

# Children's Dental Office

Dentistry for Children & Young Adults  
Dr. Casper and Associates



## Health History Form

*For your convenience...* Print this form, complete all information, and bring it with you on your first visit to our office. The parent or Guardian who accompanies the child is responsible for payment at the time of service.

### 1. Tell Us About Your Child

Child's Name \_\_\_\_\_  
Last First MI

Nickname \_\_\_\_\_  Male  Female

Child's Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Child's Age \_\_\_\_\_

Child's Home # (\_\_\_\_\_) \_\_\_\_\_

SS# \_\_\_\_\_

Child's Home Address: \_\_\_\_\_

\_\_\_\_\_  
APT. / CONDO #

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### 2. Mother's Information

Name \_\_\_\_\_

Stepmother  Guardian Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer \_\_\_\_\_

Work # (\_\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_

Home # (\_\_\_\_\_) \_\_\_\_\_

SS # \_\_\_\_\_ DL# \_\_\_\_\_

### 3. Father's Information

Name \_\_\_\_\_

Stepfather  Guardian Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer \_\_\_\_\_

Work # (\_\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_

Home # (\_\_\_\_\_) \_\_\_\_\_

SS # \_\_\_\_\_ DL# \_\_\_\_\_

Marital Status  Single  Married  Separated

Widowed  Divorced

### 4. Who is Accompanying the Child Today?

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Do you have legal custody of this child?  Yes  No

### 5. Person Responsible for Account

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Billing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home # (\_\_\_\_\_) \_\_\_\_\_

Work # (\_\_\_\_\_) \_\_\_\_\_

E-mail \_\_\_\_\_

### 6. Primary Dental Insurance

Insurance Co. Name \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Insurance Co. Phone # (\_\_\_\_\_) \_\_\_\_\_

Group # (Plan, Local, or Policy #) \_\_\_\_\_

Policy Owner's Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Policy Owner's Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

Social Security # \_\_\_\_\_

Policy Owner's Employer \_\_\_\_\_

### 7. Secondary Dental Insurance

Insurance Co. Name \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Insurance Co. Phone # (\_\_\_\_\_) \_\_\_\_\_

Group # (Plan, Local, or Policy #) \_\_\_\_\_

Policy Owner's Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Policy Owner's Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

Social Security # \_\_\_\_\_

Policy Owner's Employer \_\_\_\_\_

## 8. Dental History

Is this your child's first visit to the dentist? \_\_\_\_\_

If not, how long since the last visit to the dentist? \_\_\_\_\_

Were any x-rays taken at previous dental visits? \_\_\_\_\_

Have there been any injuries to the teeth, face or mouth? \_\_\_\_\_

If yes, please explain \_\_\_\_\_

Why did you bring the child to the dentist today? \_\_\_\_\_

Does the child have any of the following habits?

Y N Lip Sucking / Biting      Y N Nail Biting

Y N Nursing Bottle Habits      Y N Thumb / Finger Sucking

Has the child ever had a serious or difficult problem associated with previous dental work?      Yes      No

If yes, please explain \_\_\_\_\_

Is the child's water fluoridated?      Yes      No

Is the child taking fluoride supplements?      Yes      No

Has the child ever had any pain or tenderness in his/her jaw/joint? (TMJ/TMD)?      Yes      No

Does the child brush his/her teeth daily?      Yes      No

Floss his / her teeth daily?      Yes      No

## 9. Health History

Has the child ever had any of the following problems?

Y N Abnormal Bleeding      Y N Handicaps/Disabilities

Y N Allergies to any Drugs      Y N Hearing Impairment

Y N Any Hospital Stays      Y N Heart Murmur

Y N Any Operations      Y N Hemophilia

Y N Asthma      Y N Hepatitis

Y N Cancer      Y N HIV + / AIDS

Y N Congenital Heart Disease      Y N Kidney/Liver Problems

Y N Convulsions/Epilepsy      Y N Rheumatic/Scarlet Fever

Y N Pregnancy      Y N Allergies to Latex Product

Please discuss any serious medical problems the child has had

Please list all drugs the child is currently taking \_\_\_\_\_




Please list all drugs the child is allergic to \_\_\_\_\_

Child's Physician \_\_\_\_\_

Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Is the child currently under the care of a physician?      Yes      No

Please describe the child's current physical health...

 Good       Fair       Poor

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA the CDC, and the ADA.

10. 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.

Signature of Parent or Guardian \_\_\_\_\_

Date \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

## FOR OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein.

Initials \_\_\_\_\_ Date \_\_\_\_\_

Insurance Verification: Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Preventive \_\_\_\_\_%      Deductible \$ \_\_\_\_\_

Basic \_\_\_\_\_%      Maximum \$ \_\_\_\_\_

Major \_\_\_\_\_%      Electronic Claims      Yes      No

Doctor's Comments \_\_\_\_\_

Does insurance cover sealants (1351)?      Yes      No

If yes, what do they fall under? \_\_\_\_\_

Pediatric Dentistry:  
JEROME S. CASPER, D.M.D. & ASSOCIATES  
General Dentistry (Olney):  
RIZWAN AHMAD, D.D.S.

### CHILDRENS DENTAL OFFICE FINANCIAL POLICY

We would like to welcome you to our office and thank you for choosing us as your health care provider. We take that responsibility very seriously; therefore, we have in place specific financial policies which permit our staff to focus on patient care as opposed to acting as a billing service. Having these policies also allows us to control our costs and in turn, control the fee you pay for care.

Payment for professional services is **DUE AT THE TIME OF SERVICE**. For your convenience we accept **CASH, CHECKS, VISA, MASTERCARD, DISCOVER and AMERICAN EXPRESS**. For more extensive treatment needs, we offer payment through Care Credit. This is a separate line that when approved will cover family health care needs.

### REGARDING INSURANCE

In the event we **DO NOT** participate with your insurance, we **EXPECT ALL FEES TO BE PAID AT THE TIME OF SERVICE** and as a courtesy we will submit a claim to your insurance company, and they will send any reimbursement directly to you.

In the event we do participate with your insurance company, we will collect any deductibles or co-pays we consider not covered by insurance **AT THE TIME OF SERVICE** and then submit a claim for the balance. Please understand any amount not paid by your insurance within 45 days, for whatever reason, **IS YOUR RESPONSIBILITY**. Be aware that some and all services provided may be a non-covered service and not considered reasonable and necessary under the Medicare program and/or dental insurances.

### USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients. We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary.

Please help us serve all our patients needs better by keeping scheduled appointments. It is our policy that unless appointments are cancelled 24 hours in advance, you **WILL BE CHARGED FOR A MISSED APPOINTMENT AT THE RATE OF THE OFFICE FEE. NEW PATIENTS ARE SCHEDULED IN THE MORNINGS AND PATIENTS AGE 7 AND UNDER ARE SEEN IN THE MORNING HOURS ONLY.**

Thank you for taking the time to read our financial policy. By signing this agreement you fully understand and adhere to this policy.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Jerome S. Casper Childrens Dental Office, P.A.

## NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include crowns, fillings, teeth cleaning services, etc.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your dental plan for your dental services.
- **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services including release of information to friends and family members that are directly involved in your care or who assist in taking care of you. We will use and disclose your protected when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the

dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We will release your PROTECTED HEALTH INFORMATION if requested by a law enforcement official for any circumstance required by law. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs. We may release PROTECTED HEALTH INFORMATION to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your PROTECTED HEALTH INFORMATION if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your protected health information TO FEDERAL OFFICIALS FOR INTELLIGENCE AND NATIONAL SECURITY ACTIVITIES AUTHORIZED BY LAW. We may disclose PROTECTED HEALTH INFORMATION to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations. We may disclose your PROTECTED HEALTH INFORMATION to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you; (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public. We may release your PROTECTED HEALTH INFORMATION for workers' compensation and similar programs.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.
- The right to access, inspect and copy your PROTECTED HEALTH INFORMATION.

- The right to request an amendment to your PROTECTED HEALTH INFORMATION.
- The right to receive an accounting of disclosures of PROTECTED HEALTH INFORMATION outside of treatment, payment and health care operations.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

**For more information about our Privacy Practices, please contact:**

HIPAA Official, Carol Hart  
Jerome S. Casper Childrens Dental Office, P.A.  
2923-D Olney Sandy Spring Road, Olney MD 20832  
301-924-5500

**For more information about HIPAA or to file a complaint:**

The U.S. Department of Health & Human Services  
Office of Civil Rights  
200 Independence Avenue, S.W.  
Washington, D.C. 20201  
877-696-6775 (toll-free)

## **Acknowledgement of Receipt of Privacy Practices**

I, \_\_\_\_\_ have received a copy of  
**Jerome S. Casper Children's Dental Office, P.A.**'s Notice of Privacy Practices with an  
effective date of April 2, 2003.

**Name of Patient**

**Address of Patient**

**Signature of**  
**Parent/Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_  
**(or Patient if 18 or older)**

**Name of Witness** \_\_\_\_\_

**Signature of Witness** \_\_\_\_\_ **Date** \_\_\_\_\_