Upward Smiles® - Comprehensive Health History & Consent (Minor)

Patient Name: _____ Date of Birth: _____/_____/_____

MoHealthNet ID Number: _____ Gender Identity: Male Female Other

Does the patient have primary dental insurance ***IN ADDITION*** to Medicaid? Yes No

How did you hear about Upward Smiles? Facebook Google Other:_____

Please indicate if your child has been treated or is under treatment for any of the following:					
	YES	**NO**		**YES**	**NO**
Abnormal Bleeding			Cancer/Leukemia		
Disabilities/Special Needs			Hepatitis A, B, or C		
ADD			LATEX ALLERGY		
Hearing Impairment			Diabetes I or II (Last A1c: __)		
ADHD			Congenital Birth Defects		
Kidney/Liver Conditions			HIV/AIDS		
Autism/Asperger's			Seizures/Epilepsy		
Heart Disease/Heart Surgeries			Bone Disorders		
Asthma			Tobacco/Substance Abuse		
Hemophilia/Blood Disorders			Lactose Intolerant		
Tuberculosis			Rheumatic/Scarlet Fever		
Pregnant			Been sedated for dentistry?		
Down Syndrome			Anxiety/Depression		

Is this your child's first visit to the dentist? YES NO - how long since the last visit to the dentist? _____

Previous Dentist's Name: _____ Were x-rays taken at previous dental visits? YES NO

Have there been any injuries to the teeth, face or mouth? YES, please explain: _____ NO

HABITS - **Lip Sucking/ Biting:** YES NO **Nail Biting:** YES NO **Thumb/Finger Sucking:** YES NO

Is the child's water fluoridated? YES NO UNSURE Do they take fluoride supplements? YES NO

Has the child ever had any pain or tenderness in the jaw or jaw joint? YES NO

How often does your child brush per day? _____ Does your child floss daily? YES NO

Child's Physician: _____ Physician Phone Number: _____

Has the child had any hospital stays in the last 5 years? YES, explain: _____ NO

Please explain all of the child's medical conditions, and any past/upcoming surgeries:

_____

Please list all drug, dye, or food **allergies**: _____

Please list all medication your child is *currently* taking: _____

_____

Has your child been told by a **doctor** that they need **premedication before dental treatment**? YES NO

- If yes - Type and amount of antibiotic: _____ Time taken: _____

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Patient Name: _____

Parent, Guardian, or other Responsible Party's Information

Name: _____ Relationship to patient: _____

Address: _____ Zip Code: _____

Phone #1: _____ ◯ **OK to call** ◯ **OK to text**

Phone #2: _____ ◯ **OK to call** ◯ **OK to text**

Email: _____ (*you authorize email correspondence by providing*)

Employer: _____ Work Number: _____

Please list the information for any person(s) you give permission to provide consent for your child at visits to the practice (including stepparents, grandparents, aunts, uncles, siblings over the age of 18):

(Name) (Relationship to patient) (Name) (Relationship to patient)

(Name) (Relationship to patient) (Name) (Relationship to patient)

PLEASE READ FULLY - Office Policies – PLEASE READ FULLY

- We require confirmation of EACH appointment, no later than **2 PM the day prior** to the scheduled appointment. For your convenience, we will call, text, or email you to confirm. If we are unable to reach you, and we do not receive a confirmation by the 2 PM deadline: we will consider that appointment CANCELLED.
- If you are unable to make it to a confirmed appointment, we require you to notify our office as soon as possible. If we are not notified that you intend to cancel an appointment at least 4 hours prior to the appointment time, the appointment will be considered "**broken**". No shows to a confirmed appointment are also considered "**broken**".
  - 1st broken appointment will result in a 90-day suspension in scheduling
  - 2nd broken appointment will result in a 90-day suspension in scheduling
  - 3 or more broken appointments will result in *dismissal* from the practice (patient will no longer be treated by the practice, and will need to seek dental care elsewhere)
- **As a courtesy to all patients, we may reschedule any patient who arrives 15 or more minutes past their appointment time.**
- **Upward Smiles** (the "Practice") does not tolerate abusive, disruptive behavior or foul language. Anyone exhibiting such behavior is subject to immediate dismissal from the practice. Threats are reported directly to the Police.

Communication Policy

Upward Smiles utilizes a variety of mediums to contact you regarding the patient's dental care. By providing phone numbers/email addresses, you request and authorize us to communicate with you electronically, verbally, or text messaging via cell phone. In the event of an unanswered call, you authorize us to leave voice messages regarding patient and appointment information. We will send correspondence via email and/or text message to any email/phone number you provide us. By providing these contacts, you authorize us to send HIPAA-protected health information. If you choose to

cancel this electronic correspondence at any time, you must notify our office in writing. To *opt out* of text messaging services, simply reply **OPTOUT** to any message you receive.

Parents/Guardians with Children

The Practice allows a parent to be present with a child during the child's 1st visit only. If the parent is with additional children, then the parent will need to stay in the waiting room with the other children. If you are bringing more than one child to the appointment, we recommend you bring another responsible adult to watch the additional children, while you accompany your child to the hygiene room. We cannot be responsible for children left unattended in the waiting room. A parent, legal guardian, or authorized person is ***required*** to be present when a minor presents for any visit. Legal guardians must supply proof of legal guardianship before Upward Smiles will see the child. Only a parent, legal guardian, or designated adult may sign for the treatment of a minor - therefore treatment will not be rendered to minors without the written signature of the parent or guardian; in this situation, the minor will be rescheduled.

Consent of Service

Your child may receive dental services (Exams, X-Rays, Cleanings, Injections, Fillings, Sedative Fillings, Extractions, Stainless Steel Crowns, Pulpotomies, Sealants and Space Maintainers) at any appointment they make with the Practice at the direction of a licensed dental professional. You hereby give permission for your child to receive any dental services recommended by the Practice. In the event that your child presents for an appointment with an authorized adult that has been indicated on paperwork by a parent/guardian, you grant that adult permission to authorize additional treatment for your child, as requested by staff of the Practice.

HIPAA

I understand that I have certain rights to privacy regarding my protected health information (PHI), provided to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent form, I authorize Upward Smiles, Inc. to use and disclose my PHI to carry out treatment (including direct, or indirect, treatment by relevant healthcare professionals), obtain payment for services rendered, carry out day to day healthcare operations of the practice (including, but not limited to correspondence regarding appointments and PHI). I have also been informed of, and given the right to review a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that Upward Smiles, Inc. reserves the right to change the terms of this notice from time to time, and that I may contact the practice at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but that you are not required to agree to these restrictions. However, if you do agree, you are then bound to comply with these restrictions. I understand that I may revoke this consent, in writing, at any time.

I CERTIFY THAT I HAVE REVIEWED PAGES 1 through 3 of this patient information disclosure on the date below, and I understand and agree to any and all policies set forth. The information provided on this paperwork is to the best of my knowledge and I will not hold Upward Smiles, Inc. responsible for any errors or omissions I've made on these forms.

PRINT PARENT/GUARDIAN NAME: _____

SIGN: _____DATE: _____/_____/_____