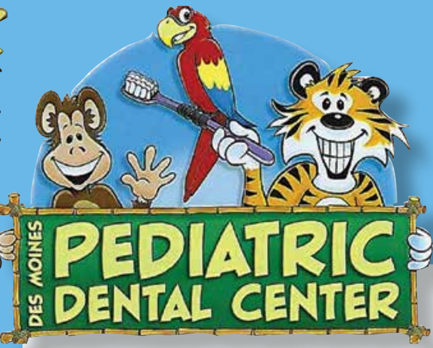

4949 Westown Pkwy., Suite 150
West Des Moines, IA 50266-6716
(515) 225-0066

tell us about your child

Today's Date:______________________________ Child's Home Phone #: ____________________________

Child's Name:____ Nickname: ___________________________
Last First MI

Social Security #:________________ Child's Birthdate: _____________ Child's Age: ___ ❑ Male ❑ Female

Child's Home Address: ____
Street City State Zip

Whom may we thank for referring you?____

Emergency Contact Name: ___________________ Phone #: _____________ Relationship #: _____________

parent information

Parent's Marital Status: ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Single ❑ Partnered

Parent: ❑ Mother ❑ Father ❑ Step Parent ❑ Guardian Does this person have custody of this child? ❑ Yes ❑ No

Please list anyone else who has custody of this child and/or any other custody arrangements that we should be aware of:____________________

Name: ____ Social Security #:_________________________

Birthdate:_________________ Home Phone #:___________________ Work Phone #:___________________

Email Address:____ Cell Phone #:___________________

Address: ____
Street City State Zip

Employer: ____ Occupation: _______________________

Parent: ❑ Father ❑ Mother ❑ Step Parent ❑ Guardian Does this person have custody of this child? ❑ Yes ❑ No

Name: ____ Social Security #:_________________________

Birthdate:__________________ Home Phone #: __________________ Work Phone #:___________________

Email Address: ____ Cell Phone #:___________________

Address: ____
Street City State Zip

Employer: ____ Occupation: _______________________

insurance information

Primary Insurance Dental Coverage? ❑ Yes ❑ No Orthodontic Coverage? ❑ Yes ❑ No

Insurance Co. Name:__________________ Phone #: _____________ Group # (Plan, Local, or Policy #): _____________

Insurance Co. Address: ____
PO Box/Street City State Zip

Insured's Name: ________________________________ Relationship to Patient: ______________________

Insured's Birthdate: ____________________________ Social Security #: ___________________________

Insured's Employer: ____

Secondary Insurance Dental Coverage? ❑ Yes ❑ No Orthodontic Coverage? ❑ Yes ❑ No

Insurance Co. Name: ______________ Phone #: _____________ Group # (Plan, Local, or Policy #):_____________

Insurance Co. Address: ____
PO Box/Street City State Zip

Insured's Name:_________________________________ Relationship to Patient: ______________________

Insured's Birthdate:______________________________ Social Security #: ___________________________

Insured's Employer:____

continued on back

dental history

Is the child currently in pain? ☐ Yes ☐ No What is the primary reason for today's visit? ____________________

Has the child experienced problems with previous dental work? ☐ Yes ☐ No

Does the child brush his / her teeth daily? ☐ Yes ☐ No

Floss his / her teeth daily? ☐ Yes ☐ No

Previous / Present Dentist: ______________________________________ Date of last visit: ________________

Please Circle

Does / did the child have any of the following habits?

☐ Lip Sucking / Biting	☐ Clenching / Grinding Teeth	☐ Tongue / Cheek Biting	☐ Mouth Breather
☐ Nail Biting	☐ Thumb / Finger Sucking	☐ Used Pacifier	☐ Speech Problems
☐ Chewing on Objects	☐ Nursing Bottle Habits	☐ Tongue Thrust	☐ Breast Fed

medical history

Child's Physician: ____________________ Phone #: ____________________ Date of last visit: ______________

Address: ____
Street City State Zip

Is the child currently under the care of a physician? ☐ Yes ☐ No Please explain: ____________________________

Please describe the child's current physical health: ☐ Good ☐ Fair ☐ Poor

Are the child's immunizations current? ☐ Yes ☐ No

Please list all drugs that the child is currently taking: ____

Besides the following, please list all drugs and/or things that cause allergic reactions:

Latex? ☐ Yes ☐ No Metals/Nickel? ☐ Yes ☐ No Plastic? ☐ Yes ☐ No Penicillin? ☐ Yes ☐ No

Tetracycline? ☐ Yes ☐ No Other? ☐ Yes ☐ No ____

____

Anything you would like to discuss with the doctor in private? ☐ Yes ☐ No

Has the child had/experienced any of the following:

☐ Abnormal Bleeding	☐ Chicken Pox	☐ Heart Murmur – requires antibiotic	☐ Mononucleosis
☐ ADHD	☐ Cleft Lip/Palate	☐ Hemophilia	☐ Psychiatric Problems
☐ AIDS/HIV+	☐ Congenital Heart Defect	☐ Hepatitis	☐ Rheumatic Fever
☐ Allergies	☐ Convulsions	☐ High Blood Pressure	☐ Scarlet Fever
☐ Anemia	☐ Diabetes	☐ Hives	☐ Seizures
☐ Any Hospital Stay/Operations	☐ Down Syndrome	☐ Kidney Problems	☐ Shunts
☐ Asthma	☐ Epilepsy	☐ Liver Problems	☐ Sickle Cell Anemia
☐ Autism Spectrum Disorder	☐ Frequent Headaches	☐ Low Blood Pressure	☐ Skin Rash
☐ Blood Transfusion	☐ Handicaps/Disabilities	☐ Lupus	☐ Tonsillitis
☐ Cancer	☐ Hearing Impairment	☐ Measles	☐ Tuberculosis (TB)
☐ Cerebral Palsy	☐ Heart Murmur – Innocent	☐ Mitral Valve Prolapse	☐ Other

Please discuss any serious medical problems the child experiences/ed: ____________________________

____

____

authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my child's medical status. I authorize Dr. Kubovich/Dr. Pelzer and the dental team to examine, clean and provide dental treatment on my child's teeth. I further authorize the taking of dental x-rays as may be considered necessary by the Doctors to diagnose and/or treat my child's dental problem. I assign the Doctors all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover.

Signature ____ Date ________________

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

OUR LEGAL DUTY

We are required by law to maintain the privacy of your protected health information ("PHI") and to provide you with this Notice of Privacy Practices, which describes our legal duties and privacy practices with respect to your PHI. Your PHI generally includes all of the records of your care generated by or at our facility and/or our affiliate facilities, whether made by our employees or made by other healthcare providers at our facilities. When we use or disclose your health information, we abide by the terms of this Notice (or other Notice in effect at the time of the use or disclosure).

This Notice takes effect on February 5, 2018, and remains in effect until we replace it. We reserve the right to change this Notice at any time, and to make the revised Notice effective for all PHI that we maintain, including PHI we created or received before we made the changes. In the event of a change in our practices, we will post a copy of the revised Notice at our facilities and on our website. Upon your written request, we will provide you with any revised Notice. For more information about this Notice, or for additional copies, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

We may use and disclose your PHI in order to provide and coordinate your care. Additionally, we may use and disclose your PHI in order to receive payment for our services and for our healthcare operations, and for other purposes permitted or required by law. Your authorization is not required when we use or disclose your PHI for the following purposes:

Treatment: We may use or disclose your PHI to personnel in our office, as well as to physicians and other healthcare professionals within or outside our office, who are involved in your medical care and need the information to provide you with medical care and related services. For example, we may use or disclose your PHI in consultations and/or discussions regarding your medical care and related services with healthcare providers who we refer to and receive referrals from.

Payment: We may use and disclose your PHI to obtain payment for services we provide to you. This health information may be disclosed to an insurance company, third party payor, or other entity or person (or their authorized representative) who may be involved in or responsible for payment of your medical bill and may include copies of or excerpts from your medical records that are necessary to obtain payment on your account. For example, we may give your health insurance provider information about you so that they will pay for your treatment.

Healthcare Operations: We may use and disclose your PHI 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. For example, we may use your PHI to evaluate the services of our personnel.

Incidental Disclosures: Some patient care may be provided in open treatment areas. We will use reasonable safeguards to maintain patient privacy in those areas, but it is still possible that others may incidentally overhear some of your patient information during your treatment.

Appointment Reminders: We may disclose PHI in the course of leaving messages and in providing you with appointment reminders via phone messages, text messages, postcards, letters, and / or other communication mediums.

Business Associates: We may use and disclose your PHI with and to our business associates, such as billing services or healthcare professionals providing services as independent contractors, for the purpose of performing specified functions on our behalf and/or providing us with services. We have written contracts with our business associates requiring them to take appropriate measures to safeguard your PHI.

Your Family, Friends, and Representatives: We may disclose your PHI to notify or assist in the notification of a family member, domestic partner, close personal friend, your personal representative or another person responsible for or involved in your care or payment for your care, if we obtain your agreement or provide you with an opportunity to object and either you do not object or we reasonably infer that you do not object. If you are not present, or the opportunity to agree or object cannot be provided because of your incapacity or an emergency circumstance, we may exercise our professional judgment to determine whether a disclosure is in your best interest. We may also disclose your health information to friends or family members to inform them of matters such as your general condition and that you are present and/or receiving treatment at our facilities.

Disaster Relief: We may disclose your PHI to entities involved in disaster relief for appropriate purposes. If you are present, we will generally obtain your agreement or provide you with an opportunity to object before disclosing your health information for appropriate disaster relief purposes. In certain circumstances, we may exercise our professional judgment to determine whether a disclosure for disaster relief purposes is appropriate.

Fundraising: We may, from time to time, use your health information, or disclose to a Business Associate, certain health information for purposes communicating with you to raise funds for our benefit; however, you have the right to opt out of receiving such communications.

Required by Law: We will disclose your PHI when we are required to do so by law.

Abuse or Neglect: We may disclose your PHI 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 use or 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 or the public.

Military/Veterans and National Security: We may disclose your PHI as required by military command authorities if you are a member of the armed forces. We also may disclose your PHI to federal officials for lawful intelligence, counterintelligence, and other national security activities authorized by law, so that they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

Inmates: Under certain circumstances, we may disclose PHI to a correctional institution or law enforcement officials having lawful custody of an inmate or other individual.

Coroners, Medical Examiners and Funeral Directors: We may disclose your PHI to coroners, medical examiners and funeral directors as necessary, for such purposes as identifying a deceased person, determining the cause of death or to perform other duties authorized by law.

Regulatory Agencies; Public Health: We may disclose your health information to health oversight agencies for activities authorized by law, which include, but are not limited to, licensure, certification, audits, inspections, and investigations. In addition, we may use or disclose your PHI with or to public health activities or legal authorities charged with preventing or controlling disease, disability, or injury, and we may also disclose your PHI for other public health activities, such as reporting deaths, reactions or incidences with drugs or medical products. For example, we may disclose your health information to a person or entity required by the Food and Drug Administration to report adverse events, product problems, to assist with product recalls, or for other related, authorized purposes. We also may disclose your PHI to a person who may have been exposed to a communicable disease or may otherwise be at risk of spreading the disease or condition.

Litigation/Law Enforcement: We may use and disclose your PHI for law enforcement purposes as required by law or in response to a valid subpoena, discovery process, or court order. Disclosures for law enforcement purposes may include, by way of example, disclosures to law enforcement officials to identify or locate a suspect, fugitive, witness, or missing person, disclosures about the victim of a suspected crime if, under certain circumstances, we are unable to get the person's agreement and disclosures about criminal conduct at our facilities.

Workers' Compensation: We may disclose your PHI for workers' compensation or similar programs that provide benefits for work-related injuries and illnesses.

Except as described above, uses and disclosures of your health information will generally occur only with your written authorization. For example, we will not use your health information to send you any marketing materials. We may, however, provide you with marketing materials in a face-to-face encounter and we are permitted to give you promotional gifts of nominal value. We also may tell you about products or services relating to your treatment, case management or care coordination, or alternative treatments, therapies, providers, or care settings. In addition, we will not sell your PHI without your written authorization.

YOUR RIGHTS REGARDING YOUR PHI

Access: You have the right to look at or get copies of your PHI, with limited exceptions. Contact us using the information listed at the end of this Notice for a full explanation of time and fees involved. We may charge you a fee for the costs of copying, mailing, and other supplies associated with your request.

Disclosure Accounting: You have the right to receive an accounting of certain disclosures of your PHI made by us prior to the date of your request. The right applies only to certain disclosures made within six years of your request. 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 the additional requests. You have the right to request such an accounting in an electronic format. This right is subject to certain exceptions, restrictions and limitations.

Notification of a Breach: You have the right to be notified if your PHI is compromised in a breach of unsecured protected health information.

Electronic, Alternative, or Confidential Communication: You have the right to request, in writing, that we communicate with you about your PHI by alternative means, such as in electronic format, or to alternative locations. Your request must specify the alternative means or location. We will attempt to accommodate all reasonable requests. We may condition our agreement to accommodate your request by obtaining information from you as to how payment will be handled and obtaining additional or alternate addresses or means of contacting you. If we are unable to contact you using the ways or locations you have requested, we may contact you using any information we have.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your PHI for the purposes of treatment, payment, or healthcare operations, and you may also request a restriction or limitation on the health information that we disclose about you to individuals who may be involved in your care or payment for your care. However, except as described below, we are not required to agree to your requests. If we do agree, we will comply with your request except in emergency situations and in certain other situations, such as where your healthcare provider believes that it would be in your best interests to use or disclose such information.

Except as required by law and excluding disclosures for treatment purposes, we are required to agree to your written request not to share PHI with your health plan that relates solely to services or a healthcare item for which you or someone on your behalf have paid in full out-of-pocket.

Amendment: You have the right to request, in writing, that we amend your PHI if you believe it is incorrect so long as we maintain such PHI. Your request must explain why the information should be amended. We may deny your request under certain circumstances.

Paper Copy of this Notice: You have the right to a paper copy of this Notice of Privacy Practices by contacting our Privacy Officer.

Revocation of Authorization: You have the right to revoke any written authorization you give us to use or disclose your PHI provided that such request is in writing and delivered in person or by mail to our Privacy Officer at the address below and provided that action has not already been taken in reliance on your authorization. You acknowledge and agree that we are unable to take back any uses or disclosures that already occurred with your permission or as otherwise permitted by this Notice or by law.

QUESTIONS AND COMPLAINTS

If you have any concerns that we may have violated your privacy rights, or if you disagree with a decision we made about access to your PHI or in response to a request you made to amend or restrict the use or disclosure of your PHI, or to have us communicate with you by alternative means or at alternative locations, you may contact us using the information listed below.

In addition, you may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the contact information for filing a complaint upon request. 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.

If you would like additional information regarding our privacy practices, or if you have questions or concerns, please contact us as indicated below.

Privacy Officer: Andy Lyness
Telephone: 404-346-3810
Email: Andy.Lyness@d4c.com
Address: 1350 Spring Street NW, Atlanta, GA 30309

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received a copy of my provider's Notice of Privacy Practices, containing information about how my protected health information may be used and/or disclosed.

Patient Name (printed):___________________________

If patient is under 18, name of Personal Representative (generally Parent or Legal Guardian)* (printed):___________________________

Signature: _____________________
Relationship to Patient: _____________________
Date: ____________________

*By signing this form, you are certifying that you have legal authority to make healthcare decisions about the minor patient listed above

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NOTICE REGARDING OTHER INDIVIDUALS INVOLVED IN THE PATIENT'S CARE

As the Personal Representative of the above-named patient, I am identifying the following individual(s) as individuals who may accompany the above-named patient to clinic visits, who are involved in the patient's care and treatment and who may receive information regarding the individual's involvement in the patient's care and treatment.

	NAME	RELATIONSHIP
1.		
2.		
3.		
4.		
5.		

Personal Representative Signature: _____________________
Date: ____________________