ADAVEN CHILDREN'S DENTISTRY

Manny Rapp, DDS Nina Mirzayan, DDS

PATIENT INFORMATION AND HEALTH HISTORY

OFFICE USE ONLY

PANO_____ Prophy _____ COOP poor fair good

PAs_____ Flo _____ OHI poor fair good

BWZ_____

Referred by: _____

Patient's name: _____ Nickname: _____

Last First

Date: _____ Sex: M ____ F ____ Age: _____ Date of birth: _____

Reason for bringing child to the dentist _____

Health history:

Physician's name /phone number _____

1. Is your child being treated by a physician at this time? Yes _____ No _____
   If yes, what? _____
2. Has your child ever been a patient in a hospital? Yes _____ No _____
   If yes, what? _____
3. Has your child ever received general anesthesia? Yes _____ No _____
   If yes, what? _____
4. Is your child allergic to anything? (medicine, food, etc) Yes _____ No _____
   If yes, what? _____
5. Is your child taking any medicine at this time? Yes _____ No _____
   If yes, what? _____

Has your child ever been diagnosed as having any of the following conditions?

If yes, please indicate by marking the appropriate box.

☐ AIDS/HIV	☐ Cerebral Palsy	☐ Excessive Bleeding	☐ Nutrition Problems
☐ Anemia	☐ Chicken Pox	☐ Eye Problems	☐ Pneumonia ☐ TB
☐ Asthma	☐ Cleft lip/palate	☐ Fainting	☐ Rheumatic Fever
☐ Autism	☐ Convulsions/Seizures	☐ Hearing Loss	☐ Scarlet Fever
☐ Bladder	☐ Diabetes	☐ Heart Condition	☐ Scoliosis
☐ Blood disorder	☐ Down Syndrome	☐ Hepatitis	☐ Sickle Cell Anemia
☐ Brain Injury	☐ Emotional Problems	☐ Measles	☐ Spina Bifida
☐ Cancer	☐ Epilepsy	☐ Mumps	☐ Whooping Cough

Other _____None _____

Dental history:

1. Has your child been seen by a dentist before today? Yes _____ No _____
   If yes, When? _____ What services were provided? _____
2. Has your child complained about any dental problems? Yes _____ No _____
3. Has your child ever received fluoride in any form? Yes _____ No _____
   If yes, What? _____When? _____
4. Are your child's teeth brushed daily? _____ times Yes _____ No _____
5. Does your child have any mouth habits? (thumb sucking, nail biting, mouth breathing, pacifier, sleeping with bottle etc) Yes _____ No _____
6. Has your child had any unhappy dental experience? Yes _____ No _____
7. What type of toothpaste does your child use? _____
8. At what age did your child stop bottle/breast feeding? _____

Financial responsibility:

Father's name: _____ SSN#: _____ DOB: _____
Address: _____
Number and Street City State Zip
E-mail Address: _____
Home phone: _____ Cell phone: _____

Mother's name: _____ SSN#: _____ DOB: _____
Address: _____
Number and Street City State Zip
E-mail Address: _____
Home phone: _____ Cell phone: _____

Father's employer: _____ Work phone: _____ Ext: _____

Do you have dental insurance for minor/child? Yes ____ No ____
Plan name: _____
Group #: _____ Policy #: _____Phone number: _____
Address: _____

Mother's employer: _____ Work phone: _____ Ext: _____
Do you have dental insurance for minor/child? Yes ____ No ____
Plan name: _____
Group #: _____ Policy #: _____Phone number: _____
Address: _____

Emergency contact:

Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____

Authorizations:

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and that it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services for my minor/child. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered.

_____ _____
Signature of parent/guardian Date

WELCOME TO ADAVEN CHILDREN'S DENTISTRY

Our desire is to provide quality treatment in a caring environment for you and your child. We provide the following information in order to familiarize you with our staff policies. All medical information and consent forms must be completed and signed prior to examination. **Please do not make any notes, exclusions, or alterations to this form.**

If you are not the natural parent or legal guardian of the child you are accompanying, please do not sign this form. This form must be read and signed prior to the visit by the natural parent or guardian and brought in with the identification of the parent or guardian. We must have original signatures on all forms including any medical history forms and insurance authorizations, as well as all consent forms. If you are the legal guardian of the child, but not the natural parent, you must provide legal documentation as well as identification at the time of the first visit. If we cannot determine custody or guardianship for the patient we are seeing, the appointment will be rescheduled until the proper documentation can be provided. If the natural parent or legal guardian has granted you permission to bring the child in, we must have a note listing names of authorized persons and we may ask for identification for the names listed on the authorization. Again, we only allow notes for subsequent visits. We do not allow friends or family members to sign any forms. That must be done prior to the appointment by the natural parent or legal guardian.

Parents may accompany their child back to the treatment area. A complete diagnosis and standard pediatric set of x-rays will be taken **if the child is cooperative**. The doctor will discuss his/her diagnosis and recommend a treatment plan as well as discuss treatment options. On subsequent visits, a parent or guardian may also come back to the treatment area. However, it is very important that your child be allowed to establish a rapport with the doctor and staff during treatment. If your child becomes uncooperative or combative you may be asked to step outside the treatment room until the doctor is able to establish control. A dental assistant will explain to you what was done as well as what the next treatment will involve. **No other children will be allowed in treatment area during your child's treatment**.

For our especially fearful patients, the doctor may suggest that your child be given a medication prior to treatment. This premedication is generally liquid Demerol and Atarax given orally in the office one hour prior to the appointment as a sedative and relaxant. During treatment, nitrous oxide (laughing gas) will be used as a relaxant (we call the rubber mask "Mr. Nose"). This does not put your child to sleep; rather it relaxes the child and makes him or her feel happy and comfortable. **Nitrous oxide is used on most children requiring dental treatment.**

In order to provide quality dental work and reduce the risk of injury to a child, it is absolutely necessary that the child remain still during treatment. Despite our efforts to calm a child with reassurances, showing the instruments and explaining the noises they will hear, at times we encounter difficult management problems. If a patient refuses to cooperate, it may be necessary to use one of the following behavioral management techniques to facilitate treatment:

VOICE CONTROL: Instruction is given in a controlled firm tone of voice.

PHYSICAL RESTRAINT ("Papoose board"): This is a padded board with a Velcro blanket designed to safely wrap the arms and legs of a child in addition to holding the child's head still. The papoose board is also designed to provide motion control so that your child and our staff are protected during a dental procedure. The papoose board is used as a "last resort" in young children who might not otherwise be able to be treated. The papoose board is not designed for older children. If circumstances arise where physical restraint is an option, a dental assistant will inform you of this first. The papoose board is used most commonly for emergencies of very young children and also to stabilize treatment that was started with a cooperative child who then became uncooperative. Even if you, as the parent, request the papoose board to facilitate treatment of your child, the doctor reserves the right to use restraint only when they feel it is in the best interest of the child.

HOSPITALIZATION: This may be recommended for the very young patients, those with health problems, which would otherwise prevent them from being treated in the normal office setting, or difficult management patients. Because of young age or lack of control, the child may have to be sedated and treatment rendered under general anesthesia in an outpatient surgical facility. This option will be discussed with you if other options cannot be used successfully.

Your child's best interests are most important to us. We will seek to conservatively manage the behavior of your child and help him or her to accept dental care in a positive, non-threatening environment. We hope to promote good, long-term attitudes toward dentistry, oral health, and self. Thank you for trusting us to treat your child.

SILVER OR WHITE FILLINGS: Many insurance companies will only cover the cost of silver fillings on primary (baby) teeth. If you prefer a white filling for your child, or if the doctor recommends a white filling for a tooth, your insurance company may only pay what it would normally pay for silver filling. As the insured, you would be responsible for the difference in cost. White fillings cost approximately $15-$20 more per tooth due to the cost of materials. If you have any questions about what your out-of-pocket expense would be, should it be necessary for your child to have a white filling, **please** check with the front desk **prior** to the work being performed.

X-RAY POLICY: In order for Adaven Children's Dentistry to provide the highest quality care to your child, it is important for the doctor to have high quality, diagnostic x-rays available at the time of your child's initial exam in our office. If you have had x-rays taken at another office, we will be happy to use them for the exam; however, they must be present at the time of the initial exam, must be of diagnostic quality, and must have been taken within the last 6-months. If the doctor determines that the x-rays brought from another office are not of diagnostic quality, we will be happy to take new ones for you. If you had x-rays taken at another office and they have not yet been sent over, we will be happy to take a new set for you or reschedule your appointment to allow more time for the x-rays to arrive. The cost of the x-rays taken in our office will be the responsibility of the parents regardless of whether or not your insurance company will cover them. Insurance companies usually only cover x-rays a certain number of times per year. If you have questions about your coverage, please check with your insurance company. **If you have questions about this policy, please feel free to ask the staff or the doctor.**

FAMILY APPOINTMENTS:

Dr. Manny encourages same day sibling appointments and appreciates the time saving convenience afforded you by doing this. It does, however, block a major portion in our schedule and it is pertinent that these appointments be kept as scheduled. Failure to cancel a "family" appointment in a timely manner will result in the inability to offer future same day appointments. We reserve the right to assess a fee for appointments missed without a 24 hour notice.

I consent for my child to be managed by the above-mentioned techniques if the doctor, in his best judgment, determines these techniques are necessary to optimize and facilitate treatment. I have been informed and understand that occasionally there are complications of the treatment, drugs, or anesthesia agents; including but not limited to vomiting, breathing difficulties or brain damage. I further understand and accept that complications may require medical assistance and/or hospitalization. An office staff member has answered all of my questions to my satisfaction.

IF YOU DO NOT UNDERSTAND THE FOREGOING INFORMATION, PLEASE NOTIFY A STAFF MEMBER AND DO NOT SIGN THIS FORM.

_____ _____

Signature of Parent/Legal Guardian Date

_____ _____

Patient's name Relationship to patient

ASSIGNMENT OF BENEFITS

Patient Name: _____

Policyholder: _____

I hereby instruct and direct my insurance _____

to: Adaven Children's Dentistry, 1701 N Green Valley Parkway # 8E, Henderson, NV or if my current policy prohibits direct payment to doctor, I hereby instruct and direct you to make out the check to me and mail it as follows: Adaven Children's Dentistry, 1701 N Green Valley Pkwy #8E, Henderson, NV 89074 for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

I hereby authorize ADAVEN CHILDREN'S DENTISTRY to deposit any checks received from my Insurance Company for my account when made payable to me.

_____ _____

Signature of Policyholder Date

_____ _____

Signature of Claimant, if not policyholder Signature of Witness

Notice of Privacy Practices Acknowledgement

Adaven Children's Dentistry
1701 N. Green Valley Pkwy #8-E
Henderson, NV 89074

I understand that, the Health Insurance Probability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health insurance. I understand that this information can and will be used:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the users and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at anytime at the address above to obtain a current copy of *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

Office Use Only

I attempted to obtain this patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:
Initials:
Reason:

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: PATIENT FOR WHOM CONSENT IS BEING GIVING

Name: _____

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, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of the other important matters about your protected health information. A copy of our Notice accompanies 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 our HIPAA Compliance Officer, Kimberly M. Rapp

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

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.

_____ _____

Parent/Guardian Signature **Date**

OR:

REVOCATION OF CONSENT (sign only if revoking 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 the 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 me after I have revoked my Consent.

_____ _____

Parent/Guardian Signature **Date**