SDC
Stockton Dental Center

Child's Information

Date_____

Child's Name_____ _____ _____

Address_____

Street City State Zip

Home Phone_____ **Cell Phone**_____ **Birthdate** _____/_____/_____

How did you hear about our office? □ Family_____ □ Friend_____ __ □ Other_____

□ Facebook □ News Paper □ Phone Book □ Internet _____ _____

Parent Permission Policy

☐ I give Stockton Dental Center permission to see my child(ren) in my absence. I understand that this consent consists of any treatment not limited to but including fillings, sealants, nerve treatment , and children's crowns/ caps. In order to complete treatment , topical and /or local anesthetic may be used.

☐ I also give consent for Stockton Dental Center to place my child's cavity free photo on their website and Facebook

_____

Parent's Signature Date

Parent's Information

Parents Name_____ _____ _____

Last First Middle

Address (if different from child's) _____

Social Security # _____**Birthdate**____/_____/_____ **Cell Phone**_____ __**Work Phone**___ _____

Employer_____ **Occupation** _____ **No. Years Employed** _____

Parents Name_____ _____ _____

Last First Middle

Address (if different from child's) _____

Social Security # _____**Birthdate**____/_____/_____ **Cell Phone**_____ __**Work Phone**___ _____

Employer_____ **Occupation** _____ **No. Years Employed** _____

Emergency Information

Name of nearest relative not living with you _____ Phone # _____

Dental Insurance Information

Do you have dental insurance Yes___ No___ Do you have dual coverage Yes___ No___

Please provide front desk with insurance card.

Stockton Dental Center 120 W. Front Avenue Stockton, IL 61085 (815) 947-3700

Stockton Dental Center
120 W. Front Ave
PO Box 146
Stockton IL 61085
815/947-3700

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Patient Name: _____ Date: _____

Signature:_____ Relationship to Patient: _____

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA).

I understand that this information can and will be used to:

□ Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly

□ Obtain payment from third-party payers for my health care services

□ Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

NOTICE OF PRIVACY PRACTICES

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.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- □ **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. For example, we may need to share information with other providers or specialists involved in the continuation of your care.
- □ **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. For example, we disclose treatment information when billing a dental plan for your dental services.
- □ **Health Care Operations** include the business aspects of running our practice. For example, patient information may be used for training purposes, or quality assessment.

Unless you request otherwise, we may use or disclose health information to a family member, friend, or other personal representative to the extent necessary to help with your healthcare or with payment for your healthcare. In addition, we may use your confidential information to remind you of appointments by sending reminder postcards and/or leaving messages at home and/or work. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your protected health information, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- □ The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- □ The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- □ The right to access, inspect and copy your protected health information.
- □ The right to request an amendment to your protected health information.
- □ The right to receive an accounting of disclosures of protected health information outside of treatment, payment and health care operations.
- □ The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

for more information about our Privacy Practices, please contact:

Stockton Dental Center
120 West Front Avenue
Stockton IL 61085
815/947-3700

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201