

# Pediatric Dentistry of Winchester

Donna Meek, DMD

## Registration Information (please print)

**Child's Name:** \_\_\_\_\_

First Middle Last Prefers

DOB: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ SSN#: \_\_\_/\_\_\_/\_\_\_ Male Female

**Father's Name:** \_\_\_\_\_

First Middle Last

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

DOB: \_\_\_/\_\_\_/\_\_\_ SSN#: \_\_\_/\_\_\_/\_\_\_

Father's Employer: \_\_\_\_\_

Employer Addresses: \_\_\_\_\_

Father's Occupation: \_\_\_\_\_

**Mother's Name:** \_\_\_\_\_

First Middle Last

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

DOB: \_\_\_/\_\_\_/\_\_\_ SSN#: \_\_\_/\_\_\_/\_\_\_

Mother's Employer: \_\_\_\_\_

Employer Addresses: \_\_\_\_\_

Mother's Occupation: \_\_\_\_\_

**EMERGENCY CONTACT** (Please specify someone **NOT** living in your household)

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

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

**Dental Insurance Company:** \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Group Name: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

DOB: \_\_\_/\_\_\_/\_\_\_ SSN#: \_\_\_/\_\_\_/\_\_\_

Insured's Employer: \_\_\_\_\_

**Referral:** \_\_\_\_\_

How did you hear about our office?

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# MEDICAL HISTORY

Donna Meek, DMD

Child's Name: \_\_\_\_\_

Child's Physician: \_\_\_\_\_ Physician Address: \_\_\_\_\_

Physician's Phone: \_\_\_\_\_

Is your child in good physical health? \_\_\_\_YES \_\_\_\_NO

Are all immunizations up to date? \_\_\_\_YES \_\_\_\_NO

**Please check YES or NO to each of the following items regarding your child's health:**

	YES	NO		YES	NO		YES	NO
ADHD	___	___	Allergies	___	___	Asthma	___	___
Bleeding Problems	___	___	Cancer	___	___	Cerebral Palsy	___	___
Diabetes	___	___	Hearing Problems	___	___	Heart Murmur	___	___
Heart Problems	___	___	Hepatitis	___	___	HIV/AIDS	___	___
Kidney Problems	___	___	Learning Disability	___	___	Latex Allergy	___	___
Liver Problems	___	___	Lung Problems	___	___	Pregnancy	___	___
Seizures	___	___	Sight Problems	___	___	Tuberculosis	___	___

Please describe these or any other medical conditions we should be aware of \_\_\_\_\_

\_\_\_\_\_

Please list all medications your child is presently taking: \_\_\_\_\_

\_\_\_\_\_

Is your child allergic to any medication?  YES  NO; If Yes, please list: \_\_\_\_\_

### DENTAL HISTORY

Reason for today's visit: \_\_\_\_\_

Has your child ever seen a dentist?  YES  NO

Child's previous/referring dentist: \_\_\_\_\_

Date of last dental visit: \_\_\_\_\_ Were x-rays taken?  YES  NO

Date of last dental cleaning: \_\_\_\_\_

Has your child had any unpleasant dental experience?  YES  NO

If yes, explain: \_\_\_\_\_

Does your child have any mouth habits?  Thumb or Finger Sucking  Pacifier

Does your child use a bottle or nurse?  YES  NO At what age discontinued? \_\_\_\_\_

Does your child take a bottle or sippy cup at bedtime or for naps?  YES  NO

Has your child ever had trauma to his/her teeth?  YES  NO

***I understand that the information I have given is true and correct to the best of my knowledge, and it will be held in the strictest of confidence. I also understand that it is my responsibility to inform this office of any changes in my child's medical status.***

Parent or Guardian's Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

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**PEDIATRIC DENTISTRY OF WINCHESTER**

**CONSENT FOR DENTAL TREATMENT**

Patient Name: \_\_\_\_\_

I give my permission for my child to receive any and all dental treatment from the doctors and staff at Pediatric Dentistry of Winchester.

It is our goal to provide safe and comfortable dental treatment for our patients. In order to achieve this goal, the following methods have been chosen by Dr. Meek and you (with this consent form) in providing dental treatment for your child.

**Nitrous Oxide**—otherwise known as “laughing gas” or “happy air” is used to relax a child during treatment. The child remains awake at all times. The gas is blown off 100% after treatment and has no lingering side effects.

**Local Anesthesia**—Medication we call “sleepy juice” which is administered with the use of a “shot” to “numb” the tooth to prevent discomfort during dental treatment. We do NOT like to use the word “shot” to describe this procedure to the child.

**Mouth Prop**—a device we call a “tooth pillow” which is used to help your child keep their mouth open wide during treatment and prevent him/her from accidentally biting down on sharp instruments.

**Rubber Dam**—otherwise known as a “raincoat” which is used to protect a child’s airway during dental treatment. It isolates the teeth that are being worked on and prevents debris and water from going into the child’s throat.

**Child without Parent in the Room during Treatment**—it is our goal to gain the trust of each child and to provide dental treatment efficiently and safely. It is therefore an office policy that all children have their dental work done without their parents present in the room. By minimizing distractions, we can ensure a positive dental experience for your child. **PARENTS MAY ACCOMPANY THEIR CHILDREN TO THE TREATMENT ROOM ON THEIR FIRST VISIT.**

I understand that the proposed treatment plan may change during any given dental visit, and that additional treatment or different treatment may be necessary and may be performed.

**Medical Emergencies and Medical Issues**—with dental treatment, there are always risks for medical emergencies. The most common dental emergency includes minor allergic reactions (such as a rash) to local anesthesia or latex. More severe allergic reactions can also occur where a child has trouble breathing. This office is equipped to handle most medical emergencies that may arise during dental treatment.

**In order to treat each of our patients in a timely manner, we reserve the right to reschedule your appointment should you show up late. I understand all of the items on this consent form and have had ample opportunity to ask any questions I may have. I therefore consent for dental treatment for my child to be performed by Dr. Meek or any other member of the dental team at Pediatric Dentistry of Winchester.**

\_\_\_\_\_ I am: mother father or legal guardian  
Signature Printed Name (circle relationship to patient)

Reviewed by staff member: \_\_\_\_\_

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## PRIVACY POLICY—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 is effective 10/21/08, 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 for 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 healthcare 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. We will be taking a photo of each patient for in-office use only. When addressing the patient we will announce both first and last name in the waiting room.

**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 discloses 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 the Notice. We may disclose your health information to a family member, friend or other person to extent necessary to help with 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 for lawful intelligence, counter intelligence, 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, and \$50.00 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 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 prior to October 21, 2008. If you request this accounting for more than 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 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 US Department of Health and Human Services. We will provide you with the address to file your complaint with the US 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 US Department of Health and Human Services.

### **Contact Officer:**

Donna Meek, DMD

2560 Bypass Rd. Suite #2

Winchester, KY 40391

Telephone: (859)737-1000

**PEDIATRIC DENTISTRY OF WINCHESTER**

**Donna Meek, DMD**

**2560 Bypass Rd. Suite # 2.**

**Winchester, KY 40391**

**(859) 737-1000**

**AUTHORIZATION FOR SIGNATURE ON FILE**

I, \_\_\_\_\_ hereby authorize the office of **Pediatric Dentistry of Winchester (Donna Meek, DMD)** to affix my name to any and all claims or documents as to any and all health benefits due me and my dependents through my employment with \_\_\_\_\_. I hereby authorize payment of dental benefits otherwise payable to me, directly to the office of **Pediatric Dentistry of Winchester**. This "Signature on File" will be valid from this date and shall expire in one year. A photocopy of this document may act as an original.

**CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION**

I, being the parent or guardian of \_\_\_\_\_ understand by signing this form. I will consent to your use and disclosure of my child's protected health information to carry out treatment, payment activities and healthcare operations. Your office will continue to use his/her health information in some of these ways: by calling them by first and last name from your waiting room, by posting pictures, by mailing reminder appointment cards with reason for visit, by reminding patients needing a pre-medication on reminder cards or confirmation calls, by calling to confirm appointments and internal audits of patient charts for practice evaluation purposes as described in our Notice of Privacy Practices. You have the right to request alternative means of delivery.

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

**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES**

I, \_\_\_\_\_, have received a copy or been given an opportunity to review this office's Notice of Privacy Practices on this date \_\_\_\_\_.

\_\_\_\_\_ Staff Use Only \_\_\_\_\_

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

\_\_\_\_\_ Individual refused to sign this acknowledgement.                      Date: \_\_\_\_\_

\_\_\_\_\_ Communication barriers prohibited obtaining acknowledgement.

\_\_\_\_\_ Emergency situation prevented us from obtaining acknowledgement.

\_\_\_\_\_ Other

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**CONSENT FOR INTERNET COMMUNICATIONS**

**Patient Name:** \_\_\_\_\_

Last,

First

MI

**E-Mail Address:** \_\_\_\_\_

I grant my permission to Pediatric Dentistry of Winchester to upload and store confidential patient information—including account information, appointment information and clinical information—to the secured web site for Pediatric Dentistry of Winchester. I understand Pediatric Dentistry of Winchester and I are dually responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that Pediatric Dentistry of Winchester is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand Pediatric Dentistry of Winchester is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to agree to immediately notify Pediatric Dentistry of Winchester of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns. I also understand State and Federal law, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit times during the terms of the Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my patient information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that Pediatric Dentistry of Winchester has the right to monitor, retrieve, store, upload and use my patient information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand Pediatric Dentistry of Winchester will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand Pediatric Dentistry of Winchester CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

I have read the information above regarding the secured uploading of patient information to the web site for Pediatric Dentistry of Winchester, and grant Pediatric Dentistry of Winchester permission to securely upload my patient information to the web site.

\_\_\_\_\_ I do not have an E-Mail address at this time.

\_\_\_\_\_  
Signature of parent or guardian

\_\_\_\_\_  
Date

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