Welcome

Health History Form

Today's Date: _____

NOTE: The parent or Guardian who accompanies the child is responsible for payment at the time of service.

1. Tell Us About Your Child

Child's Name _____
Last First MI

Goes by: _____ ☐ Male ☐ Female

Siblings that we treat _____

Child's Birthdate ____/____/____ Child's Age _____

School _____ Grade _____

Child's Home # (_____) _____

SS# _____

Child's Home Address: _____

_____
City State Zip

Email Address: _____

2. Who may we thank for referring you to our office?

_____

3. Mother's Information

Name _____

Mother ☐ Stepmother ☐ Guardian ☐ Birthdate ____/____/____

Employer _____

Work # (_____) _____ Ext. _____

Home # (_____) _____

Cellular Phone # (_____) _____

SS # _____ DL# _____

Email: _____

4. Father's Information

Name _____

Father ☐ Stepfather ☐ Guardian ☐ Birthdate ____/____/____

Employer _____

Work # (_____) _____ Ext. _____

Home # (_____) _____

Cellular Phone # (_____) _____

SS # _____ DL# _____

Email: _____

5. Who is Accompanying the Child Today?

Name _____

Relationship _____

Do you have legal custody of this child? ☐ Yes ☐ No

6. Person Responsible for Account

Name _____

Relationship _____

Billing Address _____

_____
City State Zip

Home # (_____) _____

Work # (_____) _____

Cellular # (_____) _____

E-mail _____

7. Primary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

_____

Insurance Co. Phone # (_____) _____

Group # (Plan, Local, or Policy #) _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birthdate ____/____/____

Social Security # _____

Policy Owner's Employer _____

8. Secondary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

_____

Insurance Co. Phone # (_____) _____

Group # (Plan, Local, or Policy #) _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birthdate ____/____/____

Social Security # _____

Policy Owner's Employer _____

9. Dental History

Is this your child's first visit to the dentist? _____

If not, how long since the last visit to the dentist? _____

Previous Dentist's Name_____

Were any x-rays taken at previous dental visits? _____

Have there been any injuries to the teeth, face or mouth? _____

If yes, please explain _____

_____

_____

Why did you bring the child to the dentist today? _____

_____

_____

Does the child have any of the following habits?

Y N Lip Sucking / Biting Y N Nail Biting

Y N Nursing / Bottle Habits Y N Thumb / Finger Sucking

Has the child ever had a serious or difficult problem associated with previous dental work? Yes No

If yes, please explain _____

_____

Is the child's water fluoridated? Yes No

Is the child taking fluoride supplements? Yes No

Has the child ever had any pain or tenderness in his/her jaw/ joint? (TMJ/TMD)? Yes No

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

Floss his / her teeth daily? Yes No

10. Health History

Has the child ever had any of the following conditions?

Y N Abnormal Bleeding	Y N Disabilities/Special Needs
Y N Allergies to any Drugs	Y N Hearing Impairment
Y N Any Hospital Stays	Y N Heart Disease/Murmur
Y N Any Operations	Y N Hemophilia/Blood Disorders
Y N Asthma	Y N Hepatitis
Y N Cancer	Y N HIV + / AIDS
Y N Congenital Birth Defects	Y N Kidney/Liver Conditions
Y N Convulsions/Epilepsy	Y N Rheumatic/Scarlet Fever
Y N Pregnancy	Y N Allergies to Latex Product
Y N Tuberculosis	Y N Diabetes
Y N ADD/ADHD	Y N Autism

Please discuss any serious medical conditions the child has had

_____

_____

Please list all drugs the child is currently taking_____

_____

Please list all allergies_____

_____

Child's Physician _____

Phone (_____) _____

Is the child currently under the care of a physician? Yes No

Please describe the child's current physical health...

Good Fair Poor

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA the CDC, and the ADA.

11.

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and 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 my child may need.

_____ _____ _____

Signature of Parent or Guardian Date Relationship to Patient

For Office Use Only

I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein.

Initials _____ Date _____

Doctor's Comments _____

_____

_____

_____

Heine & Associates Family Dentistry Patient Financial Policy

Welcome to our office! We are honored that you have chosen us as your dental provider and look forward to working with you. Our practice is committed to providing an excellent dental care experience to you and your family, and has implemented the financial policies outlined below to assist in that regard. These financial policies are followed by our practice so that we can stay focused on what we do best- providing you with personalized, comprehensive dental care services. Thank you in advance for your cooperation.

1. Payment for all treatment is due at the time services are rendered unless other written payment arrangements have been made with our team in advance.
2. Payment for services may be made by cash, check, or credit card. We accept Visa, MasterCard, Discover and American Express.
3. We are pleased to offer financing through CareCredit. Those who qualify will use CareCredit as a form of payment at the time of service. CareCredit will have pre-approved the patient and set up a monthly payment plan. This program is similar to a credit card and offers low monthly payments and flexibility to those who qualify, often on an interest-free basis.
4. If you fail to show for a scheduled appointment or cancel an appointment with less than 24 hours advanced notice, the practice reserves the right to charge you a fee for such broken or late-changed appointment. The fee for broken appointments is $50 per appointment.
5. As a courtesy to our patients with dental benefits, we will submit your claims to your insurance company. Your insurance coverage is a contract between you, your employer and the insurance company- not your insurance company and us. It is your responsibility to familiarize yourself with your insurance coverage. Any portion not expected to be covered by these benefits is the responsibility of the patient and is due at the time dental treatment is performed. This amount will include deductibles and co-payments. Please understand that this is only an estimate- not a guarantee of payment, and is based on the information available to us from your insurance company. Any insurance bill not settled within 60 days will be due in full and your responsibility to pay. Please be aware that some and perhaps all of the services provided may be non-covered services.
6. If services are not paid for at the time services are delivered, you will be provided a statement for the amount due, and will be expected to pay that amount in full promptly following receipt of the statement. Accounts unpaid after 60 days from the day of service are subject to a delinquent fee of $35. Furthermore, there is a $35 fee for any returned check. If the amount due is not paid in full within 60 days from the day services are delivered to you, the practice may refer the collection of the unpaid amount to a collection agency or collection attorney. If we have to submit your unpaid account to a collections process, you will be responsible for all charges our practice incurs- including court costs and reasonable attorney's fees.

Please indicate your understanding and acceptance of these financial policies by signing below. For the mutual convenience of you and the practice, it is understood that this executed copy of the Financial Policy also shall cover your dependent children who are patients of the practice.

Patient Name (Please Print): _____

Patient Signature: _____

Date: _____

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 9/23/2013, 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. 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, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care.
We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.
Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities. including disclosures to: Prevent or control disease, injury or disability; Report child abuse or neglect; Report reactions to medications or problems with products or devices; Notify a person of a recall, repair, or replacement of products or devices; Notify a person who may have been exposed to a disease or condition; or Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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.
Secretary of HHS We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensations or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. He may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

YOUR HEALTH INFORMATION RIGHTS

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. 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. If your request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. **We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment** or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice 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. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested, we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notification of breaches of your unsecured protected health information as required by law.

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 (email).

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 if 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 lf you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

OTHER USES AND DISCLOSURES OF PHI
Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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.

Our Privacy Official: Mrs. Lisa McBride

Telephone: Fax: (215) 968-4545 Telephone, (215) 968-3252 Fax

Address: 638 Newtown-Yardley Road, Suite 1A-B Newtown, PA 18940

Email: heinefamilydental@gmail.com

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 acknowledgment of but acknowledgment could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented his from obtaining acknowledgement
- Other (Please Specify)

_____

_____

_____