

CHILD MEDICAL AND DENTAL HISTORY FORM

PATIENT'S NAME _____ TODAY'S DATE: _____

DENTAL HISTORY – Please circle the appropriate answer and provide comments in the box provided.

1. Is this your child's first visit to a dentist? _____ YES NO
2. If not, how long since the last visit to the dentist? _____
3. Were any x-rays taken when your child previously visited the dentist? _____ YES NO
4. Does your child eat between meals? _____ YES NO
5. Does your child eat sweets such as candy, soda, and chewing gum in excess? ___ YES NO
6. When does your child brush his/her teeth?
 Morning Morning, after breakfast Right after meals/snacks Before bed
7. How does your child receive Fluoride?
 Community water source (please list source _____) Well Water
 Fluoride drops or tablets Fluoride rinse or gel Treatments at dental office
8. Have any cavities been noted in the past? _____ YES NO
9. Were any teeth (baby or permanent) removed by extraction? _____ YES NO
10. Have there been any injuries to teeth, such as falls, blows, chips, etc? _____ YES NO
 If yes, please explain: _____
11. Has your child had any problem with dental treatment in the past? _____ YES NO
12. Has anyone in the family, including parents, had orthodontics? _____ YES NO
13. Has your child ever received a local anesthetic? _____ YES NO
14. Has your child ever had occlusal sealants? _____ YES NO
15. Does your **child** think there is anything wrong with his/her teeth? _____ YES NO

COMMENTS

MEDICAL HISTORY – Please use the box provided for all explanations/comments.

1. Does your child have a health problem? _____ YES NO
2. Is your child under the care of a physician? _____ YES NO
 If yes, name and phone # _____
3. Is your child receiving any medication? Please list in the box provided. _____ YES NO
4. Is your child allergic to penicillin, antibiotics or other drugs? Please list. _____ YES NO
5. Is your child allergic or sensitive to latex or metals? Please list. _____ YES NO
6. Does your child have other allergies? _____ YES NO
7. Has your child had any serious illness? _____ YES NO
 When: _____ What: _____
8. Has your child ever had surgery? _____ YES NO
9. Does your child have a heart murmur? _____ YES NO
10. Is surgery contemplated for this? _____ YES NO
11. Does your child experience severe or prolonged bleeding? _____ YES NO
12. Does your child have AIDS or has he/she tested HIV Positive? _____ YES NO
13. Has your child tested positive for hepatitis? _____ YES NO
14. Is your child subject to nervous disorders? _____ YES NO
 Fainting Seizures Dizziness Behavioral/Learning Problems
15. Does your child suffer from frequent headaches? _____ YES NO
16. Has your child had a history of any of the following (please circle): diabetes, heart Trouble, asthma, kidney infection, rheumatic fever, epilepsy, cerebral palsy, liver problems, Congenital birth defects, mental illness, eyesight problems, cancer, infections, speech Impairments, hearing loss?
17. Has your child ever had an illness or medical condition not listed above? _____ YES NO
 Please explain: _____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPELTE AND ACCURATE.

PATIENT/GUARDIAN'S SIGNATURE _____ DATE: _____

DENTIST'S SIGNATURE _____ DATE: _____

Office Policies for Chip E. Webb, DDS

1. **Insurance:** If you have insurance, whether you are the subscriber or a dependant, you agree to pay your percentage due at the time of your procedure. We are not responsible for any fees that insurance does not cover. We file your insurance as a courtesy to you and you are responsible for any and all charges on your account. All Delta Dental Insurance carriers, see #7 below for a more detailed explanation of your benefits in our office. Please see your insurance information booklet for further explanation of contract limitations and specific information regarding your plan.

2. **Responsible Party:** If you are bringing in a child under the age of 18, you must provide us with accurate phone numbers and addresses for yourself **and** any parent not living with this child who may be responsible for the account. If the child has insurance coverage through a parent whom you are not married to or who does not have custody of the child, we need complete information for both parents. **No exceptions.**

3. **Account Payment:** If your account is past due for over ninety days, we reserve the right to retain a collection agency or attorney to pursue the outstanding balance. In addition, an interest rate of 2.5% per month will be assessed for all accounts which are ninety days overdue. If your account is handled by a collection agency or attorney, you will be responsible for all courts costs, discretionary costs, expenses and attorney's fees associated with the collection of the past due amount.

4. **Returned Check Fee:** If a check is returned for any reason, a \$20 Returned Check Fee will be added to your account.

5. **Cancellation Policy:** If you or a family member on your account do not show for a scheduled appointment or cancel within 24 hours of your appointment time, you will be subject to a charge of \$25 per hour you were scheduled for. For example, if you were scheduled for two hours, your account would be charged \$50. If you or a family member on your account has missed a combined total of three appointments in this manner, we reserve the right to dismiss you and/or your family as a patient(s). Please understand that we will do everything we can to fill the open appointment, therefore not charging the fee, but this cannot always happen.

6. **Insurance Contacts:** Please understand that, as a courtesy to you, we will do whatever we can to receive insurance payments on your account. However, we will only contact your insurance a total of three times to check on the status and request prompt payment. Fourteen days after the third contact, your insurance claim will be closed and the balance and any further contact with insurance will be your responsibility.

7. **Delta Dental Premier Patients:** If you are a Delta Dental Premier carrier, you are still responsible for any amount not paid due to contract limitations, deductibles and maximum benefits. Any charge over the Delta Dental Premier "allowed" charge will NOT be your responsibility. If the estimated portion of your insurance is not paid 100% for any other reason, you are responsible for that amount. This is different than Delta Dental Preferred. We are only providers for Delta Dental Premier. Please ask us for more information.

I acknowledge that I have read and understand Chip E. Webb, DDS's Office Policies, and I agree to be bound by these Policies.

Signature of Responsible Party

Date

Print Name of Responsible Party

Print Name of Patient, If Different

Chip E. Webb, DDS, LLC

**Acknowledgement 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.

Print Name _____

Signature _____

Date _____

For Office 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
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

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 protected health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect January 1st, 2011, 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 provide the new Notice at our practice location, and we will distribute it 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.

Your Authorization: In addition to our use of your health information for the following purposes, 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.

Uses and Disclosures of Health Information

We use and disclose health information about you without authorization for the following purposes.

Treatment: We may use or disclose your health information for your treatment. For example, we may 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. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. For example, 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.

To You Or Your Personal Representative: 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 your personal representative, 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 absence or incapacity or in 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.

Disaster Relief: We may use or disclose your health information to assist in disaster relief efforts.

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.

Public Health and Public Benefit: We may use or disclose your health information to report abuse, neglect, or domestic violence; to report disease, injury, and vital statistics; to report certain information to the Food and Drug Administration (FDA); to alert someone who may be at risk of contracting or spreading a disease; for health oversight activities; for certain judicial and administrative proceedings; for certain law enforcement purposes; to avert a serious threat to health or safety; and to comply with workers' compensation or similar programs.

Decedents: We may disclose health information about a decedent as authorized or required by law.

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 the protected health information of an 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, emails, text messages or letters).

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. You may also request access by sending us a letter to the address at the end of this Notice. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying. If you request copies, we will charge you \$0.50 for each page, \$25 per hour for staff time to 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. In most cases we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). We must comply with a request to restrict the disclosure of protected health information to a health plan for purposes of carrying out payment or health care operations (as defined by HIPAA) if the protected health information pertains solely to a health care item or service for which we have been paid out of pocket in full.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation of 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: You may receive a paper copy of this notice upon request, even if you have agreed to receive this notice electronically on our Web site or by electronic mail (e-mail).

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: Chip E. Webb, DDS
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Address: 708 Morganton Square Dr.
Maryville, TN 37801