

Today's Date _____

Welcome to our Practice!

We strive to make each of your child's visits pleasant and comfortable.
Our goal is to teach your child oral habits, which will help, keep their smile beautiful for their lifetime.

Your Child

Child's Name _____

Nickname _____ Sex _____

E-mail _____

Birthdate _____ Age _____

Social Security No. _____

School _____ Grade _____

Child's home address _____

City, State, Zip _____

Phone _____

Mother Stepmother Guardian
Name _____

Cell Phone _____

Home Phone _____

Work Phone _____

Social Security No. _____

Employer _____

Occupation _____

Father Stepfather Guardian
Name _____

Cell Phone _____

Home Phone _____

Work Phone _____

Social Security No. _____

Employer _____

Occupation _____

Responsible Party

Name _____

Home Phone _____

Work Phone _____

Primary Dental Insurance

Insurer's Name _____

Relationship _____

Birthdate _____

Social Security No. _____

Employer _____

Insurance Company _____

Group No. _____

Employee No. _____

Ins. Co. Address _____

Parent's Marital Status

Single Married Divorced Widowed Separated

CHILD'S HEALTH HISTORY

Your child's overall health, as well as any medications which your child takes, could have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely.

Health History

Has your child had any difficulty with previous visits? yes no

Comments:

Has your child ever had any of the following:

Asthma	yes	no
Cancer/Hepatitis	yes	no
HIV/AIDS	yes	no
Hemophilia	yes	no
Diabetes	yes	no
Allergies/Sinus	yes	no
Congenital Heart Defect	yes	no
Handicapped/Disabilities	yes	no
Convulsions/Epilepsy	yes	no
Tuberculosis	yes	no
Psychiatric/Psychological Care	yes	no
Attention Deficit	yes	no
Chemical Dependency	yes	no
Abnormal Bleeding	yes	no
Heart Murmur	yes	no
Type:		
Rheumatic Fever	yes	no
Surgery	yes	no

Child's Habits

How often does your child brush?

How often does your child floss?

Date of last dental visit:

Previous Dentists:

Child's Physician:

Physician's Phone Number:

Child's Birthdate:

Is your child's water fluoridated? yes no don't know

Does your child take fluoride supplements? yes no

Does your child:

Suck thumb/finger	yes	no
Suck/bite lip	yes	no
Bite/chew nails	yes	no
Chew hard objects (pencils, etc.)	yes	no
Grind teeth	yes	no
Clench jaws	yes	no

Please explain any medical problems that you child has:

<u>Doctor's Review</u>	
Date	Signed Dr.

.....

I understand the above information is necessary to provide my dependent with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my dependents health or medication.

Parent/Guardian Signature _____

AUTHORIZATION FOR SUBMISSION OF CLAIMS AND ASSIGNMENT OF BENEFITS

I authorize Eustis Lakeside Dental to submit claims for payment for services to the insurance companies of my behalf and assign to him the group insurance benefits otherwise payable to me. I understand that I am responsible for any charges not covered by my insurance benefits.

Parent/Guardian Signature _____

CONSENT FOR TREATMENT

- I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of _____'s dental needs.
(Name of Patient)
- Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
- I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
- Lastly, I agree to be responsible for payment of all services rendered on behalf of my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-½ % late charge (18% APR) may be added to my account.

Parent/Guardian Signature _____ Date _____ Relationship to Patient _____



Summer B. Young, D.M.D. & Wade G. Winker, D.D.S.

15 West Atwater Avenue, Eustis, FL 32726

(352) 357-2564

eustislakesidedental.com

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 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 March 12, 2003, 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 on 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.

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, 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 for each page, \$1 per hour for staff time to locate and 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 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 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, 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 Officers: Eustis Lakeside Dental - Summer B. Young, D.M.D. and Wade G. Winker, D.D.S.

Telephone: (352) 557 - 2564

Address: 15 W. Atwater Avenue, Eustis, FL 32726



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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign this Acknowledgment

I _____, have received a copy of this office's Notice of Privacy Practices.

Please Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Other (Please Specify)

