JOPPA GREEN
Pediatric Dentistry

Dentistry for Infants, Children, Young Adults
& Patients with Special Needs

Patient Health History

Please complete the following health history for your child. This information is essential in making a thorough evaluation of your child's behavioral and dental needs. This document becomes part of our continuing evaluation of your child's growth and development. You will be asked to update this history periodically, so that we are aware of any changes in your child's medical history.

Thank you for your cooperation.

Susanne S. Wallengren, D.D.S.

Patient Registration

Patient's Name: _____ Nickname: _____

Birthdate: _____ Age: _____ Sex: M/F _____

School: _____Grade: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Parent's Name: _____ Birthdate: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____

Cell Phone: _____ E-Mail:_____

Occupation: _____ Employer: _____

Marital Status: ___Married ___Separated ___Divorced ___Single ___Widowed

Parent's Name: _____ Birthdate: _____

Home Address:_____

City: _____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____

Cell Phone: _____ E-Mail:_____

Occupation: _____Employer: _____

Marital Status: ___Married ___Separated ___Divorced ___Single ___Widowed

Names and Birthdates of Siblings: _____

Whom may we thank for referring you to our office? _____

Insurance Information

Does the patient have dental insurance? Y / N If yes, please complete the following:

Primary Policy Holder: _____ Social Security Number: _____

Employer: _____ Group or Policy Number: _____

Insurance Carrier: _____ Claims Phone Number:_____

Address to Send Claim: _____

Secondary Policy Holder: _____ Social Security Number: _____

Employer: _____ Group or Policy Number: _____

Insurance Carrier: _____ Claims Phone Number:_____

Address to Send Claim: _____

Medical History

Patient's Physician: _____ Phone: _____

Date of last medical visit: _____ Purpose: _____

Is the patient under the care of a physician at this time? Y / N

If yes, for what reason? _____

Is the patient currently taking any medications? Y / N If yes, please complete the following:

	Medication:	Dosage:	Frequency:	Reason:
1)	_____	_____	_____	_____
2)	_____	_____	_____	_____
3)	_____	_____	_____	_____
4)	_____	_____	_____	_____

Has the patient ever had any unusual or allergic reactions to medications or food? Y / N

If yes, please complete the following:

Medications: _____

Foods: _____ _

Other: _____

Does the patient have a known latex allergy or sensitivity? Y / N

Has the patient ever been told they have a heart murmur or evidence of heart disease? Y / N

If yes, please describe: _____

Has the patient ever been told they need to take antibiotics prior to dental treatment, due to their heart conditions? Y / N

Were there any problems associated with the pregnancy or birth of the patient? Y / N

If yes, please describe: _____

Has the patient ever been hospitalized? Y / N

If yes, please describe: _____

Has the patient had any operations or surgical procedures? Y / N

If yes, please describe: _____

Does the patient have a history of any of the following? Please respond Y or N

___ADD/ADHD
___Anemia/Blood Disorder
___Anxiety
___Asthma
___Autism Spectrum D/O
___Bipolar Disorder
___Blind/Vision Problems
___Bleeding Disorder
___Cancer/Chemotherapy
___Cerebral Palsy
___Cleft Lip/Palate
___Colitis/Crohns
___Cystic Fibrosis
___Deaf/Hearing Problems
___Depression
___Developmental Delay
___Diabetes Type: ___
___Down Syndrome
___Feeding Problems
___Food Allergies
___HIV/Aids
___Heart Murmur
___Heart Disease/Defect
___Hemophilia Type: ___
___Hepatitis Type: ___
___Hydrocephalus
___Intellectual Disability
___Kidney Problems
___Lactose Intolerance
___Language Problems
___Learning Disability
___Liver Problems
___Obsessive-Compulsive Disorder
___Organ Transplant
___Osteogenesis Imperfecta
___Respiratory Problems
___Seasonal Allergies
___Seizures
___Sickle Cell Disease
___Spina Bifida
___Syndrome, Other _____
___Tuberculosis
___Tourette Syndrome
___Wheelchair
___Other Problems/Illnesses
_____
_____
_____

Dental History

What is the purpose of this appointment? _____

Has the patient ever been to a dentist prior to today's visit? Y / N If yes, please complete:

Dentist Name: _____ Phone: _____

City/State: _____

Date of last dental visit: _____ Purpose of last dental visit: _____

Why have you decided to change dentists? _____

How do you expect your child to react to today's visit? _____

Oral Habits

Does the patient have a history of any of the following habits? If yes, please complete:

Taking a bottle to bed at night or nap time? Y / N

Until what age? _____ What was in the bottle? _____

Pacifier? Y / N Habit Pattern: _____ Until what age? _____

Finger/thumb sucking? Y / N Habit Pattern: _____ Until what age? _____

Tongue thrust? Y / N Habit Pattern: _____ Until what age? _____

Mouth breathing? Y / N Habit Pattern: _____ Until what age? _____

Tooth grinding? Y / N Habit Pattern: _____ Until what age? _____

Fingernail biting? Y / N Habit Pattern: _____ Until what age? _____

Favorite Snacks: _____

Oral Hygiene

Does the patient brush their own teeth? Y / N When? _____

Do you assist the patient in brushing? Y / N When? _____

Is dental floss used in cleaning the patient's teeth? Y / N Frequency: _____

Fluoride

Do you have well ____ or public____ water?

Is the patient currently taking fluoride supplements? Y / N If yes, please complete:

Dosage: _____

Has the patient ever taken fluoride supplements? Y / N If yes, please complete:

Dosage: _____

Has the patient ever received topical fluoride application? Y / N If yes, please complete:

Dentist applied: _____ Home rinse: _____ School rinse: _____ Brush on Rx: _____

Does the patient use toothpaste? Y / N If yes, with fluoride? Y / N

Oral Trauma

Has the patient's teeth ever been injured? Y / N

If yes, please describe: _____

Did the injury require any medical or dental treatment? Y / N

If yes, please describe: _____

Has there ever been any injury to the patient's face or jaw? Y / N

If yes, please describe: _____

Does the patient complain of clicking, popping, or crunching noises when they chew? Y / N

Has the patient's jaw ever locked open or closed? Y / N

Consent for Treatment

To the best of my knowledge, all of the preceding answers are true and correct. If there is ever a change in the patient's health and /or medications I will inform the office. I agree to update the patient's health history as requested.

I have the legal authority to grant consent for services for the above named patient.

I give my consent for dental services to be rendered for the above named patient.

In consideration of services to be rendered, I guarantee payment of all charges incurred by the patient. I understand that I am responsible for any insurance deductibles and patient responsibilities. Please check each of the following three statements and sign below.

- o I have read and understand the office Financial Policy.
- o I acknowledge receipt of the Notice Of Privacy Practices for Joppa Green Pediatric Dentistry.
- o If the patient is accompanied by someone other than their "legal guardian," or is in fact unaccompanied, I grant consent for all dental services deemed necessary by Joppa Green Pediatric Dentistry.

Date: _____ Signature: _____

Relation to Patient: _____

JOPPA GREEN
Pediatric Dentistry
Dr. Susanne Wallengren

Our office's financial policy has been established to keep our fees fair and reasonable.

Payment is expected at the time services are rendered. For your convenience we accept: cash, personal checks, and money orders, Master Card, Visa or Discover.

DENTAL INSURANCE:
If you have dental insurance coverage, we will take care of the necessary paperwork for you, submit the claim, and have the payment sent directly to us. At the time of visit please have all the necessary policy information to enable us to submit the claim. If you do not have that information, you will be responsible for the fees incurred at the time of the visit. We will then give you a receipt that you can submit to your insurance company for reimbursement. *It is your responsibility to know your insurance information.*

Dental insurance does not cover all costs for dental services. Some companies pay fixed fees for certain procedures, while others pay a percentage of the charges. What your dental insurance covers has been negotiated between your employer and the dental insurance company. We will estimate what your insurance will cover and let you know what your initial responsibility will be. That responsibility is due at the time services are rendered. After receiving payment from your insurance company, if there is an overpayment, a refund will be sent promptly, if there is a balance due, a statement will be sent for you to remit your final responsibility for that treatment. *It must be noted, that all fees incurred are ultimately your responsibility.*

OUTSTANDING/OVERDUE ACCOUNTS
If collection action is necessary on your account, you will be liable for interest of
1 ½% per month on all outstanding balances, as well as any fees incurred for collecting said account. Those fees shall include, but not be limited to attorney's fees, court costs, as well as collection agency fees.

MISSED APPONTMENTS
We reserve the right to charge a fee for appointments missed without 24 – hour notice.

SEPARATED or DIVORCED
Payment is the responsibility of the parent accompanying the child to the dental appointment. This is very important, so there are no misunderstandings regarding the necessary treatment for your child.

We hope this clarifies our financial policy. As always, we remain ready, willing, and able to answer any questions you may have.

I acknowledge that I have reviewed the financial policies, as listed above, understand them, and agree to them. Further, I have had the opportunity to have all my questions answered regarding this policy.

Signed: _____ Date:_____

Relationship to Patient: _____

2324 W. Joppa Road Suite 430 Lutherville, MD 21093
Phone: 410-321-0200 | Info@JoppaGreenPedo.com
www.JoppaGreenPediatricDentistry.com

JOPPA GREEN PEDIATRIC DENTISTRY
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
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

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 takes effect (April 14, 2003) 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 to you.

Payment: We may use and disclose your health information to obtain payment for service 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 the other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients 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 may 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, there may be a minimal charge for staff time to locate and copy your health information in that format. 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.

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 if you are concerned about a 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: Susanne S. Wallengren, DDS
Address: 2324 West Joppa Road, Suite 430, Lutherville, MD 21093
Telephone: 410-321-0200