Dentistry for Children & Adolescents. Ltd.

Dr. Kala Hinz
Dr. Vera Kenderian

Dear Parents and Guardians,

Welcome to your child's new dental home! We are experienced and caring health care professionals who will guide your child through age appropriate dental health care instruction, supervision of growth and development, and preventive measures to prepare your child for a lifetime of excellent oral health.

Please complete the enclosed forms and bring them with you to your child's first visit. It is important that these forms are thoroughly completed prior to the visit so our clinical team can evaluate your child's individual needs when you arrive. You will have enough time at the beginning of the appointment to ask any questions that you may have regarding this packet of information.

If you have any other questions regarding your child's first appointment, please call the office. We look forward to meeting you and serving your child's dental health care needs.

Sincerely yours,

Dr. Kala L. Hinz

Dr. Kala Hinz

Dr. Vera Kenderian

2743 Superior Drive NW | Rochester, Minnesota 55901 | PHONE: (507) 288-8060 | FAX: (507) 288-3344
www.dentistryforchildrenrochester.com | email: team@dentistryforchildrenrochester.com

ADA

Today's Date ______________________ Acct. # ______________

Child's Full Name ______________________ Age_____ Sex_____ Birthdate___/___/___

Child's Nickname ______________________ Adopted: Yes____ No____ School ______________________

Financially Responsible Parent or Guardian (Print name) ______________________

Signature of Financially Responsible Parent or Guardian ______________________

Mr./Mrs./Ms./Dr.
Parent's Name ______________________ Birthdate___/___/___

Address ______________________ City ______________ State____ Zip_____ S.S. # ______________

Home Phone ______________ Cell Phone ______________ Email ______________________

Employer ______________ Occupation ______________ Work Phone ______________ Ext. __________

Dental Insurance: Yes____ No____ If yes, insurance company ______________ Group # ______________

Mr./Mrs./Ms./Dr.
Parent's Name ______________________ Birthdate___/___/___

Address ______________________ City ______________ State____ Zip_____ S.S. # ______________

Home Phone ______________ Cell Phone ______________ Email ______________________

Employer ______________ Occupation ______________ Work Phone ______________ Ext. __________

Dental Insurance: Yes____ No____ If yes, insurance company ______________ Group # ______________

Email to confirm appointments ______________________

Parent's Marital Status: Single____ Married____ Separated____ Divorced____ Widowed____ Other________

Do we see other children in your family? If yes, please name ______________________

In case of emergency (if we are unable to reach the child's parents): Name ______________________

Address ______________________ Phone ______________ Relationship ______________

RELEASE

I authorize dental health care for my minor child, ______________________, to be performed by Dr. Kala Hinz and/or Dr. Vera Kenderian. I understand that, if my child is ineligible for dental insurance, MinnesotaCare or state assistance on the service date, I will be responsible for payment of all charges.

Parent or Guardian's Signature ______________________ Date ______________

Thank you for taking the time to complete the above personal history.

Dr. Kala Hinz and Dr. Vera Kenderian

HEALTH HISTORY

Patient's Name: ___________________________ Birthdate: ____________________ Today's Date: ______________

Medical Physician's Name: ____________________________________ Location: ___________________________

Specialists (if applicable): _________________________ Date of last physical examination: __________________

Has your child ever been hospitalized? ___yes ___no If so, when and why? _______________________________

____

Is your child taking any medications? ___yes ___no If yes, please list medications and dosage: _________________

____

Allergies: ___________________________________ Allergies to Medications: ________________________________

Are your child's immunizations up-to-date? ___yes ___no

Does your child have any unusual fears? ____

DOES YOUR CHILD HAVE OR HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING CONDITIONS:
(Please circle the correct response.)

Adverse drug reaction	Yes	No	Diabetes	Yes	No	Muscular dystrophy	Yes	No
Anemia	Yes	No	Down syndrome	Yes	No	Pregnancy	Yes	No
Asthma	Yes	No	Emotional problems	Yes	No	Premature birth	Yes	No
Ataxia	Yes	No	Fainting spells	Yes	No	# weeks gestation_____		
Attention deficit disorder	Yes	No	Headaches	Yes	No	Psychiatric problems	Yes	No
Autism	Yes	No	Hearing loss/impairment	Yes	No	Rheumatic fever	Yes	No
Birth defects	Yes	No	Heart condition/murmur	Yes	No	Seizures	Yes	No
Bleeding problems	Yes	No	Hepatitis	Yes	No	Sexually transmitted disease	Yes	No
Blood transfusions	Yes	No	Herpes	Yes	No	Sickle cell anemia	Yes	No
Date_______________			High blood pressure	Yes	No	Skin disorders	Yes	No
Cancer	Yes	No	HIV/AIDS	Yes	No	Speech problems	Yes	No
Cerebral palsy	Yes	No	Infections (recurrent)	Yes	No	Spina bifida	Yes	No
Chronic ear infections	Yes	No	Jaundice (not at birth)	Yes	No	Tuberculosis	Yes	No
Cognitive delay	Yes	No	Kidney disease	Yes	No	Tumors	Yes	No
Cystic fibrosis	Yes	No	Latex allergy/sensitivity	Yes	No	Vision problems	Yes	No
Delayed speech dev.	Yes	No	Learning disabilities	Yes	No			
Development delay	Yes	No	Liver disease	Yes	No			

Please explain all "yes" responses.

____

Please list any other problems/conditions we should be aware of prior to treatment: ___________________________

____

____

____

Signature Relationship to Child Date

Patient Name____

Reason for today's visit____

Whom may we thank for referring your child? ____________________________

Has your child seen a dentist previously?____yes ____no

Name and location of dentist ____

Date of most recent exam ______________ Date of most recent x-rays ______________

Was the experience ____ favorable ____unfavorable?

How do you feel your child will react to this dental visit?

____cooperative ____uncooperative ____unsure

Was your child breast fed? ____yes ____no If yes, for how long?_____________months

At what age was bedtime nursing discontinued? ______________ months

Was your child bottle fed?____yes ____no If yes, for how long?___________months

At what age was the bedtime bottle discontinued? ______________ months

Contents of the bedtime bottle____________________

Has your child sucked his or her fingers or thumb? ____yes ____no If yes, for how long?____________years

Has your child used a pacifier? ____yes ____no If yes, for how long? _______________ years

Does your child grind his or her teeth? ____yes ____no

Is your child a mouth breather? ____yes ____no

Has your child had any injuries to his or her teeth? ____yes ____no

If yes, describe ____

How often does your child brush his or her teeth? ____________________________________

How often do you assist your child with toothbrushing?

Is your child using fluoride toothpaste _____ or non-fluoride toothpaste _____?

Does your child like to brush his or her teeth? ____yes ____no

Do you floss your child's teeth? ________________ How often?____________

What is your child's primary source of drinking and cooking water?

__ city water __ well water __bottled water __ filtered water (type of filter_____________)

Does your child currently receive any of the following fluoride supplements?

__ Fluoride drops or tablets __ vitamin/fluoride combination

__ home rinse (over the counter) __ home use gel (prescription)

Has your child ever complained of any of the following?

__ toothache __ jaw joint pain (TMJ)

__ teeth sensitive to hot/cold __ frequent headaches

Do you have any special concerns about your child or is there anything else we should know about your child prior to initiating dental care? ____

Thank you for completing this personal dental history for your child. The information which you provide allows to more appropriately plan for your child's emotional and dental needs while making a thorough evaluation of your child's dental health.

I hereby certify the foregoing information is true and correct.

Signature of parent/guardian________________________________relationship _____________date ______

DENTAL HISTORY

Dentistry for Children and Adolescents, Ltd.

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 Notice takes effect on 4/14/03, 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 services 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.

Dentistry for Children and Adolescents, Ltd.

CONSENT FOR USE & DISCLOSURE OF HEALTH INFORMATION

Parent/Guardian:______________________________ Patient Name__________________________________

Address:____

____

PURPOSE OF CONSENT: By signing this form you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

NOTICE OF PRIVACY PRACTICES: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. The Notice provides a description of treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we make changes, we will issue a revised Notice of Privacy Practices. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions, at anytime by contacting:

Office Administrator
(507) 288-8060 or fax (507) 288-3344
2743 Superior Drive NW
Rochester, MN 55901

RIGHT TO REVOKE: You have the right to revoke this Consent at any time by giving us written notification of your revocation submitted to the contact person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation. However, we may decline to treat you, or to continue treating you, if you revoke this Consent.

SIGNATURE:

I,____, have had the opportunity to read and consider the contents of this Consent form and the Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature____ **Date**____________________

If signed by parent/guardian/or personal representative on behalf of the patient, complete the following:

Personal Representative's Name:____

Relationship to Patient:____

You are entitled to a copy of this consent after you sign it.
Completed copy is included in the patient's chart.

USE OF THIS FORM IS REQUIRED BY THE STATE OF MINNESOTA.

Dentistry for Children & Adolescents, Ltd.

Dr. Kala Hinz
Dr. Vera Kenderian

PERMISSION FORM

I, ____________________, mother/father/legal guardian give my permission for the staff at Dentistry for Children and Adolescents, Ltd. to communicate and share information regarding appointments, treatment planning, and financial arrangements in writing and conversation with the following persons **(other than parents):**

Name	Relationship to Patient
______________________	______________________
______________________	______________________
______________________	______________________

Regarding the following patient(s):

____
Patient's Name

____
Patient's Name

____
Patient's Name

I have read and understand the conditions of this form. This permission is valid unless revoked by a legal guardian or Dentistry for Children and Adolescents, Ltd.

Signature of parent/legal guardian: ______________________________

Daytime phone numbers: ______________________ ______________________

Parent/Guardian Email Address: ______________________________

Date: ______________________________

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FINANCIAL POLICY FOR DENTAL SERVICES

For families who have dental insurance (for preventive appointments):

*As a courtesy, we will submit dental claims to your insurance. Once the insurance company pays, we will send you a billing statement that is due upon receipt for services not covered.

For families who have dental insurance (for restorative appointments):

*As a courtesy, we will submit a pre-treatment estimate to your insurance company to determine what they will cover. At your child's restorative appointment, we will collect from you any patient responsibility that is owed based on the pre-estimate. If you have specific questions about coverage, please contact your insurance company.

For families who have reimbursement plans or that do not carry dental insurance:

*Payment is due the date of service. For your convenience, payments can be made using Cash, Check, Visa, MasterCard, Discover and Care Credit.

Accounts over 90 days past due are subject to collection action.

*If you need financial arrangements, please contact us and we will be happy to assist you with one of the payment options we can offer your family.

____ __________________

Parent/Guardian Signature Date