REGISTRATION FORM

We appreciate you taking the time to fill out this form completely.

Patient's Name: _____ Date of Birth: ____/____/_____ Age: ____
Nickname/Preferred Name: _____ Gender: ☐ Male ☐ Female
Home Address: _____ City: _____ State: ____ Zip: _____
School: _____ Grade: _____
Mother's Name: _____ Father's Name: _____ Guardian: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____ Email: _____
Parents are: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other: _____
How did you hear about our office? _____
Reason for visit: _____

Insured Parent's Employer: _____
Insured Parent's Employer Address: _____
City: _____ State: ____ Zip: _____
Mother's Driver License #: _____ Father's Driver's License #: _____
Child's SSN: _____ Mother's SSN: _____ Father SSN: _____
Person Responsible for Account (*Other than Parent*): _____

PRIMARY DENTAL INSURANCE
Insured's Name: _____ Date of Birth: ____/____/____
Employer: _____
Insurance Co.: _____ Policy No.: _____ Effective Date: _____

SECONDARY DENTAL INSURANCE
Insured's Name: _____ Date of Birth: ____/____/____
Employer: _____
Insurance Co.: _____ Policy No.: _____ Effective Date: _____

We bill most major insurance companies on your behalf.
We accept payment by Mastercard, Visa, American Express and Discover.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered completely and fully to my knowledge and satisfaction. I acknowledge that any errors or omissions that I have made in the completion of this form may affect my child's dental care, and I will do my best to correct these errors as soon as I become aware of them. I hereby authorize payment of insurance dental benefits otherwise payable to me, to Karen Benitez, DDS, Chevy Chase Pediatric Dentistry. I realize that I am responsible for any charges not covered by this authorization.

Signature: _____ Date: _____

PEDIATRIC DENTAL AND MEDICAL HISTORY

We appreciate you taking the time to fill out this form completely.
Your answers may affect your child's dental care.

Child's Name and (Nickname): _____ Today's Date: ____/____/_____ Date of Birth: ____/____/_____

Age: ____ Gender: ☐ Male ☐ Female Is Child Adopted? ☐ Yes ☐ No From: _____

Mother's Name: _____ Father's Name: _____ Guardian: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Email: _____

Parents are: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other: _____

Does your child have ANY condition that requires ANTIBIOTICS prior to dental treatment? ☐ Yes ☐ No

DENTAL HISTORY

Date of Child's Last Visit to a Dentist: ____/____/_____ What Service? _____

Has your Child complained of dental problems? ☐ Yes ☐ No What? _____

Do you believe your Child has tooth decay? ☐ Yes ☐ No ☐ Don't Know

Has your Child had any injury to head or teeth? ☐ Yes ☐ No Describe? _____

Has your Child lost any teeth due to injury? ☐ Yes ☐ No Describe? _____

Does your Child have any mouth habits such as:

Thumb Sucking: ☐ Yes ☐ No Nursing Bottle Habits: ☐ Yes ☐ No Nail Biting: ☐ Yes ☐ No Pacifier: ☐ Yes ☐ No

Mouth Breathing: ☐ Yes ☐ No Speech Habits: ☐ Yes ☐ No Describe: _____

Has your Child had any orthodontic treatment, braces, appliances? ☐ Yes ☐ No Describe: _____

ORAL HYGIENE

Does your Child brush teeth daily? ☐ Yes ☐ No Do YOU assist child with tooth brushing daily? ☐ Yes ☐ No ☐ Sometimes

Is dental floss used? ☐ Yes ☐ No By Whom? ☐ Child ☐ Parent ☐ Both ☐ Daily ☐ Sometimes

Is your water fluoridated? ☐ Yes ☐ No, or do you HAVE or NEED a Fluoride RX? ☐ HAVE ☐ NEED

NATURE OF TODAY'S VISIT

New Patient Comprehensive Examination? ☐ Yes ☐ No or Emergency? ☐ Yes ☐ No Describe: _____

What is your Child's attitude toward visiting the dentist? ☐ Positive ☐ Neutral ☐ Negative

Has your Child had any unhappy dental experiences? ☐ Yes ☐ No Where, When? _____

Describe any concerns you have about your Child's behavior at the dentist: _____

_____

MEDICAL HISTORY

Child's Primary Care Physician: _____ Address: _____ Phone: _____

Date of last physical examination: ____/____/_____ Results: _____

Any other Physicians? ☐ Yes ☐ No Other Physician's Name, Address and Phone: _____

MEDICAL HISTORY (CONTINUED)

Are your Child's immunizations up to date? ☐ Yes ☐ No

Allergies/Sensitivities/Reactions
Anesthetics, Local and/or General ☐ Yes ☐ No Describe: _____

Sedative Agents ☐ Yes ☐ No Describe: _____

Drugs or Medications (*such as antibiotics*) ☐ Yes ☐ No Environmental (*such as pollen, dogs, cats, dust*) ☐ Yes ☐ No

Latex, Food, Dyes, Metal, Acrylic ☐ Yes ☐ No

Medications, including over-the-counter analgesics, vitamins and herbal supplements
What is the Child taking? _____ Dose: _____ Frequency: _____ Any reactions? ☐ Yes ☐ No

Hospitalizations and/or Surgeries
Reason(s), Date(s), Outcome(s): _____

Significant Injuries (*such as to head or teeth, broken bones, severe lacerations, car accidents*):
Describe, Date, Outcome: _____

Has Child had ANY History with ANY of the following?

☐ Yes ☐ No Complications during Pregnancy
☐ Yes ☐ No Prematurit
☐ Yes ☐ No Congenital Anomalies
☐ Yes ☐ No Cleft Lip/Palate
☐ Yes ☐ No Inherited Disorders
☐ Yes ☐ No Nutritional Deficiencies
☐ Yes ☐ No Problems of Growth or Stature
☐ Yes ☐ No Lesions (sores) in or around the mouth
☐ Yes ☐ No Chronic Adenoid/ Tonsil Infections
☐ Yes ☐ No Chronic Ear Infections
☐ Yes ☐ No Ear or Hearing Problems
☐ Yes ☐ No Eye or Visual Problems
☐ Yes ☐ No Sinusitis
☐ Yes ☐ No Speech Impairments
☐ Yes ☐ No Apnea/Snoring/Mouth-Breathing
☐ Yes ☐ No Transfusion
☐ Yes ☐ No Excessive Bleeding
☐ Yes ☐ No Bruising Easily
☐ Yes ☐ No Hemophilia Type: _____
☐ Yes ☐ No Sickle Cell Disease Trait: _____
☐ Yes ☐ No Cancer, Tumor, other Malignancy Type: _____
☐ Yes ☐ No Immune Disorder
☐ Yes ☐ No Chemotherapy Type: _____
☐ Yes ☐ No Radiation Therapy
☐ Yes ☐ No Hematopoietic cell (bone marrow) Transplant
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Growth Delays
☐ Yes ☐ No Hormonal Problems
☐ Yes ☐ No Precocious Puberty
☐ Yes ☐ No Thyroid Problems
☐ Yes ☐ No Eating Disorder, Ulcer, Excessive Gagging
☐ Yes ☐ No GERD (Gastro Esophageal/ Acid Reflux Disease)
☐ Yes ☐ No Hepatitis A B C or Variant
☐ Yes ☐ No Liver Disease
☐ Yes ☐ No Intestinal Problems
☐ Yes ☐ No Prolonged Diarrhea
☐ Yes ☐ No Unintentional Weight Loss
☐ Yes ☐ No Lactose Intolerance
☐ Yes ☐ No Dietary Restrictions What: _____
☐ Yes ☐ No Kidney Disease or Infections
☐ Yes ☐ No Bladder Disease or Infections
☐ Yes ☐ No Sexually Transmitted Disease(s)
☐ Yes ☐ No Females: Pregnancy
☐ Yes ☐ No Birth Control Pills
☐ Yes ☐ No Asthma
☐ Yes ☐ No Asthma Medications, Triggers, Last Attack Hospitalizations: _____
☐ Yes ☐ No Tuberculosis
☐ Yes ☐ No Cystic Fibrosis
☐ Yes ☐ No Frequent colds, coughs, syncytial virus
☐ Yes ☐ No Reactive airway disease/ breathing problems:
☐ Yes ☐ No Smoking
☐ Yes ☐ No Congenital Heart Defect or Disease
☐ Yes ☐ No Heart Murmur
☐ Yes ☐ No Rheumatic Fever or Rheumatic Heart Disease
☐ Yes ☐ No Anemia
☐ Yes ☐ No Blood Disorder
☐ Yes ☐ No Arthritis
☐ Yes ☐ No Scoliosis
☐ Yes ☐ No Bone or Joint Problems
☐ Yes ☐ No TMJ (temporomandibular joint) Problems (clicking, popping, locking, difficulties opening)
☐ Yes ☐ No Fever Blisters
☐ Yes ☐ No Eczema
☐ Yes ☐ No Rash/Hives
☐ Yes ☐ No Skin Condition
☐ Yes ☐ No Fainting
☐ Yes ☐ No Dizziness
☐ Yes ☐ No Autism Type? _____
☐ Yes ☐ No Developmental Disorders Type: _____
☐ Yes ☐ No Learning Problems/Delays Type: _____
☐ Yes ☐ No Mental Disability
☐ Yes ☐ No Brain Injury
☐ Yes ☐ No Cerebral Palsy
☐ Yes ☐ No Convulsions/Seizures
☐ Yes ☐ No Epilepsy Type: _____
☐ Yes ☐ No Headaches/Migraines: Mild, Moderate, Major Duration? _____
☐ Yes ☐ No Hydrocephaly
☐ Yes ☐ No Shunts Type: _____
☐ Yes ☐ No Measles, Mumps Rubella, Scarlet Fever, Varicella (Chicken Pox), Mononucleosis
☐ Yes ☐ No Cytomegalovirus (CMV), Pertusis (Whopping cough)
☐ Yes ☐ No Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome (HIV/AIDS)
☐ Yes ☐ No Is there a family history of Genetic Disorders, problems with general anesthesia, or serious medical problems or illnesses
☐ Yes ☐ No Passive Smoke Exposure

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information I should be aware of that we have not discussed: _____

May we request release of your Child's medical records? ☐ Yes ☐ No

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered completely and fully to my knowledge and satisfaction. I acknowledge that any errors or omissions that I have made in the completion of this form my affect my child's dental care, and I will do my best to correct these errors as soon as I become aware of them.

This information was discussed with and given by ☐ Mother, ☐ Father, ☐ Legal Guardian, ☐ Other: _____

Signature: _____ Date: _____

HIPPA PRIVACY AND SECURITY POLICY ACKNOWLEDGMENT FORM

This notice describes how medical information about you may be used and disclosed and how to get access to this information. Please review it carefully.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we will ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;

- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

---------- tear here ----------

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Chevy Chase Pediatric Dentistry's Notice of Privacy and Security Policy.

Patient's Name: _____ Signature: _____ Date: _____

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient's Name: _____ Number: _____
Address: _____ Phone Number: _____

I authorize the professional office of my dentist named above to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1. Detailed description of the information to be released:
2. To whom may the information be released [name(s) or class(es) of recipients]:
3. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):
4. Expiration date or event relating to the individual or purpose for the release:

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient's Name: _____ Signature: _____ Date: _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient: _____ Print Name: _____
Source of Authority: _____