Jay J. Harris, D.M.D. and Cathy L. Harris, D.M.D
34 W. Main Street, Suite 400
Christiana Village Professional Center
Newark, DE 19702
(302)453-1400
www.wildsmiles4kids.com

Cell Phone: _____
Email: _____

1. Tell Us About Your Child
Child's Name_____
Goes by _____
___Male ___Female Child's birthdate: ___/___/___
School _____ Grade ____
Child lives with: (circle all that apply)
Mother Father Other: _____
Child's Home Address_____
_____
Names of siblings that we treat:
_____
_____
_____
Child's Interests (sports/hobbies/character): _____
_____

2. How did you hear about us?
___Phone book ___Internet ___Magazine ad
___Referred by: Name _____

3. How do you prefer we contact you for appointment confirmation and reminders? (check any or all)
___ Text _____
___ Email _____
___ Phone_____

4. Guardian #1 Information
Name _____
(Circle one) Mother Father Guardian
Birthdate ___/___/___SS# _____
Address _____
Phone# _____
Email Address _____
Employer _____
Address of Employer _____
_____
Work Phone #_____Occupation _____

5. Guardian #2 Information
Name _____
(Circle one) Mother Father Guardian
Birthdate ___/___/___SS# _____
Address _____
Phone # _____
Email Address _____
Employer _____
Address of Employer _____
_____
Work Phone #_____Occupation _____

6. Primary Dental Insurance
Policy Holder's Name _____
Insurance Co. Name _____
Insurance Co. Address _____
_____
Insurance Co. Phone # _____
Group # _____ID# _____

7. Secondary Dental Insurance
Policy Holder's Name _____
Insurance Co. Name _____
Insurance Co. Address _____
_____
Insurance Co. Phone # _____
Group # _____ID# _____

8. Person Responsible for Account
Name _____
Relationship to patient _____
Billing Address _____
Home Phone _____
Work Phone _____
Cell Phone _____
Email Address _____

Please note that payment is expected at time of service. There may be a charge for broken appointments without 24 hours notice.
I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature: _____ **Date:** _____

9. Health History

Child's Physician: _____ Phone number: _____ Last physical: _____ Approx. weight: _____

a) Is your child presently under the care of a physician for any medical problem? YES NO

If yes, please list current medical conditions _____

b) Is your child taking any over-the-counter or prescription medications? YES NO

If yes, please list all current medications _____

c) Has your child ever been hospitalized or had a surgical procedure? YES NO

If yes, please list procedures/dates_____

d) Does your child have any drug allergies? YES NO

If yes, please list drug allergies _____

e) Has your child ever had any sensitivity or allergic reaction to any of the following (check all that apply)? YES NO

__Nuts __Soy __Latex/Rubber __Pollen/Dust __Eggs

__Metals __Animals __Berries __Milk __Wheat/Gluten

__Anesthetic __Acrylic __Dyes/Colorings __Others: _____

f) Has your child ever had a history or difficulty with any of the following?

Anemia	Yes	No	Cerebral Palsy	Yes	No	Liver Problems	Yes	No
Artificial Prosthesis	Yes	No	Diabetes	Yes	No	Pregnancy	Yes	No
Asthma	Yes	No	Eating Disorder	Yes	No	Rheumatic Fever	Yes	No
Bleeding Disorder	Yes	No	Epilepsy/Seizures	Yes	No	Speech Problems	Yes	No
Blood Transfusions	Yes	No	Hearing Problems	Yes	No	TMJ Problems	Yes	No
Bone Disorders/Fractures	Yes	No	Heart Disease	Yes	No	Tuberculosis (TB)	Yes	No
Brain Injury	Yes	No	Heart Murmur	Yes	No	Vision Problems	Yes	No
Cancer	Yes	No	Hepatitis	Yes	No	Other _____		
Congenital Birth Defects	Yes	No	HIV/AIDS	Yes	No			
Cystic Fibrosis	Yes	No	Kidney Problems	Yes	No			

g) Has your child ever had a history of or been diagnosed with any of the following?

ADD/ADHD	Yes	No	Developmental Disorder	Yes	No	Learning Problems	Yes	No
Autism	Yes	No	Depression/Anxiety	Yes	No	Emotional Problems	Yes	No
Behavioral Problems	Yes	No	Intellectual Disability	Yes	No	Other _____		

h) Are there any other precautions or limitations that we should be aware of? _____

10. Dental History

a) Is this your child's first dental visit? YES NO

b) If not, when was the last visit to the dentist? _____

Previous Dentist _____ Phone number _____

Were any x-rays taken? YES NO Was a panoramic x-ray ever taken? YES (Date:_____) NO

How was his/her experience? _____

Does your child have any dental anxiety (eg. fearful, nervous)? YES NO If Yes, what is the underlying cause (eg. previous negative experience)? _____

c) Has your child had any injuries to teeth/face/jaw? YES NO

If yes, when and how did it occur? _____

d) Does your child have a history of any of the following habits?

a) thumb/finger-sucking __Never __Yes, currently _____Yes, age when stopped

b) pacifier __Never __Yes, currently _____Yes, age when stopped

c) nursing/bottle feeding __Never __Yes, currently _____Yes, age when stopped

d) mouth breathing __Never __Yes, currently _____Yes, age when stopped

e) other _____ __Yes, currently _____Yes, age when stopped

11. I hereby attest that I am the legal, responsible parent or guardian of the aforementioned child. I understand that the information I have provided 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 the office of any changes in my child's health status. I hereby consent to such exams, diagnostic, and curative treatment, accepted behavior management techniques, x-rays, local anesthesia, inhalation, and oral medication as necessary upon the aforementioned child. If I have any objections to certain aspects of treatment, I have stated so in the space provided. _____

Signature: _____ Relationship to Patient: _____ Date:_____

Doctor's signature: _____ Date: _____

HIPAA CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PATIENT NAME:_____

ADDRESS;_____

Telephone:_____

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

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. Our Notice provides a description of our 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. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. 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 of our Notice, at any time by contacting:

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34 W. Main Street, Suite 400
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Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice 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, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I,_____, have had full opportunity to read and consider the contents of this Consent form and your 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:_____**RELATIONSHIP TO PATIENT**_____

Date:_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement.

I,_____have received a copy of this office's Notice of Privacy Practices.
Parent/Guardian

Patient name_____

Signature_____

Date_____

_____

OTHER RESPONSIBLE GUARDIANS WHO MAY ACCOMPANY PATIENT TO OFFICE VISITS:

NAME:_____ TELEPHONE #_____

NAME:_____ TELEPHONE#_____

NAME:_____ TELEPHONE #_____

_____

FOR OFFICE USE ONLY

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

___ Individual refused to sign.

___ Communications barriers prohibited obtaining the acknowledgement.

___ An emergency situation prevented us from obtaining acknowledgement.

___ Other (Please specify).

Thank you for selecting us as part of your child's personal dental care team. To promote a long-term mutually satisfying relationship, we would like to explain our office policy regarding treatment, insurance, appointments, and fees. PLEASE, read this carefully and ask any questions or bring up any concerns you may have BEFORE treatment is rendered. SUBMISSION TO TREATMENT IMPLIES YOUR CONSENT TO TERMS OF THIS AGREEMENT.

TREATMENT: You will find our entire staff dedicated to helping you improve your dental health as quickly as possible. Every effort will be made to make your appointment as comfortable and pleasant as possible. Please feel free to discuss your treatment with the doctor at any time

INSURANCE: If this office is able to accept your insurance company's assignment, the patient is still FULLY RESPONSIBLE for the charges for treatment rendered. Your insurance MAY NOT COVER the services or may only PARTIALLY cover them and any ESTIMATE given by this office is considered a GUIDELINE until the final insurance is received and the patient's account is reconciled. The office can make NO GUARANTEE of the actual payment by your insurance company.

MISSED APPOINTMENTS: When we schedule your appointment, the time is reserved exclusively for you. When you fail to notify us of your inability to keep an appointment, another patient in need of dentistry is unable to receive treatment. We request that you give us at least 24 hours notice when you realize that you cannot make the appointment. When the requested notice is not given, a fee will be charged. For those whose schedules make it difficult to effectively plan ahead, we ask that you do not schedule an appointment in advance, but that you call us the day you can come in and we will be happy to see you then-provided the time is available. LATE ARRIVALS: Because we respect the value of your time, we recognize the importance of seeing our patients at their appointed time. You may be asked to reschedule your appointment if you arrive ten minutes or more after your designated appointment time; a fee may also be applied.

PAYMENT IS DUE AT THE TIME OF SERVICES: We accept cash, personal checks, Master Card, Visa and Discover Card. When insurance applies we will collect any deductible and estimated co-payment at this time.

We have a payment option available for parents of children needing extensive dental work. Please ask the receptionist for more information if interested.

PROSTHETICS: Space Maintainers, Retainers, Appliances, etc., FAILURE BY MEMBER TO RETURN FOR THE DELIVERY OF THESE ITEMS IS SUBJECT TO DOCTOR TIME AND LAB FEES CHARGES. ____ Initials

SERVICE CHARGES:

1. MONTHLY BILLING: Even though an insurance claim has been filed, you will receive a statement each month if there is a balance due on your account, since you, not the insurance company, are responsible for payment of your account. An interest charge will be applied every month to accounts with balances outstanding 60 days or longer, regardless of outstanding insurance.
2. RETURNED CHECKS: There is a $75.00 fee for returned checks. The check must be picked up personally and cash must be paid to cover the check and fee.
3. COLLECTION FEES: Fees incurred to enforce payment required by this agreement will be charged to the patient whose failure to pay, required these fees to be incurred.

Signature: _____ Date: _____

Patient/Parent or Legal Guardian if patient is a minor

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 8 / 11 /2016, 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For example:

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

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 of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

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 if 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. 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.

Our Privacy Official: Cathy Harris, DMD

Telephone: (302)453-1400 Fax: (302)453-9553

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400 Christiana Village Professional Center , Newark, DE 19702

E-mail: info@wildsmiles4kids.com