CHILD MEDICAL AND DENTAL HEALTH HISTORY

TODAY'S DATE_____

CHILD'S FULL NAME_____ **BIRTHDATE** _____/_____/_____

Do your child have or has he/she had any of the following?
(Please check any that apply)

- ❑ ADD/ADHD
- ❑ AIDS or HIV Positive
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Abnormal Blood Pressure
- ❑ Allergies or Hives
- ❑ Anemia, Hemophelia or blood disorders
- ❑ Arthritis
- ❑ Asthma
- ❑ Autism
- ❑ Blood Transfusion
- ❑ Cancer or Tumor
- ❑ Cerebral Palsy
- ❑ Congenital Birth Defects
- ❑ Current with Immunizations
- ❑ Developmental Delay
- ❑ Diabetes or Endocrine
- ❑ Downs Syndrome
- ❑ Epilepsy, Convulsions or Seizures
- ❑ Hayfever or sinus trouble
- ❑ Handicaps or Disabilities
- ❑ Hearing Loss or Impairment
- ❑ Heart Disease or Heart Murmur
- ❑ Hepatitis A, B or C
- ❑ Herpes or Cold Sores
- ❑ History of Fainting
- ❑ History of Dizziness
- ❑ Kidney Problems
- ❑ History of Seizures
- ❑ Liver Problems
- ❑ Mental Illness or Emotional Condition
- ❑ Migraine headaches or frequent headaches
- ❑ Neurological Condition
- ❑ Obesity
- ❑ Rheumatic Fever / Scarlet Fever
- ❑ Sensory Issues
- ❑ Sickle Cell Trait/Disease
- ❑ Sight Impairment
- ❑ Severe/Prolonged Bleeding
- ❑ Speech Impairment
- ❑ Tuberculosis

Is your child allergic to, or has he/she reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Food Allergies
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocaine")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Metal Allergy
- ❑ Other:_____
  _____

Is your child taking any medications?
Please list: _____
_____
_____

Females:

- ❑ May be pregnant
  Expected delivery date: _____
- ❑ Taking hormones or contraceptives

Does your child smoke or use chewing tobacco? ❑ yes ❑ no

Is your child using any illegal substances? ❑ yes ❑ no

Has your child been advised by your physician to pre-medicate prior to dental treatments? ☐ Yes ☐ No

Dental History: Check only if the answer is yes.

- ❑ Gums bleed while brushing or flossing
- ❑ Teeth sensitive to hot, cold, sweet, or sour
- ❑ Pain in any of teeth
- ❑ Sores or lumps in or near the mouth
- ❑ Any head, neck or jaw injuries
- ❑ Any jaw joint clicking or pain
- ❑ Difficulty chewing
- ❑ Clenches or grinds teeth?
- ❑ Oral habits-Bottle or Sippy Cup
- ❑ Thumb / Finger sucking / Pacifier
- ❑ Nail Biting / Chewing objects
- ❑ Lip sucking or biting
- ❑ Does child drink tap water
- ❑ Is the child using fluoride rinses?
- ❑ Orthodontic work?
- ❑ Laughing Gas (Nitrous Oxide)
- ❑ Numbing (Local Anesthetic)
- ❑ Prolonged bleeding following an extraction?
- ❑ Does child brush teeth daily?
- ❑ Has child ever had any complications associated with previous dental treatment?

Please explain:_____
_____

Has your child had any serious illness? If yes, explain:
_____
_____

Child's Physician _____
Phone # (___)_____

Why did you bring the child to the dentist today?
_____
_____
_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If my child ever has any changes in his/her health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Print name of parent or guardian Signature of parent or guardian

For office use only: Reviewed by:_____ Date_____

Welcome to Dr. David A. Paulisin's office!
To assist us in serving you, please complete the following confidential forms.

Patient Information

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Birth Date:_____Social Security # (Of Responsible Party if child) _____

Phone (Home): _____ (Cell): _____ (Work): _____ (Extention):_____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment Name_____

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID # or SS#_____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID # or SS#_____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

I accept full responsibility for all charges for services rendered by David A. Paulisin, DDS, PC. I agree to pay all costs of collection, including reasonable attorney fees. I authorize the release of medical information necessary for completion of insurance claim forms. I assign all benefits under my current health insurance policies and authorize payment directly to David A. Paulisin, DDS, PC. I understand any balance left after insurance has settled claim is my responsibility. I agree to promptly pay any outstanding balance. I understand that I will be charged a broken appointment fee without 24 hours notice. I understand that I will be charged $40 for a returned check plus any additional bank fees.
I have read all of the information on this form and agree to these policies.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

David A. Paulisin, DDS, PC

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

David A. Paulisin, DDS, PC is 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 (06/29/2017) 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 anytime. 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

This describes the way David A. Paulisin, DDS, PC may use and disclose health information about you for treatment, payment, and healthcare operations. Except for the purposes described below, we will use and disclose health information only with your written permission. You may revoke such permission at any time writing to our practice Privacy Officer.

Treatment: DAP, DDS,PC may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: DAP, DDS, PC may use and disclose health information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, w may give your health plan information about you so that they will pay for your treatment. You have the right to restrict certain disclosure of your protected health information to your dental plan when you are paying out of pocket in full for your dental care services.

Healthcare Operations: DAP, DDS, PC 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, and accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to DAP, DDS, PC 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: DAP, DDS, PC 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: DAP, DDS, PC 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 or emergency circumstances, we will disclose health information based on 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: DAP, DDS, PC will not use your health information for marketing communications without your written authorization.

Required by Law: DAP, DDS, PC may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: DAP, DDS, PC 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 of the health or safety of others.

National Security: DAP, DDS, PC 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, counter intelligence, and other national security activities. DAP, DDS, PC may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: DAP, DDS, PC may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, text messages, postcards, or letters, or emails).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that DAP, DDS, PC 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. There may be a fee for copies.

Disclosure Accounting: You have the right to receive a list of instances in which DAP, DDS, PC 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 , 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 DAP, DDS, PC 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 DAP, DDS, PC communicate with you about your health information by alternative means or to 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 in the alternative means or location you request.

Amendment: You have the right to request that DAP, DDS, PC 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 website or by electronic mail (email), you are entitled to receive this Notice in written form.

Breach of Health Information: In the event of a breach of your protected health information, David A. Paulisin, DDS, PC will notify you via mail, telephone or email.

QUESTIONS AND COMPLAINTS

If you want more information about David A. Paulisin DDS, PC's 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. 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.

Contact Officer: Practice Administrator
Telephone: 248-516-5266
Fax: 248-516-5267
email: d.pc@att.net
Address: 28807 Eight Mile Road, Suite #101
Livonia, MI 48152

DAVID PAULISIN, DDS, PC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse To Sign This Acknowledgement

I, _____, have received a copy of this office's
(Please Print Name)
Notice of Privacy Practices.

_____
Signature

_____
Date

For Office Use Only

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

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

_____

_____