Collins Dental & Orthodontics

38 Peoples Plaza
Newark, DE 19702

Welcome to our office! We are happy to have you as our patient! Please complete the following information.

PATIENT: _____
LAST **FIRST** **MIDDLE**

HOME ADDRESS:

_____
STREET **CITY** **STATE** **ZIP**

FATHER/GUARDIAN: _____ **BIRTH DATE:** _____ **SSN** _____

EMPLOYER: _____ **OCCUPATION:** _____

WORK #_____ **CELL #** _____ **HOME#** _____

EMAIL ADDRESS:_____

MOTHER/GUARDIAN: _____ **BIRTH DATE:** _____ **SSN** _____

EMPLOYER: _____ **OCCUPATION:** _____

WORK # _____ **CELL #** _____ **HOME #** _____

EMAIL ADDRESS:_____

Are parents married, divorced, separated, or other? _____ **Who does the child live with?** _____

ADDRESS OF MOTHER OR FATHER IF DIFFERENT THAN ABOVE:

_____
STREET **CITY** **STATE** **ZIP**

PERSON RESPONSIBLE FOR CHILD'S ACCOUNT: _____

PREVIOUS DENTIST (NAME & PHONE #) _____

FAMILY PHYSICIAN (NAME & PHONE #) _____

Do you have insurance that will cover all or part of our services? Please circle: YES NO

If yes, name of insurance company and claims address: _____

_____

If you have insurance, we will submit to your insurance company (unless otherwise advised) on your behalf, but you are responsible for all balances your insurance company does not pay. If you do have insurance, your *estimated* patient portion is due and will be collected at the time of service. If you do not have insurance, payment is due IN FULL at the time of service. Ant balance due after 90 days will incur a finance charge of 1 ½% each month, an annual rate of 18%. Payment can be made by cash, check, Master Card, VISA, Discover, or American Express.

_____ _____
SIGNATURE **DATE**

COLLINS DENTAL AND ASSOCIATES

CHILDREN'S MEDICAL HISTORY FORM

WELCOME TO OUR OFFICE

NAME_____ GOES BY_____

GENDER M_____ F_____ CHILD BIRTH DATE_____

PLEASE LIST CHILD'S INTERESTS/HOBBIES_____

PARENT/GUARDIAN NAME_____RELATIONSHIP_____

CHILD'S PHYSICIAN_____PHONE #_____LAST VISIT_____

REASON FOR VISIT: CLEANING____ CAVITY____ EMERGENCY____ OTHER_____

IS THIS YOUR CHILDS FIRST VISIT TO THE DENTIST? _____ IF NO, PLEASE PROVIDE PREVIOUS DENTIST_____ PHONE # _____

HOW DO YOU THINK YOUR CHILD WILL REACT TO DENTAL CARE? _____

PARENT/GUARDIAN CONCERNS_____

PLEASE ANSWER EACH QUESTION WITH A YES OR NO AND *PLEASE EXPLAIN ANY YES ANSWER*:

ASTHMA_____
CANCER_____
EMOTIONAL PROBLEMS_____
HEART PROBLEM_____
HYPERACTIVITY/ADHD_____
KIDNEY PROBLEMS_____
MENTAL ILLNESS_____
RHEUMATIC FEVER_____
TUBERCULOSIS_____

BLEEDING DISORDER_____
DIABETES_____
HEART MURMUR_____
HEPATITIS_____
INTELLECTUAL DISABILITY_____
LEARNING DISABILITY_____
PHYSICAL DISABILITY_____
SEIZURES_____
OTHER_____

CURRENT MEDICATIONS?_____ ANY KNOWN ALLERGIES? _____

DOES YOUR CHILD HAVE A HISTORY OF ANY OF THE FOLLOWING: PLEASE CIRCLE ANY THAT APPLY

THUMB SUCKING, MOUTH BREATHING, NAIL BITING, SPEECH PROBLEMS

HAS THERE BEEN ANY INJURY TO YOUR CHILD'S TEETH OR MOUTH? _____

ANY FAMILY HISTORY OF DENTAL PROBLEMS? _____

DOES YOUR CHILD RECEIVE FLUORIDE SUPPLEMENTS? YES NO

YES, WE DO ORTHODONTIC TREATMENT (BRACES) HERE IN THIS OFFICE, ARE YOU INTERESTED IN AN ORTHODONTIC CONSULTATION? YES NO

PLEASE NOTE THAT OUR PEDIATRIC DENTISTS ROUTINELY USE NITROUS OXIDE ANALGESIA (LAUGHING OR HAPPY GAS) FOR RESTORATIVE PROCEDURES (FILLINGS, KIDS CROWNS, TOOTH REMOVAL) IN ADDITION TO A LOCAL ANESTHETIC (NOVOCAIN).

SIGNATURE_____DATE_____

****I have reviewed a copy of this office's Notice of Privacy Practices. I understand I will receive a copy of this Notice for my records upon request****

Patient Name: _____ DOB_____

Signature: _____

Print Name: _____ Relationship to patient: _____

Date: _____

You May Refuse to Sign This Acknowledgement

For office use only

_____

We attempted to obtain written acknowledgement of review of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- o Individual refused to sign
- o Communications barrier prohibited obtaining acknowledgement
- o An emergency situation prevented us from obtaining acknowledgement
- o Other (Please specify)

_____

_____

Permission to Verbally Discuss Protected Health Information

** Completion of this form is required. Listing anyone on this form is optional (write NONE) **

Patient Name: _____ **DOB**_____

Street Address: _____ **City/State/Zip**_____

Home#_____ **Work#**_____ **Cell#**_____

I give permission to **Collins Dental and Orthodontics (Doctors and staff)** to verbally discuss health information, in person or by telephone, with the following family members or friends involved in my care: (list family members/friends and state the person's relationship to patient). This permission includes scheduling/appointment information, dental health/diagnosis information, treatment plans, insurance coverage, and billing/payment information.

	NAME	**Phone #**	**Relationship**
1)			
2)			
3)			

If you would like to add additional names, please use a separate form.

Release of information under this document is **limited to verbal discussion** with my Dental Care Provider. This document **DOES NOT** permit release of any written health information to the individuals named above.

This permission will remain in effect until revoked by the patient/representative. I understand that I have the right to revoke my permission at any time except where Collins Dental and Orthodontics has already made disclosures based upon this permission form. **I understand that I MUST notify Collins Dental and Orthodontics IN WRITING if I want to revoke my permission.**

Patient Signature: _____ **Date:** _____

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

Representative Signature: _____ **Date:** _____

Representative's printed name: _____

Relationship to patient: _____

Collins Dental & Orthodontics

38 Peoples Plaza
Newark, DE 19702
(302) 834-4000

SIGNATURE ON FILE

- I authorize use of this form in conjunction with all insurance submissions made on my behalf.
- I authorize release of information to my insurance carriers.
- I understand that I am responsible for any bill for treatment or services rendered.
- I authorize my doctor to act as my agent in helping obtain payment from my insurance carrier.
- I authorize payment from my insurance carrier directly to my doctor/dental office.
- I permit a copy of this authorization to be used in place of this original.
- I authorize my employer to release information concerning my employment/dental benefits.
- I understand that there may be a charge for any missed/cancelled appointment without notification of ***at least*** 24 hours.
- I understand that in compliance with the Federal Truth in Lending Law, this office may charge a one and one-half percent (1 ½%) service charge per month (eighteen percent (18%) annually) on all delinquent accounts.
- I understand that the office may use my photos for educational purposes or publicly on their website.

Print Name: _____

Signature: _____

Date: _____

Collins Dental Associates
Notice of Privacy Practices

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

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 09 / 01 / 2013 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care.
We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:
• Prevent or control disease, injury or disability;
· Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPPA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPPA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request. or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fund raising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

OTHER USES AND DISCLOSURES OF PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

YOUR HEALTH INFORMATION RIGHTS

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic *copy.* We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

Amendment. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (email).

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Practice Name: **Collins Dental Associates**

Telephone: **(302) 834-4000**

Fax: **(302) 834-1417**

Address: **38 Peoples Plaza Newark, DE 19702**

Email: **collinsdental@comcast.net**