# Pediatric Dentistry of Winchester

Donna Klein, DMD

## Registration Information (please print)

**Child's Name:** ______________________________________________
First Middle Last

DOB: ___/___/_____ Age:_______ SSN#: ____/______/______ Male Prefers Female

**Father's Name:** ______________________________________________
First Middle Last

Mailing Address: ______________________________________________

City: ____________________ State:__________ Zip Code:______________

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

DOB: ___/___/_____ SSN#: ____/____/_____

Father's Employer: ______________________________________________

Employer Addresses: ______________________________________________

Father's Occupation: ______________________________________________

**Mother's Name:** ______________________________________________
First Middle Last

Mailing Address: ______________________________________________

City: ____________________ State:__________ Zip Code:______________

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

DOB: ___/___/_____ SSN#: ____/____/_____

Mother's Employer: ______________________________________________

Employer Addresses: ______________________________________________

Mother's Occupation: ______________________________________________

**EMERGENCY CONTACT** (Please specify someone **NOT** living in your household)

Name: ______________________________ Phone: ______________________

Relationship to Patient: ______________________________________________

**Dental Insurance Company:** ______________________________ Phone: ______________

Address: ______________________________________________

City: ____________________ State: __________ Zip Code: ______________

Group Name: ______________________________ Group #: ______________________

Insured's Name: ______________________________ Relationship to Patient: ______________

DOB: ___/___/_____ SSN#: ____/____/_____

Insured's Employer: ______________________________________________

**Referral:** ______________________________________________
How did you hear about our office?

*****Scanned Copy Serves as an Original*****

## MEDICAL HISTORY

Donna Klein, DMD

Child's Name: ____________________

Child's Physician: ____________________ Physician Address: ____________________

Physician's Phone: ____________________

Is your child in good physical health? ____YES ____NO

Are all immunizations up to date? ____YES ____NO

**Please check YES or NO to each of the following items regarding your child's health:**

| | YES | NO | | YES | NO | | YES | NO |
|---|---|---|---|---|---|---|---|---|
| ADHD | ___ | ___ | Allergies | ___ | ___ | Asthma | ___ | ___ |
| Bleeding Problems | ___ | ___ | Cancer | ___ | ___ | Cerebral Palsy | ___ | ___ |
| Diabetes | ___ | ___ | Hearing Problems | ___ | ___ | Heart Murmur | ___ | ___ |
| Heart Problems | ___ | ___ | Hepatitis | ___ | ___ | HIV/AIDS | ___ | ___ |
| Kidney Problems | ___ | ___ | Learning Disability | ___ | ___ | Latex Allergy | ___ | ___ |
| Liver Problems | ___ | ___ | Lung Problems | ___ | ___ | Pregnancy | ___ | ___ |
| Seizures | ___ | ___ | Sight Problems | ___ | ___ | Tuberculosis | ___ | ___ |

Please describe these or any other medical conditions we should be aware of ____________________

Please list all medications your child is presently taking: ____________________

Is your child allergic to any medication? ____YES ____NO; If Yes, please list:____________________

## DENTAL HISTORY

Reason for today's visit: ____________________

Has your child ever seen a dentist? ____YES ____NO

Child's previous/referring dentist: ____________________

Date of last dental visit: ____________ Were x-rays taken? ____YES ____NO

Date of last dental cleaning: ____________

Has your child had any unpleasant dental experience? ____YES ____NO

If yes,explain:____________________

Does you child have any mouth habits? ____Thumb or Finger Sucking ____Pacifier

Does your child use a bottle or nurse? ____YES ____NO At what age discontinued?________

Does your child take a bottle or sippy cup at bedtime or for naps? ____YES ____NO

Has your child ever had trauma to his/her teeth? ____YES ____NO

*I understand that the information I have given is true and correct to the best of my knowledge, and it will be held in the strictest of confidence. I also understand that it is my responsibility to inform this office of any changes in my child's medical status.*

Parent or Guardian's Signature: ____________________ Date: ___/___/___

*****Scanned Copy Serves as an Original*****

# Pediatric Dentistry of Winchester

Donna S. Klein, DMD

## Consent for Dental Treatment

Patient Name: ______________________________________________

I give my permission for my child to receive any and all dental treatment from the doctors and staff at Pediatric Dentistry of Winchester.

It is our goal to provide safe and comfortable dental treatment for our patients. In order to achieve this goal, the following methods have been chosen by Dr. Klein and you (with this consent form) in providing dental treatment for your child.

**NITROUS OXIDE**-otherwise known as "laughing gas" or "happy air" is used to relax a child during treatment. The child remains awake at all times. The gas is blown off 100% after treatment and has no lingering side effects.

**LOCAL ANESTHESIA**-Medication we call "sleepy juice" which is administered with the use of a "shot" to "numb" the tooth to prevent discomfort during dental treatment. We do NOT use the word "shot" to describe this procedure to the child.

**MOUTH PROP**- a device we call a "tooth pillow" which is used to help your child keep their mouth open wide during treatment and prevent him/her from accidentally biting down on sharp instruments.

**RUBBER DAM**- otherwise known as a "raincoat" which is used to protect a child's airway during dental treatment. It isolates the teeth that are being worked on and prevents debris and water from going into the child's throat.

**TREATMENT**- it is our goal to gain the trust of each child and to provide dental treatment efficiently and safely. By minimizing distractions, we can ensure a positive dental experience for your child. Therefore, one (1) parent/guardian may accompany the child to the treatment room.

**MEDICAL EMERGENCIES**- with dental treatment, there are always risks for medical emergencies. The most common dental emergency includes minor allergic reactions (such as rash) to local anesthesia or latex. More severe allergic reactions can also occur where a child has trouble breathing. This office is equipped to handle most medical emergencies that may arise during dental treatment.

**FINANCIAL RESPONSIBILITIES**- I agree to pay all costs and fees to collect monies owed by me, including collection costs (up to 40% of total due) that may be assessed to the dentist's collection agency, should collection procedures become necessary.

I understand that the proposed treatment plan may change during any given dental visit, and that additional treatment or different treatment may be necessary and may be performed.

KRS 313.040 allows a Licensed Dental Hygienist to examine patients without the doctor being present in the office if the doctor has examined the patient within the last 7 months. The statute requires a signed consent form for a patient to be seen under General Supervision.

______ I agree to let my child be seen without the doctor being present in the office.

______ I do not agree to let my child be seen without the doctor being present.

In order to treat each of our patients in a timely manner, we reserve the right to reschedule your appointment should you arrive late to your appointment. I understand all the items on this consent form and have had ample opportunity to ask any questions I may have. I therefore consent for dental treatment for my child to be performed by Dr. Meek or any other member of the dental team at Pediatric Dentistry of Winchester.

______________________________ Signature

______________________________ Printed Name

I am: MOTHER FATHER or LEGAL GUARDIAN (please circle one)

# CONSENT FOR INTERNET COMMUNICATIONS

**Patient Name:** ______________________________________________

Last, First MI

**E-Mail Address:** ______________________________________________

I grant my permission to Pediatric Dentistry of Winchester to upload and store confidential patient information—including account information, appointment information and clinical information—to the secured web site for Pediatric Dentistry of Winchester. I understand Pediatric Dentistry of Winchester and I are dually responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that Pediatric Dentistry of Winchester is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand Pediatric Dentistry of Winchester is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to agree to immediately notify Pediatric Dentistry of Winchester of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns. I also understand State and Federal law, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit times during the terms of the Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my patient information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that Pediatric Dentistry of Winchester has the right to monitor, retrieve, store, upload and use my patient information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand Pediatric Dentistry of Winchester will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand Pediatric Dentistry of Winchester CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

I have read the information above regarding the secured uploading of patient information to the web site for Pediatric Dentistry of Winchester, and grant Pediatric Dentistry of Winchester permission to securely upload my patient information to the web site.

_____ I do not have an E-Mail address at this time.

______________________________________ ____________

Signature of parent or guardian Date

***Scanned Copy Serves as an Original***

PEDIATRIC DENTISTRY OF WINCHESTER
Donna Klein, DMD
2560 Bypass Rd. Suite # 2.
Winchester, KY 40391
(859) 737-1000

## AUTHORIZATION FOR SIGNATURE ON FILE

I, ________________________________ hereby authorize the office of **Pediatric Dentistry of Winchester (Donna Klein, DMD)** to affix my name to any and all claims or documents as to any and all health benefits due me and my dependents through my employment with ____________________. I hereby authorize payment of dental benefits otherwise payable to me, directly to the office of **Pediatric Dentistry of Winchester**. This "Signature on File" will be valid from this date and shall expire in one year. A photocopy of this document may act as an original.

## CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I, being the parent or guardian of ____________________________ __________ understand by signing this form. I will consent to your use and disclosure of my child's protected health information to carry out treatment, payment activities and healthcare operations. Your office will continue to use his/her health information in some of these ways: by calling them by first and last name from your waiting room, by posting pictures, by mailing reminder appointment cards with reason for visit, by reminding patients needing a pre-medication on reminder cards or confirmation calls, by calling to confirm appointments and internal audits of patient charts for practice evaluation purposes as described in our Notice of Privacy Practices. You have the right to request alternative means of delivery.

Signature: ______________________________________________

## ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I, ________________________________, have received a copy or been given an opportunity to review this office's Notice of Privacy Practices on this date ____________.

______________________________Staff 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 this acknowledgement. Date:__________________

_____Communication barriers prohibited obtaining acknowledgement.

_____Emergency situation prevented us from obtaining acknowledgement.

_____Other

*****Scanned Copy Serves as an Original*****

**Pediatric Dentistry of Winchester, PLLC** Dr. Donna K. Klein

In order to make your visit as prompt and as pleasant as possible, please provide the following information:

I, ________________________________________hereby give the following persons, my permission to bring my child/children to Pediatric Dentistry of Winchester.

| Name | Relationship to child/children |
| --- | --- |
| ______________________________ | ______________________________ |
| ______________________________ | ______________________________ |
| ______________________________ | ______________________________ |

# PRIVACY POLICY—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 is effective 10/21/08, 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.

## 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 for 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 healthcare 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. We will be taking a photo of each patient for in-office use only. When addressing the patient we will announce both first and last name in the waiting room.

**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 discloses 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 the Notice. We may disclose your health information to a family member, friend or other person to extent necessary to help with 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, counter intelligence, 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).

## 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 $1.00 for each page, and $50.00 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 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 prior to October 21, 2008. If you request this accounting for more than 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 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 Website or by electronic mail (E-Mail_, you are entitled to receive this Notice in written form.

## QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices of 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 use using the contact information listed at the end of this Notice. You also may submit a written complaint to the US Department of Health and Human Services. We will provide you with the address to file your complaint with the US 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 US Department of Health and Human Services.

**Contact Officer**:
Donna Klein, DMD
2560 Bypass Rd. Suite #2
Winchester, KY 40391
Telephone: (859)737-1000