Patient Registration

Child's Full Name _____ Birth Date: _____

Child is Called: _____ Child's Social Security Number: _____ Circle One: Male Female

Social History

Please circle any of the following that describes your child:

Advanced	Normal	Slow learner	Compulsive	Moody	Shy
Cooperative	Temper	High-strung	Sickly	Spoiled	Suspicious
Fearful	Healthy	Friendly	Defiant	Active	

What or who are your child's friends, hobbies or special interests? _____

_____

School / Daycare: _____ Grade: _____

Child lives with (Please circle): Father Mother Other: _____

Medical History

Child's Physician: _____ Last physical exam? _____

Any hospitalizations (since birth? No Yes _____

Is your child currently taking any medicine? No Yes _____

Are your child's immunizations up to date? Yes No _____

Does your child have any allergies (food, medicine, latex, hay fever, etc. No Yes _____

Does your child have, or has your child ever had, any of the following (please circle Yes or No for each one):

Heart Disease	Yes No	Seizures	Yes No	Snoring	Yes No
Oral Ulcers	Yes No	Pregnancy	Yes No	Stomach Problems	Yes No
Liver Disease	Yes No	Fainting, Dizziness or Headaches	Yes No	Acid reflux	Yes No
Diabetes	Yes No	Hearing or Speech Problems	Yes No	Learning problems	Yes No
Asthma	Yes No	Immune Deficiency	Yes No	Hyperactivity / ADD	Yes No
HIV	Yes No	Kidney Disease	Yes No	Cancer	Yes No
Tuberculosis	Yes No	AIDS	Yes No	Rheumatic Fever	Yes No
Emotional Problems	Yes No	Chemotherapy	Yes No	Bleeding Problems	Yes No
Anemia	Yes No	Hepatitis	Yes No	Pneumonia	Yes No
Bladder Infections	Yes No	Thyroid Problems	Yes No	Autism	Yes No
High Blood Pressure	Yes No	Shortness of Breath	Yes No	Heart Murmur	Yes No

Are there any medical problems not noted above? No Yes _____

_____

Has there ever been a concern by you, or your child's physician, about your child's development? No Yes _____

_____

Over, Please!

Dental History

Is this your child's first visit to the dentist? Yes No Previous Dentist _____

Has your child had any unfavorable experiences in a dental or medical office? No Yes _____

_____

How do you think your child will react to dental treatment? _____

Does your child have, or have a history of, any of the following (circle the ones that apply):

Toothache	Speech Difficulties	Lip Biting	Injury to teeth
Grinding of teeth	Popping, pain or clicking in jaw	Cleft Palate	Cavities
Mouth Ulcers	Fever blisters	Pacifier	Thumb or finger habit
Bad breath	Injuries to mouth or head	Tobacco use	Orthodontics
Snoring			

Type of water at home: well spring city filtered _____

Does your child take fluoride supplements or at-home treatments? No Yes _____

Do you have any special concerns about your child's dental health? _____

_____

Parents' Dental Health (Circle all that apply)

Father: Regular checkups lots of problems in the past currently has dental problems braces

currently has good dental health has had bad experiences with the dentist

Mother: Regular checkups lots of problems in the past currently has dental problems braces

currently has good dental health has had bad experiences with the dentist

I understand that the information requested above is necessary to provide my child with dental care in a safe and efficient manner. I have understood each question and have completed these two pages accurately to the best of my knowledge.

Date: _____ Signed: _____ Relation to Patient _____

Updates

(To be filled in at future appointments)
Has there been any change in your child's health since you last completed this form? NO YES _____

_____

Has any information on this form changed NO YES _____

Date: _____ Signed: _____ Relation to Patient _____

(To be filled in at future appointments)
Has there been any change in your child's health since you last completed this form? NO YES _____

_____

Has any information on this form changed NO YES _____

Date: _____ Signed: _____ Relation to Patient _____

Compound Authorization for Release of Information

Name of Patient _____ Date of Birth _____
Dr. Dennis Campbell & Staff is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section
☐ Voice Mail	☐ Appointment information ☐ Account information
☐ Give information to employer ☐ Give information to school	☐ Appointment absentee information
☐ Other (provide name)_____ _____ _____ _____ _____ _____	☐ Family billing information ☐ Financial ☐ Appointment information ☐ Treatment completed and needed

Acknowledgement of Receipt of Notice of Privacy Practices

By signing this statement, you are acknowledging that you have received a copy of our notice of Privacy Practices. However, you may also refuse to sign this acknowledgment.

Right of the Patient
I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Dr. Dennis Campbell's office. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient or personal representative.

Please print your name: _____

Signature: _____ Date: _____

Description of Personal Representative's Authority (attach necessary documentation)
_____

For Office Use Only

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

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An Emergency situation prevented us from obtaining the acknowledgement

☐ Other (please specify)

_____

_____

FAMILY REGISTRATION

Responsible Party Information

Child's Father's / Guardian's Full Name

Relationship to Patient | Spouse's Name

Address

City | State | ZIP

How long at this address? | Home Phone Number

Previous address (If less than 3 years)

Social Security Number | Date of Birth | Marital status

Employer | Occupation

No. Years Employed | Work Phone number (with extension)

E-Mail | Fax / Cell Phone / Pager

Child's Mother's / Guardian's Full Name

Relationship to Patient | Spouse's Name

Address

City | State | ZIP

How long at this address? | Home Phone Number

Previous address (If less than 3 years)

Social Security Number | Date of Birth | Marital status

Employer | Occupation

No. Years Employed | Work Phone number (with extension)

E-Mail | Fax / Cell Phone / Pager

Who may we thank for referring you?

Emergency Information

Name of nearest relative not living with you

Relationship to Patient

Address

City | State | ZIP | Phone

Dental Insurance

Insured's Name

Insurance Company

Insurance Company Address

Group Number

Signature on File: I authorize that payment of dental benefits be made to Dr. Dennis Campbell on any claims submitted for services furnished me by Dr. Campbell and his team. I agree that this authorization shall be valid until recinded.

Signed _____

Your Children

Name	Sex	Birth Date

I understand that the confidential information requested above is necessary to provide my children with dental care in an efficient manner. I understand that, where appropriate, credit bureau reports may be obtained. I have completed this page accurately to the best of my knowledge.

Signature (Parent or Guardian) _____

Today's Date: _____ Updates: _____ _____ _____

and a copy of the most recent xrays will generally be provided at least once at no charge. You may request that we provide photocopies of the actual record. There may be a charge to do this, because of the expense and time involved, and we will discuss the actual charge when you make the request.. We will use the format you request unless we cannot practicably do so. You must make your request in writing. A form is available at the front desk if you wish to make this request

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 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 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 health information by alternative means or to alternative locations. **You must make your request in writing.** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend 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 Web site 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 health information or in response to a request you made to amend or restrict the use or disclosure of 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.

Dennis R. Campbell, DDS, PA

Notice Of Privacy Practices

This document presents the information that federal law requires us to give our patients regarding our privacy practices.

You will be asked to sign an acknowledgment that you have been given the opportunity to review this document, and that you have been given the opportunity to receive a copy for your records, if you desire.

We provide a copy in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice.

It will also be available on our web site, www.babytoothdoc.com, after September 1, 2003.

Whenever the Notice is revised, we will make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions.

Contact Officer: Dennis R. Campbell, DDS

Telephone: (828) 254-7291

E-mail: babytoothdoc@charter.net

Address: 172 Asheland Avenue, Asheville, NC 28801

Original: April 14, 2003

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOUR CHILD OR CHILDREN MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR CHILD'S HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning 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 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 tell any of our team members, or call us at (828) 254-7291.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose health information to a physician, dentist or other healthcare provider providing treatment.

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

Healthcare Operations: We may use and disclose health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of health information for 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. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your child's health information for any reason except those described in this Notice.

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 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 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 child's care, of your child's location, general condition, or death. If you are present, then prior to use or disclosure of 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 common practice to make reasonable inferences of your child's 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 health information for marketing communications without your written authorization.

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

Abuse or Neglect: We may disclose health information to appropriate authorities if we reasonably believe that a child is a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose health information to the extent necessary to avert a serious threat to the health or safety of your child 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 appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your child's health information, with limited exceptions. Treatment summaries, financial summaries,

North Carolina

We will take reasonable steps to provide free-of-charge language assistance services to people who speak languages we are likely to hear in our practice and who don't speak English well enough to talk to us about the dental care we are providing.

Spanish:
Tomaremos acciones razonables para proporcionar servicios de asistencia lingüística gratuitos a aquellas personas cuyo lenguaje escuchemos frecuentemente en nuestro consultorio y que no hablen un inglés lo suficientemente bueno como para hablar con nosotros sobre el servicio odontológico que suministramos.

Chinese:
我们将有序地做到提供免费的语言服务使我们能听懂英语不好的人向我们咨询有关牙齿护理

Vietnamese:
Chúng tôi sẽ thực hiện các bước cần thiết để cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho những người giao tiếp bằng những ngôn ngữ mà chúng tôi có thể nghe thấy tại phòng khám của mình và cho những người không có đủ trình độ tiếng Anh để thảo luận về dịch vụ chăm sóc nha khoa mà chúng tôi đang cung cấp.

Korean:
저희는 적절한 조치를 통하여 언어 지원 서비스를 무료로 제공할 것입니다. 다만, 실제로 저희에게 관심이 있는 언어를 쓰지만 저희 치아 관리 서비스에 대해 의견을 줄 수 있을 만큼 영어로 의사소통이 원활하지 않는 경우로 한정합니다

French:
Nous prendrons les mesures raisonnables pour fournir des services d'assistance linguistique gratuits pour les individus qui parlent des langues que nous sommes susceptibles d'entendre durant nos séances et qui ne parlent pas suffisamment bien l'anglais pour discuter avec nous concernant les soins dentaires que nous fournissons.

Arabic:
سوف نقوم باتخاذ خطوات معقولة من أجل توفير خدمات المساعدة اللغوية بدون تكلفة للأشخاص الذين يتحدثون لغات أخرى من المرجح أن نستمع إليها خلال ممارستنا والذين لا يتقنون تحدث الإنجليزية بشكل جيد يمكنهم من التحدث إلينا فيما يتعلق برعاية الأسنان التي نقدمها.

Hmong:
Peb yuav tsum nrhiav kev pab-dawb los ntawm kev pab cuam txhais lus rau cov neeg uas hais lus peb yeej tau hnov hauv peb txoj kev kawm thiab tus uas tsis paub hais lus Askiv txaus los tham rau peb txog cov kev pab kho hniav peb muaj.

Russian:
Мы принимаем необходимые меры, чтобы предоставить бесплатные услуги переводчика для общения на языках, с которыми мы сталкиваемся в нашей практике с клиентами, которые не владеют английским языком достаточно, чтобы обсудить с нами стоматологическое обслуживание, которое мы предоставляем.

Tagalog:
Gagawin namin ang mga makatwirang hakbang para maibigay namin ng walang bayad ang mga tulong na serbisyo sa wika para sa mga taong nagsasalita ng mga wikang karaniwan naming naririnig sa aming pagsasagawa at sa mga hindi bihasa sa pagsasalita ng Ingles na sasangguni sa amin tungkol sa pangangalaga ng ngipin na ibinibigay namin.

Gujarati:
અમે એવા લોકોને વિના મૂલ્યે ભાષા સહાય સેવા પૂરી પાડવા ઉચિત પગલાં લઇશું
જેઓ એ ભાષાઓ બોલે છે જે અમને (તબીબી) પ્રેકટીસમાં સાંભળવા મળી શકે અને
જેઓ અમે જે દંત સુરક્ષા પ્રદાન કરીએ છીએ તેના વિષે વાત કરવા પૂરતું યોગ્ય ઇંગ્લીશ બોલી શકતા નથી.

Mon-Khmer, Cambodian:
យើងខ្ញុំនឹងចាត់វិធានការសមហេតុផលដើម្បីផ្តល់ជូននូវសេវាជំនួយភាសាដោយឥតគិតថ្លៃដល់អ្នកនិយាយភាសាដែលយើងខ្ញុំចង់ស្តាប់នៅក្នុងការអនុវត្តរបស់យើងខ្ញុំ
និងអ្នកដែលនិយាយភាសាអង់គ្លេសមិនសូវបានល្អក្នុងការនិយាយមកកាន់យើងខ្ញុំអំពីការថែទាំមាត់ធ្មេញដែលយើងខ្ញុំកំពុងផ្តល់ឲ្យ។

German:
Wir werden angemessene Schritte unternehmen, um denen eine gebührenfreie Sprachunterstützung zu bieten, die Sprachen sprechen, die wir möglicherweise in unserer Praxis hören, die aber kein Englisch sprechen, das gut genug ist, um mit uns über die Zahnpflege zu sprechen, die wir anbieten.

Hindi:
हम उन व्यक्तियों को, जो कि ऐसी भाषाएं बोलते हैं जो हम अपने अभ्यास में संभावित रूप में सुनना चाहते हैं और जो हमारे द्वारा प्रदान की जाने वाली डैंटल देखभाल के बारे में हमारे साथ उचित ढंग से अंग्रेज़ी नहीं बोलते, मुफ़्त सेवाएं प्रदान करने के लिये उचित कदम उठायेंगे।

Laotian:
ພວກເຮົາຈະໃຊ້ຂັ້ນຕອນທີ່ເໝາະສົມ
ເພື່ອໃຫ້ບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາບໍ່ເສຍຄ່າແກ່ຄົນຜູ້ທີ່ເວົ້າພາສາທີ່ພວກເຮົາອາດຈະໄດ້ຍິນຢູ່ໃນການຝຶກຊ້ອມຂອງພວກເ
ຮົາ ແລະ ຜູ້ທີ່ບໍ່ເວົ້າພາສາອັງກິດໄດ້ດີພໍ ເພື່ອລົມກັບພວກເຮົາກ່ຽວກັບການເບິ່ງແຍງດູແລແຂ້ວທີ່ພວກເຮົາກຳລັງຈັດໃຫ້.

Japanese:
実際に練習の中で耳にするく可能性がある言語を話す人々で、弊社が提供している歯科治療について、英語がそれほど上手でない人々に、無償の言語支援サービスを提供するために合理的な措置を講じるつもりです。

Discrimination is Against the Law

Dennis R. Campbell, DDS Pediatric Dentistry
complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Dennis R. Campbell, DDS Pediatric Dentistry
does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Dennis R. Campbell, DDS Pediatric Dentistry

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact Name of appropriate dental office staff member.

If you believe that Dennis R. Campbell, DDS Pediatric Dentistry
has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.