

Welcome!

Proper dental hygiene begins at an early age. Please take a few minutes to complete the following information so we can better care for your child's dental needs.

Patient and Family Information

Child's Name _____ Birthdate _____ Male Female
 Social Security # _____ Home Phone _____
 Home Address _____
 City _____ State _____ Zip _____
 School _____ Grade _____
 Responsible Party _____
 Relationship to Child _____

Name of Mother/Guardian _____ Birthdate _____
 Social Security # _____ Home Phone _____
 Address _____
 City _____ State _____ Zip _____
 Employer _____ Business Phone _____
 Cell Phone _____ E-mail _____

Name of Father/Guardian _____ Birthdate _____
 Social Security # _____ Home Phone _____
 Address _____
 City _____ State _____ Zip _____
 Employer _____ Business Phone _____
 Cell Phone _____ E-mail _____

Child's Dental History

Former Dentist _____ Office Phone _____
 Address _____
 City _____ State _____ Zip _____
 Date of last dental visit _____
 How often does your child brush? _____
 How often does your child floss? _____

Please check all that apply to your child:

<input type="checkbox"/> Thumb/Finger Sucking	<input type="checkbox"/> Fingernail Biting	<input type="checkbox"/> Grinding Teeth
<input type="checkbox"/> Lip or Cheek Biting	<input type="checkbox"/> Jaw Difficulty: Clicking and/or Pain	

Child's Health History

Please check all that apply to your child:

<input type="checkbox"/> Allergies	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hepatitis - Type _____	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Anemia	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Other _____
<input type="checkbox"/> Asthma	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Scarlet Fever	_____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Tonsillitis	_____



Primary Dental Insurance



Person Responsible for Account _____
Relationship to Patient _____ Birthdate _____
Social Security # _____ Home Phone _____
Address _____
City _____ State _____ Zip _____
Employer _____ Business Phone _____
Business Address _____ Occupation _____
Insurance Company _____
Insurance Company Address _____
Subscriber I.D. # _____ Group # _____

Additional Insurance



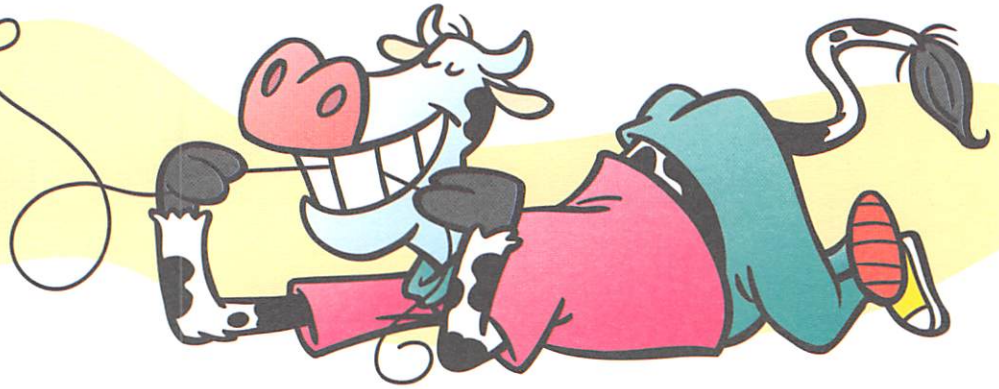
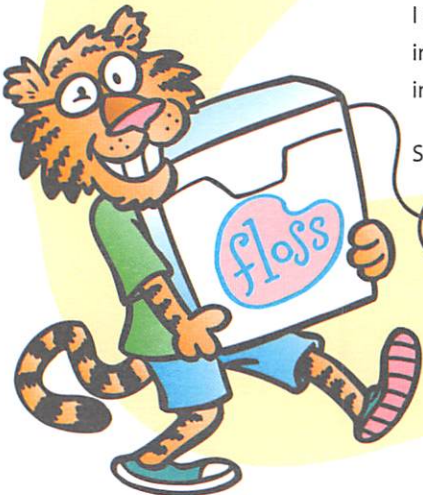
Person Responsible for Account _____
Relationship to Patient _____ Birthdate _____
Social Security # _____ Home Phone _____
Address _____
City _____ State _____ Zip _____
Employer _____ Business Phone _____
Business Address _____ Occupation _____
Insurance Company _____
Insurance Company Address _____
Subscriber I.D. # _____ Group # _____

Assignment and Release

I hereby authorize payment directly to _____
for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____



NOTICE OF PRIVACY PRACTICES (DENTAL)

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 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 to 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 and 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 a paper copy of this notice from us upon request.

**MAGNOLIA FAMILY DENTAL CARE
MELISSA JACKSON DDS PLLC
6939 South 66th East Avenue
Tulsa, Oklahoma 74133
918-492-3771**

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

Patient Name: _____ Date: _____

I may refuse to sign this acknowledgement.

I have been offered and / or received a copy of Magnolia Family Dental Care's Notice of Privacy Practices.

I understand that my PHI (Protected Health Information) can and will be used for purposes of treatment and for payment from both myself and/or third party. I understand that I may request a copy of the privacy policies at any time.

**Expiration -- 3 Years from Initial Signature; Insurance Change;
Patient reaches age of 18**

I consent for the office of Dr. Melissa Jackson to share my personal information with the following: (family, friends, etc.)

Name / Relationship / Phone

_____/_____/_____
_____/_____/_____

Signature: _____

Patient Parent Guardian / Other