CHILDREN'S DENTISTRY

NICHOLAS Y. CHING, D.D.S., INC
EDWARD M. MATSUISHI, D.D.S.
7001 Stockton Avenue, Suite 3, El Cerrito, CA 94530 Telephone (510) 524-4633

A B C

CONFIDENTIAL PATIENT INFORMATION

Patients Name _____
Last First Middle

Address_____
Street City State Zip

Whom may we thank for referring you to our office? _____

CONFIDENTIAL RESPONSIBLE PARTY INFORMATION

☐ Parent ☐ Guardian_____ _____
Last First M Marital Status

Residence_____ ☐ Own ☐ Rent
Street City State Zip

Mailing
Address_____
Street City State Zip

How long at this address?_____Home Phone_____Work Phone_____Cell/Pgr_____

Previous Address (if less than 3 yrs.) _____
Street City State Zip

Email Address_____

Social Security #_____Birthdate _____/_____/_____ Relationship to Patient_____

Employer_____Occupation_____No. Years Employed_____

Spouse's Name_____Relationship to Patient _____
Last First M

Email Address _____

Employer_____Occupation_____No. Years Employed_____

Social Security #_____ Birthdate _____/_____/_____ Work Phone_____Cell/Pgr_____

Who does child reside with? _____

Dental Insurance Information

Policy Holder's Name_____ Policy Holder's Soc. Sec. #_____

Insurance Company/Address_____Group No. _____

Policy Holder's Employer_____Phone No._____
Do you have dual coverage? Yes or No If yes:

Policy Holder's Name_____Policy Holder's Soc. Sec. #_____

Insurance Company/Address_____Group No. _____

Policy Holder's Employer_____Phone No._____
Assignment of Benefits: I hereby authorize payment directly to Nicholas Y. Ching, D.D.S. and Edward M. Matsuishi, D.D.S. the dental benefits otherwise payable to me but not to exceed the charges shown on any claim. I understand that I am financially responsible for any charges not covered by this authorization. I authorize release of any information relating to any claim.
Signature_____Date_____

Emergency Information

Name of nearest relative not living with you_____ Relationship_____
Complete Address_____ Phone No._____

I GIVE MY PERMISSION TO NICHOLAS Y. CHING, D.D.S. AND EDWARD M. MATSUISHI, D.D.S. TO RENDER ALL NECESSARY DENTAL SERVICES, including diagnostic X-rays, medication and anesthetics as they see fit.
I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____Date_____

Office use only:
UPDATES _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____

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GETTING TO KNOW YOUR CHILD

Please fill out this form completely. This information will allow us to better understand your child and provide quality dental care.

Child's Name_____ _____ _____Nickname_____
First Last Middle

Sex: Female / Male Age_____ Birthdate_____

What is the reason for this visit? _____

Is this your child's first dental visit? _____Date of last visit_____Purpose_____

What is your child's attitude toward previous dental care? _____

Have we seen other children in your family? _____

Name(s) and age(s) of brother(s) and sister(s) _____

Name of child's pet_____Child's interests_____

Name of family dentist_____Child's previous dentist_____ _____

HEALTH HISTORY

Child's Pediatrician_____Phone number_____

Date of last physical exam_____ Is your child under a doctor's care now? _____

For what reason? _____Kaiser Medical #_____

Is your child taking any medications? _____ What Kind? _____

Have your child ever been hospitalized? _____ For what reason_____

Is your child allergic to any medications? _____ Please list_____

_____ Reaction_____

Does your child have any allergic reactions to food_____ What Kind? _____ _____ animals_____ pollen_____ dust____

Does your child have good physical coordination? _____ Has your child received all immunizations? _____

Has your child taken fluoride? _____ In what form and when? _ _____

Does your child brush regularly? _____ Does an adult assist with brushing? _____

Does your child use dental floss? _____ Does an adult assist with flossing? _____

Has either parent or child been treated orthodontically? _____

How would you expect your child to behave in our office? _____

Has your child had a history of or difficulty with:

YES	NO		YES	NO	
_____	_____	Premature birth	_____	_____	Speech disorder
_____	_____	First year of life	_____	_____	Hearing
_____	_____	Heart	_____	_____	Gag Reflex
_____	_____	Brain Injury	_____	_____	Bladder
_____	_____	Bruising	_____	_____	Seizures
_____	_____	Cancer or malignancies	_____	_____	Fainting or dizziness
_____	_____	Diabetes	_____	_____	Nosebleeds
_____	_____	Hepatitis	_____	_____	Asthma
_____	_____	Earaches	_____	_____	Liver
_____	_____	Kidney	_____	_____	Bone disorder
_____	_____	Cerebral Palsy	_____	_____	Rheumatic fever
_____	_____	Bleeding	_____	_____	Developmental problems
_____	_____	Anemia	_____	_____	Other _____
_____	_____	Motion Sickness			

COMMENTS/DETAILS_____

_____

_____

Does your child have any phobias? _____

Was your child bottle fed? _____ Breast fed? _____ Until what age_____

Does your child have any oral habits, such as: finger/thumb sucking_____ pacifier_____ nail biting _____

Lip sucking_____ mouth breathing_____ other_____

Has your child ever had any injuries to his/her teeth, mouth or head? _____

If so, please describe_____

Date_____ Signature_____

Office use only:
UPDATES _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____

Thank you for completing this detailed information so that we may become better acquainted with your child.

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DENTISTRY

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EDWARD M. MATSUISHI, D.D.S.
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This worksheet is designed to help identify your concerns to assure a positive dental visit when your family meets with us. Please feel free to use it in any way which is helpful, and bring it with you when you come to meet us. Thanks!

What prompted you to phone our office?

What do you hope to accomplish from your meeting with us?

What things, from previous dental experience, would you like to find in our office?

What experiences would you hope to avoid or eliminate?

Are there any problems, issues, or challenges you'd like us to help you with? Please explain.

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

Notice of Privacy Practices

OUR LEGAL DUTY

We are required by federal and state law to maintain the privacy of your child's health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your child's health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003 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. We reserve the right to make the changes in our privacy and the new terms of our Notice effective for all health information that we maintain including health information we created or received before we made the changes. Before we make a significant change in our privacy practices we will change this Notice. 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.

Uses and disclosures of Health Information

We use and disclose health information about your child for treatment, payment, and health care operations. For example:
Treatment: We may use or disclose your child's health information to another healthcare provider providing treatment to your child.

Payment: We may use and disclose your child's health information to obtain payment for services we provide to your child.

Healthcare Operations: We may use and disclose your child's health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of health-care professionals, evaluating practitioners and provider performance, conducting training programs, accreditations, certification, licensing or credentialing activities.

Incidental Disclosure: In order to create a relaxed atmosphere for your child, we work in an open environment, therefore, there may be occasional, incidental information disclosed to persons transiting the area.

Your Authorizations: In addition to your use of your child's health information for your treatment, payment or healthcare operations, you may give us written authorization to use your child's health information or to disclose it to anyone for any purpose. If you give us an authorization you may revoke it in writing at any time.

To Your Family and Friends: We must disclose your child's health information to you as described in the Patient Rights section of this Notice. We may disclose your child's health information to a family member, friend, or other person to the extent necessary to help with your child's healthcare or with payment for your child's healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your child's care, of your child's location, your child's general condition, or death. If you are present, then prior to use or disclosure of your child's health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information, based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your child's healthcare. We will also use our professional judgment and our experience with our common practice to make reasonable inferences of your child's best interest in allowing a person to pick up files, prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services
We will not use your child's health information for marketing without your written authorization.

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

Abuse or neglect: We may disclose your child's health information to appropriate authorities if we reasonably believe that your child is a possible victim of abuse, neglect or the possible victim of other crimes. We may disclose your child's information to the extent necessary to avert a serious threat to their health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of armed forces personnel under certain circumstances. We may disclose to authorize federal officials health information required of lawful intelligence, counter intelligence, and other national security activities. We may
disclose to correctional institution or the law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders We may use or disclose your child's health information to provide you with appointment reminders (such as voice mail messages, postcard, or letters.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclose your health information for purposes, other than treatment, payment, health care operations, and certain other activities for the last six years, but not before April 14, 2003. If you request this accounting more then once in a twelve month period, we may charge you a reasonable cost based fee for responding to these additional requests.

Access: You have the right to look at or get copies of your child's health information, with limited exceptions. You may request that we provide copies in a format other than photo copes in a format other than photo copies. We will use the format you request unless we cannot practicable do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this notice. We will charge you a reasonable cost based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we reserve the right to charge you $0.10 for each page $1.00 for each sheet of x-rays duplicated, and postage if you want the copies mailed to you. If you request an alternative format we will charge a cost based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Restrictions: you have the right to request that we place additional restrictions on our use or disclosure of your child's health information. We are not required to agree to those additional restrictions, but if we do, we will abide by our agreement (except in an emergency.)

Alternative Communication: You have the right to request that we communicate with you about your child's health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative mean or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendments: You have the right to request that we amend your child's 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.

Questions: Sally Matsuishi
7001 Stockton Ave.
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(510) 524-4633

In order to comply with the privacy notification requirements of the Health Insurance Portability and Accountability Act we are providing you with a copy of our privacy practices

I, _____ the parent / legal guardian
(circle one)

Of _____

I acknowledged that I have received, from Nicholas Y. Ching, D.D.S. and Edward M. Matsuishi, D.D.S., a copy of their privacy practice.

Date_____ Signature _____