



Dr. Jane Bennett, DDS • Pediatric Dentist

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Patient Information, Office and Privacy Policies, Medical/Dental History Questionnaire, and Consent Forms

To provide the safest and most comprehensive dental care for your child, we ask for your cooperation in completing our detailed questionnaire.

Date: _____ Child's Name: _____

Nickname/Preferred Name : _____ Birth date: Mo: _____ Day: _____ Year: _____
Last First MI

Age: _____ SSN: _____ Gender (M/F): _____ Home Phone: _____

Address: _____ Apt No.: _____

City: _____ State: _____ Zip: _____ Primary Language Spoken: _____

Child Primarily Lives With: _____

Is your child presently under the care of a physician for any reason? Yes No

Explain: _____

Physician's Name: _____ Date of last exam: _____

Physician's Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____

Is your child taking any medications? Yes No

List: _____

Has your child ever been hospitalized, sedated, or had surgery? Yes No

Explain: _____

Does your child have any allergies to medicines, latex, foods, or metals? Yes No

List: _____

Are antibiotics necessary for dental work because of a heart murmur, defect, prosthesis, shunt, organ transplant or other medical reasons? Yes No

Explain: _____

Has any member of the family, including your child, had a problem with sedation or general anesthesia?

Yes No

Explain: _____

Are your child's immunizations up to date? Yes No

Medical History

If your child has or ever had any of the following conditions please check yes below.
Please explain any yes's to the Doctor.

Condition		Condition		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	ADD/ADHD—Attention Deficit Disorder/ Attention Hyperactivity Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing Impairment
<input type="checkbox"/> Yes	<input type="checkbox"/> No	AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Autism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Behavioral Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis/Liver Disease
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Birth defects	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bleeding gums	<input type="checkbox"/> Yes <input type="checkbox"/> No	Injury to Front Teeth
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Blood Transfusions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bone or Joint Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mentally Handicapped
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Brain Injury	<input type="checkbox"/> Yes <input type="checkbox"/> No	Metallic Implant, Shunts, Pins/Rods
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cerebral Palsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Premature Birth
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cancer/Tumor	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prolonged bleeding When Cut
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Chemotherapy/Radiation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell Disease
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Child Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sore Throats
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cleft Palate/Lip	<input type="checkbox"/> Yes <input type="checkbox"/> No	Speech Impairment
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cold Sore/Canker Sores	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Developmentally Delayed Age level is ___	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Earaches/Ear Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No	Transplants, Organ Specify

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Epilepsy/Seizure Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Eye Conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other Please Specify

Is there any other health information that should be known? Yes No

Explain: _____

Staff Medical History Review (for internal use only)			
Signed: _____	Date: _____	Signed: _____	Date: _____
Signed: _____	Date: _____	Signed: _____	Date: _____
Signed: _____	Date: _____	Signed: _____	Date: _____
Signed: _____	Date: _____	Signed: _____	Date: _____
Signed: _____	Date: _____	Signed: _____	Date: _____

Dental History

Is this your child's first dental visit? Yes No

Previous Dentist: _____ Date of Last Visit: _____

Date of Last X-rays: _____

Has your child experienced any unfavorable reaction from previous dental or medical care? Yes No

Explain: _____

How often does your child brush? _____

Is tooth brushing supervised? Yes No

Is dental floss used? Yes No

Does your child receive (check all that apply):

Fluoride in vitamins Bottled water Fluoridated water Fluoride tablets/drops Well water

Has there been any injuries to your child's teeth or jaws? Yes No

Explain : _____

History of (check all that apply):

Breast feeding Thumb sucking Bottle habits Pacifier Sippy cup Teeth grinding/clinching

How do you think your child will act toward the dentist?

Explain: _____

Has your child had recent dental pain? Yes No

Explain: _____

Does your child have a specific dental problem that needs attention? Yes No

Explain: _____

How Did You Hear About Us?

Family Friend Doctor Other: _____

Referrer's Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Primary Responsible Party Information

Resident Parent's Name: _____
Last First MI Gender (M/F): _____

Marital Status: _____ SS#: _____ Birth Date: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Email: _____ Cell Phone: _____

Home Phone: _____ Work Phone: _____ Ext: _____

Secondary Responsible Party Information

Secondary Name: _____
Last First MI Gender (M/F): _____

Marital Status: _____ SS#: _____ Birth Date: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Email: _____ Cell Phone: _____

Home Phone: _____ Work Phone: _____ Ext: _____

Primary Dental Insurance

Insured's Name: _____
Last First MI

Insurance Company Group Plan: _____

Employer: _____

Insurance Company Address: _____

City: _____ State: _____ Zip: Code: _____

Insurance Company's Phone #: _____

Group #: _____ Local Group #: _____

Secondary Dental Insurance

Insured's Name: _____
Last First MI

Insurance Company Group Plan: _____

Employer: _____

Insurance Company Address: _____

City: _____ State: _____ Zip: Code: _____

Insurance Company's Phone #: _____

Group #: _____ Local Group #: _____

Emergency Contact Information

Name: _____

Relationship to child: _____

Address: _____

City: _____ State: _____ Zip: Code: _____

Phone: _____ Cell Phone: _____ Work Phone: _____

Treatment Consent

The permission of a parent or legal guardian is necessary for dental treatment of a minor.

As a minor child, it is necessary that signed permission be obtained from a parent or legal guardian before any dental care can begin. As a parent or legal guardian of the above patient, I acknowledge that the above information is correct and grant Papillion Pediatric Dentistry permission to provide my child's dental and related medical/surgical treatment as deemed necessary, including digital radiographs (x-rays), diagnostic, restorative, oral surgery, and patient management techniques that are reasonable, necessary and advisable. Protective restraints are used when a child might harm themselves or when certain procedures may jeopardize their health and welfare without such restraints. I also authorize the administration of anesthetics or analgesics that are advisable by Dr. Bennett, such as nitrous oxide (laughing gas).

I have given an accurate report of this patient's physical and mental health history. I have also reported any prior allergic or unusual reactions to medications, latex, foods, or metals, and any other disease or condition, including pregnancy.

I agree to inform Dr. Bennett and the staff of Papillion Pediatric Dentistry of any changes in the medical history. This authorization is valid until revoked by me in writing.

Signature

Relationship to Child

Date

Financial Consent

The Financial responsibility of a parent or legal guardian is necessary for dental treatment of a minor.

I accept financial responsibility for this child.

I authorize the release of any dental information necessary to process this claim and all future claims.

I authorize insurance payments directly to Dr. Jane Bennett/Papillion Pediatric Dentistry.

I will be responsible for reporting any changes in my child's dental insurance coverage,

I will be responsible for any late fees due on my account.

I agree to inform Dr. Bennett and the staff of Papillion Pediatric Dentistry of any changes in the Financial arrangements prior to treatment. This authorization is valid until revoked by me in writing.

Signature

Relationship to Child

Date

Office Policies

No-show Policy

Missed appointments without 24 hour prior notification are considered 'NO SHOW' appointments and will result in a \$55.00 fee. This fee must be paid before being scheduled again.

Missed Appointments

After **THREE** 'No Show' appointments (missed appointments without 24 hour prior notification) you will be dismissed from our practice.

Late Arrivals

Late arrival for a scheduled appointment leads to inadequate time to accommodate the remaining patients on the schedule. As such, late arrivals of greater than 10 minutes may not be seen depending on the time available. In addition, those patients who are on the schedule and here at the assigned time will be seen first. We will try to accommodate late appointments if time permits.

Payment Policies

For patients without insurance, payment in full is expected for services rendered on that day of service. Major credit cards, checks, and cash are accepted.

For those patients with dental insurance, the office will send claims to the insurance carrier, provided that the insurance card is presented to the office at the time of the visit. Dental insurance may not cover all of the costs of your child's dental care. **Most plans include coinsurance provisions, a deductible, and certain other expenses which must be paid by the responsible party at the time of services.**

Any portion of services not covered by dental insurance along with your deductible is due on the day services are rendered. Based on the information from your insurance, we give you an **estimate** of the total cost to you, however if there is a balance due after insurance pays, it will become your responsibility, and is due within 30 days.

Payment plans are available through the Citi Health card program. Please ask for details.

By my signature, I acknowledge and understand the office policies at Papillion Pediatric Dentistry.

Signature

Relationship to child

Date

HIPAA PRIVACY FORM

Notice of Privacy Practices

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices.

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

Papillion Pediatric Dentistry

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 (02-17-2009), 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 another dentist, physician or other health care 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.

Initials

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, 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 \$0.25 for each page, \$15 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 Web site 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 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 Officer: Jane L. Bennett, DDS
Telephone: 402-502-1256
E-mail: drjane@janebennettds.com
Address: 545 Fortune Drive, Suite 400, Papillion, NE 68046.

I, _____, have had full opportunity to read and consider the contents of this Consent Form. I understand that, by signing this form, I am giving my consent to Papillion Pediatric Dentistry's use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature and 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:

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