1615 Woods Court, Hood River, Oregon
Phone (541) 490-4993 Fax (541) 436-4418
info@littleshreddersdental.com www.littleshreddersdental.com

Christopher A. Swisher, DDS
Pediatric Dentistry

Child's Name: _____ Sex: M F Birthdate: _____

Mailing Address: _____ Phone: (_____)_____

Purpose of visit: _____ Concerns:_____ Name and age of brothers/sisters: _____ Is your child adopted? Y N

Child's Interests: _____ Any phobias? _____

Does your child have any special needs? _____ Child's learning: **Slow** **Average** **Accelerated**

Child's school: _____ Who may we thank for referring you to us? _____

GENERAL INFORMATION

Parent(s) are: **Married** ___ **Divorced**___ **Single**___ **Widowed** ___ Child lives with: **Both Parents** **Mother** **Father** **Other** _____

Primary Guardian (full name) _____ SSN: _____ DOB: _____ Driver's License #: _____

Address:_____ Phone: (_____)_____

E-mail Address:_____ Employer: _____

Secondary Guardian (full name) _____ SSN: _____ DOB: _____ Driver's License #: _____

Address:_____ Phone: (_____)_____

E-mail Address:_____ Employer: _____

Person financially responsible for child's dental care: _____

Emergency Contact:_____ Address:_____ Phone: (____)_____

How would you like us to contact you? **Home** **Work** **Cell** **E-mail**

AUTOHRIZATION

In my absence, I hereby give authorization for the person(s) listed below to bring my child to Little Shredders Dental and to consent for any and all recommended dental/medical services.

Authorized Person(s)	Relationship to child	Contact Number
_____	_____	(_____)_____-_____
_____	_____	(_____)_____-_____
_____	_____	(_____)_____-_____

The permission of parent or guardian is necessary for dental treatment of a minor. I give the permission to use such measures as deemed necessary in his/her professional judgment to render the best dental treatment for my child. I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform the office of any changes in my child's health status.

INSURANCE INFORMATION

Do you have dental insurance coverage for your child? Y N

Primary Insurance Name: _____ Subscribers Name: _____

ID Number: _____ Group Number: _____ Insurance Phone: _____

Insurance Address:_____

Secondary Insurance Name: _____ Subscribers Name: _____

ID Number: _____ Group Number: _____ Insurance Phone: _____

Insurance Address:_____

SIGNATURE: _____ Relationship: _____ Date: _____

Child's Name: _____ Birthdate: _____

HEALTH HISTORY

Doctor's Name: _____ Phone Number: (_____) _____ Last Physical: _____

Is your child under a physician's care now? Y N If yes, reason: _____ Immunization up to date? Y N

Is your child taking any medications currently (including Bisphosphonates and over the counter)? Y N If yes, please list: _____

Is your child allergic to any medication? Y N If yes, please list: _____

Any history of hospitalization or surgery: (if yes, when)_____

Does your child have allergic reaction to: (if yes: please check all that applies)

___ Berries	___ Peanuts/Tree nuts	___ Animals	___ Dyes/Coloring	___Pollen/Dust/Environmental
___ Eggs	___ Soy	___ Acrylic	___ Latex/Rubber	___ Other: _____
___ Milk	___ Wheat/Gluten	___ Anesthetics	___ Metals	_____

Has your child had a history or difficulty with any of the following?

ADHD/ADD	Y N	Cardiac Disease/Heart	Y N	Hepatitis	Y N
Anemia	Y N	Cerebral Palsy	Y N	Immune Disorder	Y N
Allergies	Y N	Chemo/Radiation Therapy	Y N	Kidney	Y N
Arthritis/Joint Disorder	Y N	Cystic Fibrosis	Y N	Liver	Y N
Asthma	Y N	Delayed Development	Y N	Murmur	Y N
Allergies to Medications	Y N	Depression/Anxiety	Y N	Muscular Disorder	Y N
Autism	Y N	Diabetes	Y N	Premature Birth	Y N
Bladder	Y N	Down's Syndrome	Y N	Rheumatic Fever/Heart	Y N
Bleeding Disorder	Y N	Earaches/Infections	Y N	Speech Disorder	Y N
Bone Disorder	Y N	Eating Disorder	Y N	Sinusitis	Y N
Brain Injury	Y N	Emotional/School Problems	Y N	TMJ Problems	Y N
Bruising	Y N	Epilepsy/Seizure	Y N	Tuberculosis	Y N
Cancer/Malignancy	Y N	Hearing Impaired	Y N	Visual Impaired	Y N

Other: _____

DENTAL HISTORY

Is this your child's first dental visit? Y N If no, previous dentist: _____ Date of last visit: _____

How was his/her experience? _____ Were any x-rays taken? Y N

Child's attitude towards the dentist or dental care: _____

Has your child had any injuries to teeth, mouth, or head? Y N If yes, please describe: _____

Has your child done any of the following (past or present)? Please circle:

Thumb/Finger-Sucking Pacifier Nail Biting Lip Sucking Mouth-Breathing Snoring Teeth Grinding Nursing Bottle-Feeding

Is your water fluoridated? Y N Does your child take fluoride supplements? Y N

Does your child use fluoridated toothpaste? Y N How often does your child brush his/her teeth? _____

With adult supervision? Y N How often does your child floss? _____ Are you interested in a fluoride supplement? Y N

How may we help to make this visit a positive experience for your child? _____

SIGNATURE: _____ Relationship: _____ Date: _____

For office use only: Medical Alert Premedication Allergies Anesthesia

Comments: _____

_____ Reviewed by_____ Date: _____

1615 Woods Court, Hood River, Oregon
Phone (541) 490-4993 Fax (541) 436-4418
info@littleshreddersdental.com www.littleshreddersdental.com

Christopher A. Swisher, DDS
Pediatric Dentistry

EXAM CONSENT

Child's Name: _____ Birthdate: _____

I understand that by signing below that I request and authorize the procedure to be done and have read and understand the possible risks and complications of the procedure.

X-Rays & Examination

I understand that I will be receiving a dental examination from a state licensed dental practitioner. I understand that while X-rays are taken on my teeth that I will be exposed to a minimal amount of radiation as part of the necessary requirements to complete thorough and comprehensive examination. I also understand that if I am pregnant (teens) radiation exposure possess a serious threat to the life and health of my unborn child. Pregnant teens are required to have medical release from their Medical Doctor prior to X-rays and Dental treatment.

Changes in Treatment Plan

I understand that during treatment it may be necessary to change procedures or add procedures because of conditions discovered while working on the teeth that were not found during examination. I understand that there may be unforeseen changes that may occur during treatment. I understand that whenever possible, I will be informed of any treatment changes in advance. I give my permission to the Dentist to make any and /or all changes and additions as necessary.

Drugs and Medication

I understand that antibiotics, analgesics and other medications can cause allergic reactions. The reactions can cause redness and swelling of tissues, pain, itching, vomiting, and or anaphylactic shock.

I understand that there has been no guarantee or assurance made by anyone in regard to my dental treatment that I have authorized. I also acknowledge that I am responsible for payment of all my dental fees regardless of any dental insurance coverage.

I understand that occasionally the office may record my interactions with the doctor and staff solely to ensure quality of care. I consent to such recording as well as additional staff or doctors observing the exam/procedure provided my identity is not revealed.

SIGNATURE: _____ Relationship: _____ Date: _____

1615 Woods Court, Hood River, Oregon
Phone (541) 490-4993 Fax (541) 436-4418
info@littleshreddersdental.com www.littleshreddersdental.com

Christopher A. Swisher, DDS
Pediatric Dentistry

FINANCIAL INFORMATION

For patients with dental insurance: I hereby authorize the Little Shredders Dental to release any information including diagnosis and records to the third-party payer and/or other health care practitioners. I authorize and request my insurance to pay directly to Little Shredders Dental, otherwise payable to me but not to exceed the charges shown on the claim. Patients with dental insurance must provide accurate and complete insurance information so we may assist you in filing your claim promptly. We allow 60 days for your insurance to make a payment to us. After this time, any outstanding balance will be your responsibility. You will be required to pay your portion the day of dental treatment. I understand I am financially responsible for any charges not covered by my insurance or by this authorization. I realize that the failure to keep this account current may result in the dentist unable to provide additional dental services except for dental emergencies or where there is a prepayment for additional services. I understand a late charge of 1.5% per month, or a monthly late charge of $20 will be added to unpaid balances over 30 days past due.

For patients without insurances: payment in full is expected at the time of dental service. When this is not possible, financial arrangements must be made in advance. I realize that the failure to keep this account current may result in the dentist unable to provide additional dental services except for dental emergencies or where there is a prepayment for additional services. I understand a late charge of 1.5% per month, or a monthly late charge of $20 will be added to unpaid balances over 30 days past due.

Cancellation: It is the patient's responsibility to keep scheduled appointments. Our practice requires notification of cancellation at least 24 hours prior to the appointment or earlier if possible. Our practice will consider an appointment a No Show any time a patient has not given 24 hours advance notice of cancellation or has failed to arrive within 15 minutes of their appointment time. Patients who No Show for 2 appointments in a 1-year period will be dismissed from the practice. Patients will also be subject to a $65.00 missed appointment fee. The Cancellation and No-Show fees are solely your responsibility and must be paid in full before the patient's next appointment.

Notice to Parents/Guardians: You may allow your child to have prizes at their own risk. WARNING: Items in the treasure chest may pose a choking hazard. Small prizes are not for children under 3 years old. Prizes may also contain unknown and/or harmful materials. Parents accept all the responsibility and will not hold Little Shredders Dental or its employees liable. Childs play area is not supervised by our staff at Little Shredders Dental; it is the responsibility of the parent to monitor your child's safety while they are in the waiting area. Parents accept all the responsibility and will not hold Little Shredders Dental or its employees liable.

SIGNATURE: _____ Relationship: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I, (please print parent/guardian name) _____ have received a copy of this office's Notice of Privacy Practices to read and/or take home.

Child's Name: _____

SIGNATURE: _____ Relationship: _____ Date: _____

For Office Use Only:
We attempted to obtain written acknowledgment of receipt of our NOTICE OF PRIVACY PRACTICES, but acknowledgment could not be obtained because of:

___ Individual refused to sign ___ Communication barriers prohibited obtaining the acknowledgement

___ An emergency situation prevented us ___ Acknowledgment not returned by parent.

1615 Woods Court, Hood River, Oregon
Phone (541) 490-4993 Fax (541) 436-4418
info@littleshreddersdental.com www.littleshreddersdental.com

Christopher A. Swisher, DDS
Pediatric Dentistry

FOR THE CONVENIENCE OF OUR INSURED PATIENTS:

Although we are asking for a deposit at the time of most services, there are times when insurance does not pay the entire remaining balance. For this reason, Little Shredders Dental requires a credit card on file for your account. This information is kept in a secure HIPAA-compliant system and will be held until insurance has paid their portion and notified Little Shredders Dental of the amount due. Any remaining balance owed on the account will be charged to the credit card on file. This authorization will remain in effect until canceled in writing by the patient.

Additionally, you may use your card on file to pay co-pays, percentages, and deductibles due at the time of surgery.

If you have any questions about this payment method, please do not hesitate to ask.

Sincerely,
Little Shredders Dental

I authorize Little Shredders Dental to charge outstanding balances on my account or my dependent's account to the following credit card.

Special Instructions: _____

SIGNATURE: _____ Date: _____

Patient Name (Please Print): _____

Cardholder Name (Please Print): _____

Cardholder Secure Email Address: _____

Cardholder Phone Number: _____

Cardholder Address: _____

Visa **MasterCard** **Amex** **Discover** **Debit**

Card Number: _____

Card Expiration Date: _____ CVV:_____ Employee Initials: _____

RECORD RELEASE AUTHORIZATION

Patient (s) Name: _____

Patient(s) Date of Birth: _____

Parent's Name: _____

Release all dental/medical record information and X-rays for the patient(s) listed above

To ☒ From ☐

Office Name: _____

Phone: _____

Fax: _____

Email: _____

Little Shredders Dental
Christopher A. Swisher, DDS

1615 Woods Court, Hood River, Oregon

Phone (541) 490-4993 Fax (541) 436-4418

info@littleshredders.com www.littleshreddersdental.com

Please release any and all records and information which you may have in your possession, including but not limited to the following; dental records including operative records, diagnosis, dental history, findings and procedures, treatment notes, radiographs, diagnostic models and additional materials.

In consideration of such disclosure on the part of the above-named parties, I hereby release them from any and all liability arising from such disclosure.

Parent Signature _____ Date _____

Printed Name: _____ Relationship to Patient: _____

NOTICE OF PRIVACY PRACTICE

Effective Date: February 25th, 2015

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

CONTACT INFORMACION

For more information about our privacy practices, or to get additional copies of this notice, please contact our Privacy Officer:

Title: Privacy Officer: Christopher A. Swisher, DDS Telephone (541) 490-4993 Fax (541) 436-4418

Email: info@littleshreddersdental.com Address: 1615 Woods Court, Hood River, Oregon 97031

OUR PROMISE TO YOU AND OUR LEGAL DUTY

We are required by law to protect the privacy of your child's health information (medical information"). We are also required to send you this notice about our privacy practices, our legal duties, and your rights concerning your child's medical information.

We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect on the date set forth at the top of this page and will remain in effect unless 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. We reserve the right to make any changes in our privacy practices and the new terms of our notice applicate to all medical information we maintain, including medical information we created or received before we made the change.

We may amend the terms of this notice at any time. If we make a material change to our policy practices, we will provide to you the revised notice. Any revised notice will be effective for all health information that we maintain. The effective date of a revised notice will be noted. A copy of the current notice in effect will be available in our facility and on our website if applicable. You may request a copy of the current notice at any time.

We collect and maintain oral, written and electronic information to administer our business and to provide products, services and information of importance to our patients. We maintain of our patients' medical information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction or misuse.

USES AND DISCLOSURES OF YOUR CHILD'S MEDICAL INFORMATION

Treatment: We may disclose your child's medical information, without your prior approval, to another dentist, a physician or other health care provider working in our facility or otherwise providing your child's treatment for the purpose of evaluating your child's health, diagnosis medical conditions, and providing treatment. For example, your child's health information may be disclosed to an oral surgeon to determine whether surgical intervention is needed.

Payment: we provide dental services. Your child's medical information may be used to seek payment from your insurance plan. For example, your insurance plan may request and receive information on dates that your child received services at our facility in order to allow your employer to verify and process your insurance claim.

Health Care Operations: We may use and disclose your child's medical information, without your prior approval, for health care operations. Health care operations include:

- Healthcare quality assessment and improvement activities;
- Reviewing and evaluation dental care provider performance, qualifications and competence, health care training programs, provider accreditation, certification, licensing and credentialing activities;
- Conducting or arranging for medical reviews, audits, and legal services, including fraud and abuse detection and prevention; and
- Business planning, development, management and general administration, including customer service, complaint resolutions and billing, de-identifying medical information, and creating limited data sets for health care operations, public health activities, and research.
- We may disclose your child's medical information to another dental or medical provider or health plan subject to federal privacy protection laws, as long as the provider or plan has or had a relationship with your child and the medical information is for that provider's or plan's health care quality assessment and improvement activities, competence and qualification evaluation and review activities, or fraud and abuse detection and prevention.

Your Authorization: You (or your legal personal representative) may give us written authorization to use your child's medical information or to disclose it to

Anyone for any purpose. Once you give us authorization to release your child's medical information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, will not use or disclose your child's medical information for any purpose other than those described in this notice. We will obtain your authorization prior to using your child's medical information for marketing, fundraising purposes or for commercial use.

Family, Friends, and Others Involved in Your Child's Care or Payment for Care: We may disclose your child's medical information to a family member, friend or any other person you involve in your child's care or payment for your child's health care. We will disclose only the medical information that is relevant to the person's involvement.

We may use or disclose your child's name, location, and general condition to notify, or to assist an appropriate public or private agency to locate and notify, a person responsible for your child's care in appropriate situations, such as a medical emergency or during a disaster relief efforts.

We will provide you with an opportunity to object to these disclosures, unless you are not present or are incapacitated or it is an emergency or disaster relief situation. In those situations, we will use our professional judgment to determine whether disclosing your child's medical information is in your best interest under the circumstances.

Health-Related Products and Services: We may use your child's medical information to communicate with you about health-related products, benefits, services, payment for those products and services, and treatment alternatives.

Reminders: We may use or disclose medical information to send you reminders about your child's dental care, such as appointment reminders.

Plan Sponsors: If your child's dental insurance coverage is through an employer's sponsored group dental plan, we may share summary health information with the plan sponsor.

Public Health and Benefit Activities: We may use and disclose your child's medical information, without your permission, when required by law, and when authorized by law for the following kinds of public health and public benefit activities:

- for public health, including to report disease and vital statistics, child abuse, and adult abuse, neglect or domestic violence;
- to avert a serious and imminent threat to health or safety;
- for health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities, and fraud prevention agencies;
- for research;
- in response to court and administrative orders and other lawful process;
- to law enforcement officials regarding crime victims and criminal activities;
- to coroners, medical examiners, funeral directors, and organ procurement organizations;
- to the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; and
- as authorized by state worker's compensations law.

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Business Associates: We may disclose your child's medical information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclosed any information other than as specified in our contract.

Data Breach Notification Purposes: We may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your child's health information.

Additional Restrictions on Use and Disclosure: Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about your child. "Highly confidential information" may include confidential information under Federal laws governing alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information:

1. HIV/AIDS;
2. Mental health;
3. Genetic tests;
4. Alcohol;
5. Sexually transmitted diseases and reproductive health information;
6. Child or adult abuse or neglect, including sexual assault.

OUR PROMISE TO YOU AND OUR LEGAL DUTY

Access: You have the right to examine and receive a copy of your child's medical information, with limited exceptions. We will use the format you request unless we cannot practicably do so. You should submit your request in writing to our Privacy Officer.

We may charge you reasonable, cost-based fees for a copy of your child's medical information, for mailing the copy to you, and for preparing any summary or explanation of your child's medical information you request. Contact our Privacy Officer for information about our fees.

Disclosure Accounting: You have the right to a list of instances in which we disclose your child's medical information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities.

You should submit your request to our Privacy Officer. We will provide you with information about each accountable disclosure that we made during the period for which you request the accounting, except we are not obligated to account for a disclosure that occurred more than 6 years before the date of your request.

Amendment: You have the right to request that we amend your child's medical information. You should submit your request in writing to our Privacy Officer.

We may deny your request only for certain reasons. If we deny your request, you may have a statement of your disagreement added to your child's medical information. If we accept your request, we will make your amendment part of your child's medical information and use reasonable efforts to inform others of the amendment who we know may have a rely on the unamended information to your detriment, as well as persons you want to receive the amendment.

Restrictions: You have the right to request that we restrict our use or disclosure of your child's medical information for treatment, payment or health care operations, or with family, friend or others you identify. Except in limited circumstances, we are not required to agree to your request, but if we do agree, we will abide by our agreement, except in a medical emergency or as required or authorized by law. You should submit your request to our Privacy Officer. Except as otherwise required by law, we must agree to a restriction request if:

1. except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and not for purposes of carrying out treatment); and

2. the medical information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full by the patient.

Confidential Communication: You have the right to request that we communicate with you about your child's medical information in confidence by means or to locations that you specify. You should submit your request in writing to our Privacy Officer.

Breach Notification: you have the right to receive notice of a breach of your unsecured medical information. Breach may be delayed or not provided if so, required by a law enforcement official. You may request that notice be provided by electronic mail. If you are deceased and there is a breach of your child's medical information, the notice will be provided to your next of kin or personal representatives if we know the identity and address of such individual(s).

Electronic Notice: If you receive this notice on our web site or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact our Privacy Officer to obtain this notice in written form.

COMPLAINTS

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your child's medical information, about amending your child's medical information, about restricting our use or disclosure of your child's medical information (including a breach notice communication), you may contact our Privacy Officer.

You also may submit a written complaint to the Officer for Civil Rights of the United States Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, Washington, D.C. 20201. You may contact the Office for Civil Rights' Hotline at 1 (800) 368-1019.

We support your right to the privacy of your child's medical 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.