Upward Smiles™ | Patient Information Disclosure

Patient Name: ___________________________________ Date of Birth: ______/______/_______

MoHealthNet ID Number: ____________________________ Circle One: Male Female

Does the patient have primary dental insurance ***in addition*** to Medicaid? Yes No

How did you hear about Upward Smiles? Facebook Google YouTube Other:_____________

Parent or Guardian Information

Name: ____ Mother/Father/Stepmother/Stepfather/Guardian

Address: __________________________________ City: _____________________ Zip Code: _____________

Phone #1: __________________________________ Phone #2: __________________________________

Email: ______________________________________ (used for e-confirm, newsletters, and patient correspondence)

Employer: ______________________________________ Work Number: ____________________

Please list the information for any person(s) you give permission to bring your child to our office in the event you cannot bring them in (including stepparents, grandparents, aunts, uncles, siblings over the age of 18):

____

(Name) (Relationship to patient) (Name) (Relationship to patient)

____

(Name) (Relationship to patient) (Name) (Relationship to patient)

Dental History

Is this your child's first visit to the dentist? YES NO, how long since the last visit to the dentist? ___________

Previous Dentist's Name: _______________________ Were x-rays taken at previous dental visits? YES NO

Have there been any injuries to the teeth, face or mouth? YES, please explain: ____________________ NO

Does the child have any of the following habits: Lip Sucking/ Biting: YES NO Nail Biting: YES NO
Thumb/Finger Sucking: YES NO

Is the child's water fluoridated? YES NO Do they take fluoride supplements? YES NO

Has the child ever had any pain or tenderness in the jaw or jaw joint? YES NO

How often does your child brush per day? ___________ Does your child floss daily? YES NO

Medical History

Child's Physician: _________________________________ Physician Phone Number: _______________________

Has the child had any hospital stays in the last 5 years? YES, explain: ___________________________NO

Please discuss the child's serious medical conditions or **past/upcoming surgeries**:

____

Please list all dye or food allergies: ____

Please list all drugs your child is currently taking: ____

Please list all **drugs** your child is **allergic** to: ____

I have provided accurate information above. I agree to all policies set forth and understand the entirety of the information provided. PARENT/GUARDIAN INITIAL: __________

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Patient Name: ___________________________________

Has your child been told by a **doctor** that they need **premedication before dental treatment**? YES NO

Type and amount of antibiotic: ________________________ Time taken: __________

Please indicate if your child has been treated or is under treatment for any of the following:					
	YES	**NO**		**YES**	**NO**
Abnormal Bleeding			Cancer/Leukemia		
Disabilities/Special Needs			Hepatitis A, B, or C		
ADD			LATEX ALLERGY		
Hearing Impairment			Diabetes I or II (Last A1c: __)		
ADHD			Congenital Birth Defects		
Kidney/Liver Conditions			HIV/AIDS		
Autism/Aspergers			Convulsions/Epilepsy		
Heart Disease/Surgeries			Bone Disorders		
Asthma			Tobacco/Substance Abuse		
Hemophilia/Blood Disorders			Lactose Intolerant		
Tuberculosis			Rheumatic/Scarlet Fever		
Pregnant			Been sedated for dentistry?		

***PLEASE READ FULLY - General Office Policies – PLEASE READ FULLY ***

- We will attempt to confirm an appointment multiple times the week of the appointment.
- We NEED to hear confirmation from you either by speaking to the receptionist or by voicemail that you will be coming to your appointment no later than 3:00 PM on the day prior to the appointment.
- If we have not been informed of reachable phone numbers and have received no confirmation for the appointment we are confirming, it is our office policy to consider that appointment CANCELLED.
- **Upward Smiles** (the "Practice") does not tolerate abusive or disruptive behavior or foul language. Patients/Parent/Guardian exhibiting such behavior will be dismissed from the practice. Threats are taken seriously and will be turned over to the local Police Department.

Contact and Voicemail Policy

The Upward Smiles staff will need to contact you to confirm your appointment date, make appointment schedule changes, or return any of your phone calls. In order to make this process more efficient and productive, we would like to contact you by telephone. By signing this authorization, you give us permission to contact you by phone. You are also acknowledging you are aware that "Upward Smiles" will appear on any caller ID device you may have. Any phone number that you provide us via verbal or written correspondence will be used to contact you. For example: if we attempt to call your home and mobile number to confirm an appointment unsuccessfully, we will call your work or alternative phone numbers. Any phone numbers you do not wish to be called should not be provided to us. In the event of an unanswered call, we will leave voice messages on any number that you provide to us, unless you notify us in writing not to do so. We will send correspondence via email to any email address you provide us. By providing an email address, you authorize us to send HIPAA covered patient information via email in regards to appointments, treatment plans, and continuing care. We can cancel this correspondence at any time, so long as you notify our office in writing that you would like to cancel electronic communications.

Late/Cancellation/Missed Appointment Policy

As a courtesy to all patients, we will re-schedule any patient who is more than 15 minutes late for an appointment. **We kindly ask that you give our office at least 24 hours advance notice prior to canceling or changing your**

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appointment. Patients that give 24 hours are given priority when being rescheduled. If you give a same-day notice of non-attendance as the scheduled appointment, the appointment is considered "broken". No shows are also considered "broken". The first broken appointment will automatically cancel future appointments for 3 months. This means you or your child will NOT be able to be seen for 3 months unless there is an emergent concern or medical issue. The same protocol is effective for the second broken appointment. Three recorded missed or broken appointments in a patient's history will result in dismissal from the practice, except when prohibited by law. This means that you will not be seen by the Practice, and will have to receive care from another office. We are unable to make exceptions to this policy.

Parents/Guardians with Children

The Practice allows a parent to be present with a child during the child's 1st visit only. If the parent is with additional children, then the parent will need to stay in the waiting room with the other children. If you are bringing more than one child to the appointment we recommend you bring another responsible adult to watch the additional children while you accompany your child to the hygiene room. We cannot be responsible for children left unattended in the waiting room. A parent or legal guardian/authorized person is required to be present when a minor presents for any visit. Legal guardians must supply proof of legal guardianship before Upward Smiles will see the child. Only a parent, legal guardian, or designated adult may sign for the treatment of a minor therefore treatment will not be rendered to minors without written signature of parent or guardian; in this situation the minor will be rescheduled.

Consent of Service

Your child may receive dental services (Exams, X-Rays, Cleanings, Injections, Fillings, Sedative Fillings, Extractions, Stainless Steel Crowns, Pulpotomys, Sealants and Space Maintainers) at any appointment they make with the Practice at the direction of a licensed dental professional. You hereby give permission for your child to receive any dental services recommended by the Practice. In the event that your child presents for an appointment with another authorized adult, you give that adult permission to authorize additional treatment on your child as requested by staff of the Practice.

HIPAA

I understand that I have certain rights to privacy regarding my protected health information (PHI). These rights have been given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent form, I authorize Upward Smiles, Inc. to use and disclose my protected health information to carry out treatment (including direct or indirect treatment by other healthcare providers involved in my treatment), obtain payment from third party payers, carry out day to day healthcare operations of the practice including, but not limited to phone calls regarding appointments and patient information, and forward any of mine and/or my children's health information to any provider in which the practice refers me to. I have also been informed of, and given the right to review a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that Upward Smiles, Inc. reserves the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to these restrictions. However, if you do agree, you are then bound to comply with these restrictions. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

I CERTIFY THAT I HAVE REVIEWED PAGES 1 through 3 of this patient information disclosure on the date below, and I understand and agree to any and all policies set forth. The information provided on this paperwork is to the best of my knowledge and I will not hold Upward Smiles, Inc. responsible for any errors/omissions that I on these forms.

PRINT PARENT/GUARDIAN NAME: ____

SIGN: ____DATE: _____/_____/_______