



5

## Child's Dental Information

Reason for today's visit:  Exam  Emergency  ConsultationIs Child in pain?  No  Yes How Long? \_\_\_\_\_Please indicate  any of the following problems:

- Discomfort, clicking or popping in jaw.  Lost/Broken Filling(s)  Stained teeth  
 Red, swollen or bleeding gums.  Teeth grinding  Locking Jaw  
 Sensitive tooth, teeth or gums.  Ringing in Ears  Bad breath  
 Blisters/Sores in or around the mouth.  Broken/Chipped tooth  Loose tooth  
 Other(s): \_\_\_\_\_

Does child require pre-medication?  Yes  No  Don't know

Previous Dentist: \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_

Last Dental exam: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Last Dental X-rays: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Times a day child brushes? \_\_\_\_\_ Times a week child flosses? \_\_\_\_\_

Is the child's water fluoridated?  Yes  No

How would you rate the child's smile? Best 1 2 3 4 5 6 7 8 9 10 Worst

6

## Child's Medical History

Is Child taking any of the following medications?  Pain killers (INCLUDING ASPIRIN)  Ritalin  Stimulants  
 Blood Thinners  Tranquilizers  Insulin  Muscle relaxers  Others: \_\_\_\_\_Child's Physician: \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
DOCTOR'S NAME OR CLINIC NAME PHONE#

Last Medical Exam: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

ADDRESS CITY STATE ZIP

Does Child have or ever had any of the following diseases, medical conditions or procedures?

- |                                    |  |   |
|------------------------------------|--|---|
| <b>Y N</b> Heart Murmur            | <b>Y N</b> Tonsillitis                 | <b>Y N</b> High/Low Blood Pressure          |
| <b>Y N</b> Rheumatic fever         | <b>Y N</b> Respiratory Problems        | <b>Y N</b> Hepatitis                        |
| <b>Y N</b> Artificial Heart Valves | <b>Y N</b> Asthma/Difficulty Breathing | <b>Y N</b> Artificial Bones/Joints/Implants |
| <b>Y N</b> Congenital Heart defect | <b>Y N</b> Blood Transfusion(s)        | <b>Y N</b> Liver/Kidney/Organ Problems      |
| <b>Y N</b> Scarlet Fever           | <b>Y N</b> Leukemia/Anemia             | <b>Y N</b> HIV+/AIDS/ARC                    |
| <b>Y N</b> Surgeries/Operations    | <b>Y N</b> Diabetes/Hypoglycemia       | <b>Y N</b> Tuberculosis TB                  |
| <b>Y N</b> Cancer/Tumors           | <b>Y N</b> Hemophilia                  | <b>Y N</b> Psychiatric Problems             |
| <b>Y N</b> Chemotherapy            | <b>Y N</b> Abnormal Bleeding           | <b>Y N</b> Hyper Active/ADD                 |
| <b>Y N</b> Jaw Problems TMJ/TMD    | <b>Y N</b> Cleft Lip/Palate            | <b>Y N</b> Fainting/Seizures/Epilepsy       |
| <b>Y N</b> Hearing Problems        | <b>Y N</b> Birth Defects               | <b>Y N</b> Cerebral Palsy                   |

Please list any other medical condition(s) child has or ever had: \_\_\_\_\_

Is Child allergic to:  Latex  Penicillin/Amoxicillin  Tetracycline  Dental Anesthetics (Novocaine)  
 Aspirin  Food allergies  Other(s): \_\_\_\_\_Please rate the child's general health from 1-10: \_\_\_\_\_ Does child wear contact lenses?  Yes  NoHas this child ever taken the drug Ritalin?  No  Yes/How long? \_\_\_\_\_ Child's Blood type: \_\_\_\_\_Does this child do any of the following?  Thumb/Finger Sucking  Tongue Thrusting/Sucking  
 Heavy Snoring  Mouth Breathing  Lip Sucking/Biting

**■** We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.

**■** Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

**■** I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

**■** I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature \_\_\_\_\_

Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

 Parent or Guardian  Other:UPDATE  
(OFFICE USE)Initials \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Date

Comments

Initials \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Date

Comments

Initials \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Date

Comments

**Carla E. Skaates D.D.S.**

**Consent for Examination**

We are committed to doing our best for you. This begins with understanding your dental needs and goals. This is followed by a thorough and complete dental exam, a thoroughly documented dental record and diagnosis. This is the foundation on which all services provided are based.

Please let my signature below evidence my consent to your dental examination. As part of that examination, I acknowledge to you that I have been given the opportunity to ask questions about the examination, the procedures to be used and the risks involved however slight. I believe that I have sufficient information to give my consent.

Patient signature \_\_\_\_\_ Date \_\_\_\_\_

**Consent to Release or Review Dental Information/Records**

I have the right to expect that all communications and records pertaining to my case will be treated as confidential, so that you may make a thorough examination and diagnosis. I also understand that you may need to obtain information from my medical doctor and/or prior dentist(s). Therefore, I grant you the right to obtain information about my health condition from my medical doctors and other dentists.

I also give you permission to share my health information with other health care professionals and dental specialists which would include the release of my dental charts and records for the sole purpose of consultation regarding diagnosis, treatment planning and care.

I also give my permission to an authorized auditor who may review the record as part of a general survey of patient care to assure standards of high quality and service.

Patient signature \_\_\_\_\_ Date \_\_\_\_\_

**Consent for Examination and Routine Treatment (Children less than 18 years of age)**

I hereby give consent for my child to have a complete examination including necessary x-rays, study models, photographs and other diagnostic procedures which Dr. Skaates deems necessary to make a thorough diagnosis of my child's dental condition and needs.

I further give my permission for Dr. Skaates and her staff to provide preventive and restorative services necessary including composite (tooth colored) fillings, tooth buildups, stainless steel crowns, teeth cleaning and polishing, fluoride treatments and other similar services. I acknowledge that I have been given the opportunity to ask questions about the examination and the kinds of procedures routinely used by Dr. Skaates and her staff and the risks involved however slight. I hereby sign my consent for treatment.

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Parent Signature \_\_\_\_\_

### Insurance Benefits and Payments

When this office provides an estimate of your insurance coverage for service provided, it is **for your convenience only**. The information given reflects our experience with payments made from insurance companies such as yours in the past but because information is subject to change, the estimate provided **is not a guarantee of payment**. If it is important to you that the exact information be known in advance of dental work, it is best that all dental work to be completed is pre-determined. Most insurance policies specify a **maximum per year** amount allowed per patient. **It is the patient's responsibility** to verify before they receive each dental service, if their maximum has been met. When your insurance company states that they will pay a percent of any given dental service, that percent applies to what the insurance company considers "usual and customary" for that dental service. That amount varies with each insurance company and also varies according to the policy or contract that your employer has purchased for his employees. That percent does not apply to our fees. I understand that this office is not responsible for what my insurance company does or does not pay. I agree, as the patient, parent or legal guardian, to pay for all services received which are not covered by my insurance.

I also understand that the final cost of my dental care will be determined when the service is complete and the portion that I am expected to pay may vary from the initial estimate.

\_\_\_\_\_  
Patient signature  
(parent or legal guardian)

\_\_\_\_\_  
Date

\_\_\_\_\_  
(witness)

\_\_\_\_\_  
Date

## NOTICE OF PRIVACY PRACTICES

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**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.**

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### **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 Jan. 9, 2006, 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.

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### **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, 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).

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## 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, \$10.00 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 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.

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## 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: Carla E. Skaates, D.D.S.

Telephone: 906-228-9592

Fax: 909-228-5855

E-mail: \_\_\_\_\_

Address: 1320 W. Ridge St. Marquette, MI 49855

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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\* You May Refuse to Sign This Acknowledgement \*

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

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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### For Office Use Only

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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)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_