



SERENITY VALLEY Family Dentistry

We are happy to have you join our great family of patients and friends. Please complete this form so that we can provide the best care possible for you.

Thank you!

ABOUT YOUR CHILD

Name: _____ Female Male

Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____

Birth date: ___/___/___ Grade: _____ Age: _____ Is this your child's first dental visit? Yes No

Who can we thank for referring you? _____

EMERGENCY INFORMATION

Person to contact: _____

Relationship: _____ Phone: _____

I give permission for Serenity Valley Family Dentistry to share my medical and account information with:

DENTAL HISTORY

Do you have any concerns with your child's teeth, such as a chipped tooth, decayed tooth, gumboil, etc.?

Yes No If Yes, please explain _____

How often do they brush? _____ How often do they floss? _____

Medical History

Is your child in good health? Yes No When was your child's last medical exam? Date ___/___/___

Has your child required hospitalization or had a serious illness? Yes No

If Yes, please explain: _____

Are your child's immunizations up-to-date? Yes No

Is your child sensitive/allergic to anything? Yes No

If Yes, please explain: _____

Is your child presently taking any medications? Yes No

If Yes, please explain: _____

Please check any of the following that apply to your child:

- | | | |
|--|---|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mitral valve prolapse |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Attention disorder | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Visual impairment |
| <input type="checkbox"/> Breathing disorders | <input type="checkbox"/> Hearing impairment | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Counseling | <input type="checkbox"/> Heart murmur | |

The information I have given is true and accurate to the best of my knowledge.

**HIPAA OMNIBUS RULE
 PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES
 CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM**

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

 Please print name of Patient

 Please sign Patient / Guardian of Patient

 Legal Representative / Guardian

 Relationship of Legal Representative / Guardian

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:

- First Name Only Proper Surname Other _____

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION VIA:

- | | |
|--|--|
| <input type="checkbox"/> Cell Phone Confirmation | <input type="checkbox"/> Email Confirmation |
| <input type="checkbox"/> Text Message to my Cell Phone | <input type="checkbox"/> Work Phone Confirmation |
| <input type="checkbox"/> Home Phone Confirmation | <input type="checkbox"/> Any of the Above |

I AUTHORIZE INFORMATION ABOUT MY HEALTH BE CONVEYED VIA:

- | | |
|--|--|
| <input type="checkbox"/> Cell Phone Confirmation | <input type="checkbox"/> Email Confirmation |
| <input type="checkbox"/> Text Message to my Cell Phone | <input type="checkbox"/> Work Phone Confirmation |
| <input type="checkbox"/> Home Phone Confirmation | <input type="checkbox"/> Any of the Above |

I APPROVE BEING CONTACTED ABOUT SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO on behalf of this Healthcare Facility via:

- | | |
|--|--|
| <input type="checkbox"/> Phone Message | <input type="checkbox"/> Any of the Above |
| <input type="checkbox"/> Text Message | <input type="checkbox"/> None of the Above (opt out) |
| <input type="checkbox"/> Email | |

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

OFFICE USE ONLY

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

- It was emergency treatment
- I could not communicate with the patient
- The patient refused to sign
- The patient was unable to sign because
- Other (please describe) _____

Signature of Privacy Officer _____