type="checkbox"/> Thyroid Disease |                                   |
| <input type="checkbox"/> Bladder Problem | <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Heart Problems  | <input type="checkbox"/> Mononucleosis  | <input type="checkbox"/> Tuberculosis    |                                   |
| <input type="checkbox"/> Cancer          | <input type="checkbox"/> Drug/Alcohol Abuse | <input type="checkbox"/> Hepatitis       | <input type="checkbox"/> Mumps          | <input type="checkbox"/> Other           |                                   |



## EMERGENCY CONTACT

In the event of an emergency, whom should we contact?

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

## AUTHORIZATIONS

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

### Minor/Child Consent

I am the parent, guardian, or personal representative of \_\_\_\_\_ and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

### Insurance Assignment and Release

I certify that my dependent(s) is covered by insurance with \_\_\_\_\_ and assign directly to **Inland Dental Center** all insurance benefits, if any, otherwise payable to me for services of my signature on all insurance submissions.

The above-name doctor may use my minor/child's health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for released services. This consent will end when the current treatment plan is complete or one year from the date signed below.

\_\_\_\_\_  
Signature of Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print name of Parent, Guardian or Personal Representative

\_\_\_\_\_  
Relationship to Patient

## UPDATE

### TO BE COMPLETED AT A LATER VISIT

Has there been any change in patient's health since last dental appointment?  Yes  No

If yes, please describe: \_\_\_\_\_

Is patient taking any medications? Yes No

If yes, please list: \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Dentist \_\_\_\_\_ Date \_\_\_\_\_

## UPDATE

### TO BE COMPLETED AT A LATER VISIT

Has there been any change in patient's health since last dental appointment?  Yes  No

If yes, please describe: \_\_\_\_\_

Is patient taking any medications? Yes No

If yes, please list: \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Dentist \_\_\_\_\_ Date \_\_\_\_\_



# NOTICE of PRIVACY PRACTICES



6982 Boulder Avenue  
Highland, CA 92346  
(909) 862-2121  
Fax (909) 862-6648

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**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.**

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## **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 your 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 4/15/03 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.

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## **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:** Our dental facility employs an open system of delivering dental care. We will make every reasonable attempt to avoid accidental disclosure of your protected health information. Should you have any concerns, please advise us and we will attempt to accommodate you.

We may use or disclose, as needed, your protected health information in order to support our business activities.

For example, we may use a sign-in sheet at the reception desk where you will be asked to sign in. We may call you by name in the reception room when the doctor is ready to see you and he may have a copy of that day's schedule with your name on it in his operatory. We may use or disclose your protected health information, as needed, to contact you by phone or mail to confirm your dental appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g. billing, etc.) for the practice.

Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to send you a newsletter or information regarding other services we might offer. We may also send you information about products or services we feel might be beneficial to you. You may contact our Privacy Officer to request that these materials not be sent to you.

**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 reasons 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.

**Persons 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 your 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 by 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.

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## 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 practically 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 \$5.00 without x-rays and \$10.00 if x-rays are requested. 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 April 14, 2003. 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 use 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 Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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## 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.

Contact Officer: Sharon R. Bailon

Telephone: (909) 862-2121, Fax (909) 862-6648

Address: 6982 Boulder Avenue, Highland, CA 92346



6982 Boulder Avenue  
 Highland, CA 92346  
 (909) 862-2121  
 Fax (909) 862-6648

## CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

### SECTION A: PATIENT GIVING CONSENT

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Telephone: \_\_\_\_\_  
 Patient #: \_\_\_\_\_ Social Security #: \_\_\_\_\_

### 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, 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 accompanies this Consent. 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.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Sharon R. Bailon  
 Telephone: (909) 862-2121 Fax: (909) 862-6648

**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 the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

### SIGNATURE

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 healthcare operations.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

Personal Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.  
 Include completed Consent in the patient's chart.**

### REVOCAION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

