

Date _____



**PEDIATRIC
DENTAL
CARE**

Patient Name _____

Nickname _____

Birthdate _____ Age _____ Sex _____

Home Address _____

Phone _____

Pets, Hobbies _____

Brothers/Sisters (names and ages) _____

How did you hear about our office _____

Reason for seeking Dental Care _____

Father's Name: _____ **Marital Status: S M W O Se**

Address: _____ Daytime Phone: _____

City, State, Zip: _____ Birthdate: _____

Occupation: _____ Soc. Sec. No.: _____

Employer: _____ Carrier Name: _____

Employer Address: _____

Mother's Name: _____ **Marital Status: S M W O Se**

Address: _____ Daytime Phone: _____

City, State, Zip: _____ Birthdate: _____

Occupation: _____ Soc. Sec. No.: _____

Employer: _____ Carrier Name: _____

Employer Address: _____

Legal guardian (if other than parent) _____

Place of Business _____ Phone: _____

Business Address _____

Person responsible for this account _____

Dental History

1. Is this your child's first visit to a dentist? 0 yes 0 no

2. If no, give date of last examination _____ Dentist's Name _____

3. Does your child receive fluoride from: (check all that apply)

- Your water supply
- Rinses
- Toothpaste
- Tablets or drops
- School water supply
- Day care water supply

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Patient Name: _____

SECTION B: TO THE PATIENT - 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 health care 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:

Contact Person: Chris Carroll, D.M.D.
Telephone: 507-452-1543

Fax: 507 -452-687
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Address: 150 East Fourth Street. Winona, MN 55987

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.

GUARDIAN SIGNATURE

I, _____, have had full opportunity to read and consider the
(please print)

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: _____ Date: _____
Guardian

If this Consent is signed by a 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.
Include completed Consent in the patient's chart.