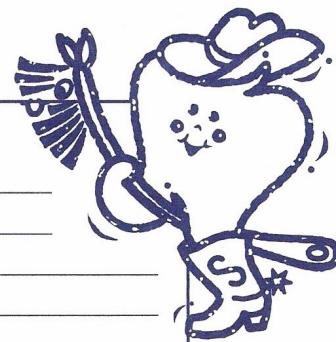


# Welcome and thank you for selecting us!

We strive to make each of your child's visits pleasant and comfortable. Please fill out this form completely in ink.

Patient ID # \_\_\_\_\_

Date: \_\_\_\_\_



## Your Child

Child's Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_  
Nickname \_\_\_\_\_ Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_  
School \_\_\_\_\_ Grade \_\_\_\_\_  
Child's Home Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_ Phone \_\_\_\_\_

## Responsible Party

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_ Phone \_\_\_\_\_  
Social Security # \_\_\_\_\_ DL# \_\_\_\_\_

Who is Responsible for Making Appointments? \_\_\_\_\_

## Parent or Guardian Information    Mother    Stepmother    Guardian

Name \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Social Security # \_\_\_\_\_ DL # \_\_\_\_\_  
Marital Status     Single     Married     Separated     Divorced     Widowed  
**Parent or Guardian Information**     Father     Stepfather     Guardian  
Name \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Social Security # \_\_\_\_\_ DL # \_\_\_\_\_  
Marital Status     Single     Married     Separated     Divorced     Widowed

## Primary Insurance

Insured's Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_  
Employer \_\_\_\_\_ Date Employed \_\_\_\_\_ Occupation \_\_\_\_\_  
Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_ Employee # \_\_\_\_\_  
Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Deductible \_\_\_\_\_ Copay \_\_\_\_\_ Amount already used \_\_\_\_\_ Max. annual benefit \_\_\_\_\_

## Additional Insurance

Insured's Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_  
Employer \_\_\_\_\_ Date Employed \_\_\_\_\_ Occupation \_\_\_\_\_  
Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_ Employee # \_\_\_\_\_  
Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Deductible \_\_\_\_\_ Copay \_\_\_\_\_ Amount already used \_\_\_\_\_ Max. annual benefit \_\_\_\_\_

Over Please



# Dental/Medical Health History (Confidential)

Your child's overall health as well as any medications which your child takes could have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely.

Patient ID # \_\_\_\_\_

How often does your child brush? \_\_\_\_\_

How often does your child floss? \_\_\_\_\_

Is your child's water fluoridated?  Yes  No

Does your child take fluoride supplements?  Yes  No

**Does your child:**

Suck Thumb/Finger  Yes  No

Suck/Bite Lip  Yes  No

Bite/Chew Nails  Yes  No

Chew Hard Objects (pencils, etc.)  Yes  No

Grind Teeth  Yes  No

Clench Jaws  Yes  No

Date of Last Dental Visit \_\_\_\_\_

Previous Dentist \_\_\_\_\_

Address \_\_\_\_\_

Has your child had difficulty with previous dental visits?  Yes  No

Child's Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_

Previous Hospitalizations/Surgeries/Serious Illnesses \_\_\_\_\_ When? \_\_\_\_\_

Is your child currently taking any medications?  Yes  No (if yes, please list) \_\_\_\_\_

Does your child have a history of allergies/sensitivities/adverse reactions to any drugs or medications (Penicillin, Novocain, etc.)?  Yes  No  
(if yes, please describe) \_\_\_\_\_

Does your child have a history of allergies to any other substances (latex, environmental, etc.)? \_\_\_\_\_

Please explain any medical problems that your child has: \_\_\_\_\_

## Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

Cash  Personal Check  Credit Card  VISA  MasterCard  I wish to discuss the office's payment policy.

**Authorization and Release**

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dentist's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient or Guardian, if minor

Date

**Dentist's Review:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of Dentist \_\_\_\_\_ Date \_\_\_\_\_

**Justin P Wong DDS PC  
5639 E 5th St, Ste C  
Tucson, AZ 85711**

**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**

**The Privacy of your Health Information is important to us.**

**Our Legal Duty:** We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 11/01/2003 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 practices 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 and make the new Notice available 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.

**USES AND DISCLOSURES OF HEALTH INFORMATION:**

We use and disclose health information about you for treatment, payment, and healthcare operations, For Example:

**TREATMENT:** We may use or disclose your health information to a physician or other healthcare provider providing treatment for you.

**PAYMENT:** we may use and disclose you health information to obtain payment for services we provide to you.

**HEALTHCARE OPERATIONS:** We may use and disclose your health information in connection with our healthcare operations.

Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professional, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**YOUR AUTHORIZATION:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your 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. Your revocation will not affect any use or disclosures permitted by your authorizaiton while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**TO YOUR FAMILY AND FRIENDS:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**PERSONS INVOLVED IN CARE:** We may use or 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 care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your 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 judgement disclosing only health information and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**MARKETING HEALTH-RELATED SERVICES:** We will not use your health information for marketing communications without your written authorization.

**REQUIRED BY LAW:** We may use or disclose your health information when we are required to do so by law.

**ABUSE OR NEGLECT:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your 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 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 of protected health information of inmate or patient under certain circumstances.

**APPOINTMENT REMINDERS:** We may use or disclose your health information to provide you with an appointment reminders (such as voicemail messages, postcards, texts, or letters)

### **PATIENT RIGHTS**

**ACCESS:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably 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 or 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 will charge you \$1.00 for each page, \$45 per hour for staff time to locate and copy your health information, and postage if you want the copied mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information for a fee. Contact us using the information listed at the end of this Notice for full explanation of our fee structure.)

**DISCLOSURE ACCOUNTING:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last six (6) years, but not before April 14, 2003. 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 these additional requests.

**RESTRICTION:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these 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 health information by alternative means or alternative locations. (You must make your request in writing). Your request must specify the alternative means or location, and provide satisfactory explanation how payment will be handled under the alternative means or location you request.

**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.

**ELECTRONIC NOTICE:** If you receive this Notice on our Website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

### **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 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.

**Contact Officer: Judy Lee or Crissy Baselice**

**Telephone: 520-745-0223**

**Fax: 520-745-2419**

**E-mail: info@justinwongdds.com**

**Address: 5639 E 5th Street, Ste C; Tucson, AZ 85711**

Reproduction of this form by dentists and their staff is permitted. Any other use, duplication or distribution of this form requires ADA written approval.

This Form is educational only, does not constitute legal advice and covers only federal, not state law in effect as of 3/27/2002.

**Justin P Wong DDS PC  
5639 E 5th St, Ste C  
Tucson, AZ 85711**

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

\*You may refuse to sign this acknowledgement\*

I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices.  
Please Print Name

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**For Office Use Only:**

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

- Individual refused to sign.  
 Communications barriers prohibited obtaining the acknowledgement  
 An emergency situation prevented us from obtaining acknowledgement  
 Other (Please Specify) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Justin P Wong DDS PC  
5639 E 5th St, Ste C  
Tucson, AZ 85711**

**CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION**

**Section A: Patient Giving Consent**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Cell \_\_\_\_\_ E-mail: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

**Section B: To the Patient: PLEASE READ CAREFULLY the following Statements:**

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time by contacting:

Contact Persons: Judy Lee or Crissy Baseline

Telephone: 520-745-0223 Fax: 520-745-2419      E-mail: [info@justinwongdds.com](mailto:info@justinwongdds.com)

Address: 5639 E 5th St, Ste C; Tucson, AZ 85711

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations

**Signature:** X \_\_\_\_\_

**Date:** \_\_\_\_\_

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

Personal Representative Name: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.**