DATE:___________________

Patient Information

Name ____ Nickname __________ Sex **M** **F**
Last First Middle

Address ____
Street City Zip

Age _____ Birthdate _____/_____/_____ School ______________________ Grade ______

Sports/Hobbies/Interests ____

Siblings ____

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

Responsible Party Information

Name ____
Last First Middle

Address ____
Street City State ZIP

Home Phone ________________ Cell Phone ____________________ Preferred Contact **Home** **Cell**

Email Address ____

Relationship to Patient _________________ SS # _________________ Occupation _____________

Birthdate _____/_____/_____ Employer ______________________Work Phone ______________________

Marital Status **Single** **Married** **Divorced** **Adoptive Parent** **Foster Parent**

Significant Other's Name ____

Relationship to Patient_________________ SS # _________________ Occupation _____________

Birthdate _____/_____/_____ Employer _____________________ Cell Phone _______________________

Dental Insurance Information

Policy Owners Name ______________________ Policy Owner's SS# ______________________

Policy Owner's Birthdate _____/_____/_____ Relationship to Patient ______________________

Insurance Company ______________________ Group No. ______________________ Phone No. ______________________

Insurance Company Address ______________________

Do you have dual coverage? **YES** **NO** If Yes:

Policy Owners Name ______________________ Policy Owner's SS# ______________________

Policy Owner's Birthdate _____/_____/_____ Relationship to Patient ______________________

Insurance Company ______________________ Group No. ______________________ Phone No. ______________________

Insurance Company Address ______________________

Medical History

Has your child ever had any of the following conditions?

- **Y N** Asthma/Lung Troubles
- **Y N** Anemia
- **Y N** Allergies to Drugs/Foods
- **Y N** Autism/Asperger's
- **Y N** Behavior Issues (ADD/ADHD)
- **Y N** Blood Disorders
- **Y N** Cancer
- **Y N** Cong. Birth Defects
- **Y N** Diabetes
- **Y N** Disabilities/Special Needs
- **Y N** Epilepsy or Seizures
- **Y N** Hearing Impairment
- **Y N** Heart Conditions/Murmur
- **Y N** Hepatitis/HIV/AIDS
- **Y N** Hospitalizations/ Surgeries
- **Y N** Kidney/Liver Conditions
- **Y N** Neurological Conditions
- **Y N** Pregnancy
- **Y N** Premature Birth
- **Y N** Tuberculosis

If **YES**, please explain ______________________

Please list all drugs/medications the child is currently taking ______________________

Child's Physician ________________________ Phone Number ________________________

Dental History

Is this your child's first visit to the dentist? **YES** or **NO**

If No, where and when was your child last seen? ________________________

Were any X-rays taken at previous dental visits? **YES** or **NO**

Has your child ever had a traumatic experience at the dental office? ________________________

Any questions or concerns about your child's teeth? ________________________

Any of the following habits?

Y N Frequent snacking
Y N Lip Sucking / Biting
Y N Sleeping with a bottle
Y N Tooth Grinding
Y N Sippy Cup Use
Y N Night-time feeding
Y N Nail Biting
Y N Thumb/Finger Sucking
Y N Snoring
Y N Pacifier Use

Does your child brush his/her own teeth? **YES** **NO**

How often? ____________ x a day

Do you floss his/her teeth? **YES** **NO**

Is your child able to spit? **YES** **NO**

What kind of toothpaste do you use? ________________________

ACKNOWLEDGEMENT AND AUTHORITY

Since the child is a minor, it becomes necessary that signed permission is obtained from a parent or guardian before services can be rendered. 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.

I ALSO ACKNOWLEDGE FULL RESPONSIBILITY FOR THE PAYMENT OF SUCH SERVICE AND AGREE TO PAY FOR THEM, IN FULL, AT THE TIME OF SERVICE. I ALSO UNDERSTAND THAT WHERE APPROPRIATE, CREDIT BUREAU REPORTS MAY BE OBTAINED.

____

Signature of Parent or Guardian Date Relationship to Child

____

Doctor Signature Date

Sea of Smiles Pediatric Dentistry
1501 N. Main Street
Warrington
Pennsylvania, 18976

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH AND MEDICAL 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 AND MEDICAL INFORMATION IS IMPORTANT TO US.

OUR RESPONSIBILITIES

We at Sea of Smiles Pediatric Dentistry understand that medical information about you and your health is personal. Applicable federal and state law requires us 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 07/30/2018, and will remain in effect until we replace it. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. 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 may use and disclose health information about you for treatment, payment, and healthcare operations. For example:

To Treat You: We can use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Billing and Payment For Services: We can use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We can use and disclose your health information in connection with our healthcare operations which 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 another 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 purposes without your written permission.

Required by Law: We may use or disclose your health information when we are required to do so by state or federal law, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy 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 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.

Respond to organ and tissue donation requests: We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director: We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests: We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions: We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, text messages 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, mailing, 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 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 at 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 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 by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

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.

Privacy Officer: Jordan Dierolf
Telephone: 215-433-1835
E-mail: info@seaofsmilespa.com
Address: 1501 N. Main Street
Zip Code: 18976
State: Pennsylvania
City: Warrington

Sea of Smiles Pediatric Dentistry - 301 Oxford Valley Road, Suite 1801, Yardley PA

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"You May Refuse to Sign This Acknowledgment"

I, ______________________ have been informed of this office's Notice of Privacy Practices.

____
Print Name

____
Signature

____
Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

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

____
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