Robert B. Ruyak, DMD, PC

Creating Beautiful Smiles

(610) 861-0777
2299 Brodhead Road, Suite K
Bethlehem, PA 18020
www.drrobertruyak.com

Child's Registration and Medical History

Your child's complete oral health is our main concern. Communication is key to helping us give your child a happy, healthy smile. We therefore ask that you complete this form in its entirety.

1 About Child

Today's Date:____________

Name:____
LAST FIRST MI

Nickname:______________________________ ❏ Male ❏ Female

Birthdate:___/___/___ Age:__________ SS #:________________

Home Address:____
APT / CONDO #

____
CITY STATE ZIP

Home #: (___)__________Cell #: (___)__________

Where and when are best times to reach you?________________

Whom may we thank for referring you?_____________________

Other family members seen by us:_________________________

2 Parent Information

Father's Name:____

Birthdate:___/___/___ Age:__________ SS #:________________

Employer:____

Home #: (___)__________Cell #: (___)__________

Work #: (___)__________Ext:_____DL #:______________

Mother's Name:____

Birthdate:___/___/___ Age:__________ SS #:________________

Employer:____

Home #: (___)__________Cell #: (___)__________

Work #: (___)__________Ext:_____DL #:______________

Person Responsible for Account:

Work #: (___)__________ Ext: ____Home #: (___)__________

Billing Address: ____

Relation: ____________________ SS #: ____________________

Employer:____________________ DL #: ____________________

ARE YOU ON MEDICAID?.................. ❏ YES ❏ NO

DO YOU HAVE DSHS COUPONS?.......... ❏ YES ❏ NO

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3 Dental Insurance

Primary Dental Insurance

Insurance Co. Name: _____________________________________

Insurance Co. Address: ___________________________________

Insurance Co. Phone #: (___)______________________________

Group # (Plan, Local or Policy #): __________________________

Insured's Name: ____________________ Relation: __________

Insured's Birthdate:___/___/___Insured's ID #: ______________

Insured's Employer: ______________________________________

Employer's Address: ______________________________________

Secondary Dental Insurance

Insurance Co. Name: _____________________________________

Insurance Co. Address: ___________________________________

Insurance Co. Phone #: (___)______________________________

Group # (Plan, Local or Policy #): __________________________

Insured's Name: ____________________ Relation: __________

Insured's Birthdate:___/___/___ Insured's ID #: ______________

Insured's Employer: ______________________________________

Employer's Address: ______________________________________

In the event of an emergency, who should be notified, other than a parent?

Name:____________________Relation:______________

Address:____

Work #: (___)______________Home #: (___)__________

4 Medical History

Does your child have a personal physician?.................. ❏ Yes ❏ No

Physician's Name: ____

Phone #: (___)____________ Date of last visit: ____________

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

Please Explain: ____

CONTINUED ON NEXT PAGE

4 MEDICAL HISTORY continued

Date of last physical:__________________________________

Child's current physical health is:................ ❏ Good ❏ Fair ❏ Poor

Is child taking any prescription, over-the-counter, or supplement drugs? ❏ Yes ❏ No

Please list each one:__________________________________

Does your child smoke or use tobacco in any other form?..... ❏ Yes ❏ No

Has your child ever had any of the following diseases or medical problems? (Please check all that apply):

- ❏ Aids or Other Immunosuppressive Disorders
- ❏ Allergies to Anesthetics
- ❏ Allergies to Medicines or Drugs
- ❏ Asthma
- ❏ Artificial Heart Valves or Joints
- ❏ Bladder Problems
- ❏ Cerebral Palsy
- ❏ Chemical Dependency
- ❏ Convulsions
- ❏ Diabetes
- ❏ Epilepsy
- ❏ Hearing Problems
- ❏ Heart Problems
- ❏ Hemophilia
- ❏ Hepatitis, Jaundice, or Liver Disease
- ❏ Kidney Problems
- ❏ Mononucleosis
- ❏ Radiation Treatment
- ❏ Rheumatic Fever
- ❏ Thyroid Problems
- ❏ Tuberculosis

Please list any serious medical condition(s) that your child has had:

____

Is your child allergic to any of the following?

- ❏ Aspirin
- ❏ Codeine
- ❏ Dental Anesthetics
- ❏ Erythromycin
- ❏ Jewelry/Metals
- ❏ Latex
- ❏ Penicillin
- ❏ Tetracycline
- ❏ Other

Please list any other drugs/materials that child is allergic to:____________

We appreciate your effort to fill out this complete form. It will ensure that we can provide the most effective care possible. Please do not hesitate to ask if you have any questions. We are here for you.

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

5 DENTAL HISTORY

Why have you come to the dentist today?

____

When was child's last dental visit?__________________

Experiencing any discomfort now?__________________

Do you desire complete dental service for your child?________

Has your child ever responded adversely to medical or dental treatment?

Has your child ever been on or has any physician ever told you your child needs to have premedication before dental work?......... ❏ Yes ❏ No

Is there anything else we should know about child's dental history?_____

How many times a week does child floss?________

How many times a day does child brush?________

Type of bristles? ❏ Hard ❏ Medium ❏ Soft

I understand the information I have given today is correct to the best of my knowledge. I also understand this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature Date

Relationship to child

Payment is due in full at the time of treatment unless prior arrangements have been approved.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein. Initials: Date:

Doctor's Comments: __________________________________

MEDICAL HISTORY UPDATE

1. Date: ________ Comments: ____________________ Signature: ____________
2. Date: ________ Comments: ____________________ Signature: ____________
3. Date: ________ Comments: ____________________ Signature: ____________

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Consent For Use and Disclosure of Health Information

SECTION A: PATIENT GIVING CONSENT

Name: ____

Address: ____

Telephone: ____________________ Social Security # ____________________

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting our office at (610) 861-0777 or by mailing us at 2299 Brodhead Road, Suite K, Bethlehem, PA 18020.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the address above. Please understand that revocation of this Consent will not affect any action we took before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, ____________________, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature: ______________________________ Date: ____________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ____________________ Relationship: ____________________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

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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* means providing, coordinating, or managing health care and related services by one or more health care providers. Examples would be teeth cleaning services, extraction letters, and periodontal or endodontic referrals.
- *Payment* means such activities as obtaining reimbursement for services, confirming coverage, and obtaining specific benefit information such as benefit maximums and deductibles met, etc., billing or collection activities, and utilization review.
- *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 individual 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—and we have the obligation to provide—a paper copy of this notice from us at your first delivery of services date.
- The right to provide—and we are obligated to receive—a written acknowledgement that you have received a copy of our Notice of Privacy Protection 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.

This notice is effective as of April 2003 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 Notice of Privacy Practices and to make the new notice provisions effective for all protected 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 our 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 their provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

By signing this form, I agree to allow the use and disclosure of my medical record information for the purposes described above. A copy of this authorization (consent) form will be given to me.

Signature:____ Date:____________________

Please contact us for more information:
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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, SW
Washington, DC 20201
202-619-0257 or Toll Free: 1-877-696-6775