

PLEASE PRINT THE FOLLOWING INFORMATION

This Information is Important for Our Records and Your Youngsters Health

1. REASON FOR VISIT

Date _____

☐ CHECK UP (EXAMINATION & CLEANING)

☐ PAIN - DISCOMFORT - EMERGENCY

☐ FULL MOUTH CARE

☐ DEVELOPMENTAL SUPERVISION (ORTHODONTIC CARE)

PATIENT INFORMATION

2. (This information is necessary for our files and will be considered confidential)

PATIENT'S LAST NAME _____	FIRST NAME _____	MIDDLE _____	HOME PHONE _____	
CURRENT STREET ADDRESS _____	CITY _____	STATE _____	ZIP _____	HOW LONG? _____
FATHER'S NAME _____		MOTHER'S NAME _____		
FATHER EMPLOYED BY _____	HOME PHONE _____	BUSINESS PHONE _____	EXT. # _____	
MOTHER EMPLOYED BY _____	HOME PHONE _____	BUSINESS PHONE _____	EXT. # _____	
PATIENT'S BIRTHDATE _____				
METHOD OF PAYMENT _____ CASH _____ CHECK _____ (MASTERCARD, VISA, AMERICAN EXPRESS)				

3: FOR YOUR CHILD ABOVE, PLEASE ANSWER THE FOLLOWING:

	CHECK ONE	
	YES	NO
1. IS YOUR CHILD PRESENTLY UNDER THE CARE OF A PHYSICIAN FOR ANY MEDICAL DISORDER? _____	<input type="checkbox"/>	<input type="checkbox"/>
2. DOES YOUR CHILD TAKE ANY MEDICATION REGULARLY? _____	<input type="checkbox"/>	<input type="checkbox"/>
3. IS YOUR CHILD SENSITIVE OR ALLERGIC TO ANY DRUG (EG. PENICILLIN)? _____	<input type="checkbox"/>	<input type="checkbox"/>
4. IS YOUR CHILD SUBJECT TO ANY BLOOD OR BLEEDING DISORDERS? _____	<input type="checkbox"/>	<input type="checkbox"/>
5. DOES YOUR CHILD HAVE A HISTORY OF ALLERGIC REACTION OR ALLERGY? _____	<input type="checkbox"/>	<input type="checkbox"/>
6. DOES YOUR CHILD HAVE A HISTORY OF HEART TROUBLE, DIABETES, ASTHMA, EPILEPSY, RHEUMATIC FEVER, TUBERCULOSIS, KIDNEY, LIVER OR OTHER MEDICAL DISORDER? (PLEASE CIRCLE) _____	<input type="checkbox"/>	<input type="checkbox"/>
7. HAS YOUR CHILD EXPERIENCED ANY UNFAVORABLE REACTION FROM ANY PREVIOUS DENTAL OR MEDICAL TREATMENT? _____	<input type="checkbox"/>	<input type="checkbox"/>
8. DOES YOUR CHILD SUCK HIS THUMB OR FINGER? _____	<input type="checkbox"/>	<input type="checkbox"/>
9. IS YOUR CHILD TAKING A FLUORIDE/VITAMIN SUPPLEMENT OR DRINKING FLUORIDATED WATER? _____	<input type="checkbox"/>	<input type="checkbox"/>
10. IN ORDER TO MORE PROPERLY TREAT YOUR CHILD, IT IS IMPERATIVE THAT YOU DESCRIBE ANY AND ALL DIFFICULTIES OF MEDICAL OR DENTAL NATURE WHICH YOUR CHILD HAS EXPERIENCED. (IF NONE, PLEASE WRITE NONE) _____	<input type="checkbox"/>	<input type="checkbox"/>

How did you find out about us? Our practice grows by referrals from our dental family... who may we thank for referring you to us for your child's dental care?

Name _____

Address _____

City _____

\$15.00 CHARGE FOR ANY MISSED APPOINTMENT

FOR ALL PATIENTS

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy, that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistance as he deems fit. I also understand that previous to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or his staff. I agree to pay for all services rendered by this office.

SIGNATURE OF RESPONSIBLE PARTY _____

RELATIONSHIP _____

DATE _____

Dental Risk Assessment Questionnaire

Parents and caregivers- use this form to tell us about the oral health of your child. This will be part of your child's health record.

Parent/Guardian Name _____

Date _____

Child's Name _____

Child's Age _____

Yes No

1. Does your family drink water with fluoride in it or do your children take fluoride tablets? _____

2. Does your child use toothpaste with fluoride in it? _____

3. Do you help your child with tooth brushing? _____

4. Does your child take a bottle to bed? _____

5. Does your child use a sippy cup? _____

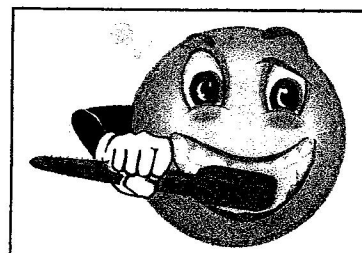
6. Does your child have any oral habits? Please circle.
Examples: pacifier, suck a thumb or finger _____

7. How is your own dental health? _____ Good _____ Fair _____ Poor

DID YOU KNOW?

For every 100 school children, more than 5 days of school per year are lost due to dental disease.

Good dental health is important?



HIPAA Notice of Privacy Practices

JOHN F. ZUMMO, D.D.S., P.C.
16125 CAIRWAY DRIVE, SUITE 108
HOUSTON, TX 77084
281-859-9878

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

(OVER)

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature _____ | Date _____