Edward E. Dove, D.D.S. PC

Pediatric Dentist Specialist

3130 Union Avenue • Bakersfield, CA 93305 (661) 872-2170 • Fax (661) 872-9257
20523 Devonshire Street • Chatsworth, CA 91311 (818) 773-0911 • Fax (818) 773-9720

Referred by ______________________________

Father's Information:

Last name	First Name	Home Phone #
Mailing Address		Alternate phone #
City	State	Zip Code
Social Security #	Birth Date	Drivers' License #
Occupation/ Employer		Spouse's Name

Mother's Information:

Last name	First Name	Home Phone #
Mailing Address		Alternate phone #
City	State	Zip Code
Social Security #	Birth Date	Drivers' License #
Occupation/ Employer		Spouse's Name

Patient's Information:

Last name	First Name	Birth Date M/F
Hobbies		Pets
Names of brothers and sisters		
Emergency Contact		Phone

Primary Insurance

Name of insured	SS#	Birth Date
Insurance Company		

Secondary Insurance

Name of insured	SS#	Birth Date
Insurance Company		

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Child's Physician ______________________________

Is your child taking any prescribed medications? ❑ Yes ❑ No

If so, what kind and why? ______________________________

____

____

If your child has had any of the following, please check box:

- ❑ Rheumatic Fever
- ❑ Heart Disease
- ❑ Heart Murmur
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Bleeding Disorders
- ❑ Sickle Cell Anemia
- ❑ Epilepsy
- ❑ Nervous Disorders
- ❑ Hepatitis
- ❑ Cerebral Palsy
- ❑ Lung Disease
- ❑ Asthma
- ❑ Diabetes
- ❑ Hyperactivity
- ❑ Cleft Palate
- ❑ Autism
- ❑ Down's Syndrome
- ❑ Seizures

Developmental Problems Which affect:

- ❑ Speech
- ❑ Hearing
- ❑ Sight
- ❑ Physical Ability
- ❑ Mental Ability

OTHER HEALTH PROBLEMS (please explain): ______________________________

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____

Does your child have any allergies or had any unfavorable reaction to drugs? ❑ Yes ❑ No

Is your child taking Fluoride? Tablets / Drops ❑ Yes ❑ No Rinse ❑ Yes ❑ No

Remarks: ______________________________

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Permit for Dental Services Upon a Minor

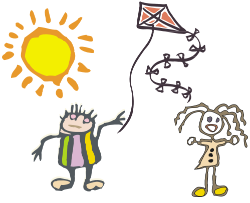
I. I understand that I will be informed of all services before any treatment is rendered.

II. I do also authorize and request the administration of such anesthetics, medications, X-rays and / or sedatives as may be deemed advisable by Dr. Dove.

III. I, being the parent or legal guardian of ______________________________ do hereby authorize and request the performance of dental services upon the person of this patient, and permit Dr. Dove and any staff under his supervision to perform whatever procedures that Dr. Dove judges to be dictated during treatment.

IV. I understand that I am financially responsible for all treatment provided, and a credit report may be obtained where necessary.

Signed ______________________ Date ____________ Relationship ______________________



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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”) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act 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.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations:

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.

- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

- Health care operations include the business aspects of running our practice, such as conducting quality assess assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest you.

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 the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- 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 reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

- The right to inspect an copy your protected health information.

- The right to amend your protected health information.

- The right to receive an accounting of disclosures of protected health information.

- The right to obtain and we have the obligation to provide to you a paper copy of this notice from us at your first service delivery date.

- The right to provide and we are obligated to receive a written acknowledgment that you have received a copy of our Notice of Privacy Practices.

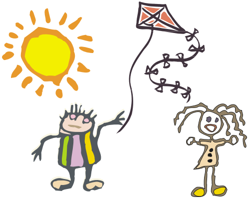
We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of October 2002 and 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 health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. 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, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:
Privacy Officer
Edward E. Dove, D.D.S., PC
3130 Union Avenue
Bakersfield, CA 93305
(661) 872-2170

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
(202) 61 9-0257
Toll Free: 1-877-696-6775



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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that your restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ______________________________

Relationship to Patient: ______________________________

Signature: ______________________________

Date: ______________________________

Office Use Only

I attempted to obtain the patient's signature in acknowledgment of this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date __________ Initials __________ Reason ______________________________

<u>Authorization Form</u>

This form must be completed by the parent or guardian of each patient seen in our office. Please read the following and sign in the indicated area below.

I agree to be responsible for all charges for dental services and materials not paid by my dental benefits plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges.

To the extent permitted under applicable law, I authorize release of any information relating to any dental claims.

I herby authorize payment of the dental benefits to be paid directly to the below-named dental entity.

<Edward E. Dove, D.D.S., PC>

____________________________________ ________________

Signature of parent or guardian Date

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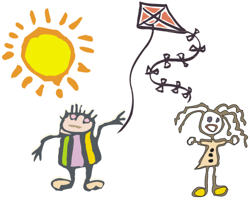
I, _________________________ as the parent or guardian of _________________________ understand that my child has dental coverage. If for some reason the eligibility is not current for my child on the day of service I am financially responsible for <u>all</u> services rendered on that day.

Dr. Dove's office is not able to <u>guarantee</u> eligibility.

____________________________________ ________________

Signature of parent or guardian Date



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CONSENT FOR DENTAL TREATMENT

1. I, as the legally responsible parent/guardian of ______________________________ hereby authorize Dr. Dove and his dental assistants as may be selected to complete treatment plan as described by Dr. Dove.

2. The procedure(s) necessary to treat the condition(s) have been explained to me and I understand the nature of the procedure(s).

3. I have been informed of possible alternative methods of treatment (if any), including no treatment at all and the risks of non-treatment. I further understand that this is an elective procedure and other forms of treatment or no treatment at all are choices that I have, and that this treatment is intended to provide improved dental health and prevent future potential problems.

4. Dr. Dove and/or his employees have explained to me that there are certain inherent and potential risks in any treatment plan or procedure, and that such treatment risks include, but are not limited to, the following:
   a. Possible postoperative discomfort and swelling.
   b. Possible biting of lip and tongue while anesthetized causing discomfort and swelling.
   c. Possible stretching of corners of mouth with possible cracking of lips.
   d. Possible decision of leave small piece of root in jaw if tooth is extracted and if removing root tip would require extensive surgery.
   e. Possible prolonged bleeding following tooth extraction.
   f. Possible damage to adjacent teeth or restorations during procedure.

5. It has been explained to me that, during the course of the procedure(s) unforeseen conditions may be revealed that necessitate an extension of the original procedure(s) or different procedure(s) than those set forth above. I therefore authorize and request that the doctors perform such procedures as are necessary and desirable in the exercise of their professional judgment. This authorization shall extend to the treatment of all conditions that require treatment and that are not known at the time the original procedure started.

6. I consent to administration of nitrous oxide/oxygen, analgesia and topical, and local anesthesia in connection with the procedure(s) referred to above.

7. It has been explained to me, and I understand that a perfect result in not guaranteed or warranted and cannot be guaranteed or warranted.

8. I certify that I read and write English and have read and fully understand this consent for treatment.
   PLEASE ASK THE DOCTOR IF YOU HAVE ANY QUESTIONS CONCERNING THIS CONSENT BEFORE YOU SIGN.

______________________________ ______________

PARENT OR LEGAL GUARDIAN DATE

______________________________ ______________

WITNESS (DOCTOR OR STAFF MEMBER) DATE