CHILD MEDICAL AND DENTAL HEALTH HISTORY

TODAY'S DATE_____

CHILD'S FULL NAME_____ **BIRTHDATE** _____/_____/_____

Do your child have or has he/she had any of the following?
(Please check any that apply)

- ❑ ADD/ADHD
- ❑ AIDS or HIV Positive
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Abnormal Blood Pressure
- ❑ Allergies or Hives
- ❑ Anemia, Hemophelia or blood disorders
- ❑ Arthritis
- ❑ Asthma
- ❑ Autism
- ❑ Blood Transfusion
- ❑ Cancer or Tumor
- ❑ Cerebral Palsy
- ❑ Congenital Birth Defects
- ❑ Current with Immunizations
- ❑ Developmental Delay
- ❑ Diabetes or Endocrine
- ❑ Downs Syndrome
- ❑ Epilepsy, Convulsions or Seizures
- ❑ Hayfever or sinus trouble
- ❑ Handicaps or Disabilities
- ❑ Hearing Loss or Impairment
- ❑ Heart Disease or Heart Murmur
- ❑ Hepatitis A, B or C
- ❑ Herpes or Cold Sores
- ❑ History of Fainting
- ❑ History of Dizziness
- ❑ Kidney Problems
- ❑ History of Seizures
- ❑ Liver Problems
- ❑ Mental Illness or Emotional Condition
- ❑ Migraine headaches or frequent headaches
- ❑ Neurological Condition
- ❑ Obesity
- ❑ Rheumatic Fever / Scarlet Fever
- ❑ Sensory Issues
- ❑ Sickle Cell Trait/Disease
- ❑ Sight Impairment
- ❑ Severe/Prolonged Bleeding
- ❑ Speech Impairment
- ❑ Tuberculosis

Is your child allergic to, or has he/she reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Food Allergies
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocaine")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Metal Allergy
- ❑ Other:_____
  _____

Is your child taking any medications?
Please list: _____
_____
_____

Females:

- ❑ May be pregnant
  Expected delivery date: _____
- ❑ Taking hormones or contraceptives

Does your child smoke or use chewing tobacco? ❑ yes ❑ no

Is your child using any illegal substances? ❑ yes ❑ no

Has your child been advised by your physician to pre-medicate prior to dental treatments? ☐ Yes ☐ No

Dental History: Check only if the answer is yes.

- ❑ Gums bleed while brushing or flossing
- ❑ Teeth sensitive to hot, cold, sweet, or sour
- ❑ Pain in any of teeth
- ❑ Sores or lumps in or near the mouth
- ❑ Any head, neck or jaw injuries
- ❑ Any jaw joint clicking or pain
- ❑ Difficulty chewing
- ❑ Clenches or grinds teeth?
- ❑ Oral habits-Bottle or Sippy Cup
- ❑ Thumb / Finger sucking / Pacifier
- ❑ Nail Biting / Chewing objects
- ❑ Lip sucking or biting
- ❑ Does child drink tap water
- ❑ Is the child using fluoride rinses?
- ❑ Orthodontic work?
- ❑ Laughing Gas (Nitrous Oxide)
- ❑ Numbing (Local Anesthetic)
- ❑ Prolonged bleeding following an extraction?
- ❑ Does child brush teeth daily?
- ❑ Has child ever had any complications associated with previous dental treatment?

Please explain:_____
_____

Has your child had any serious illness? If yes, explain:
_____
_____

Child's Physician _____
Phone # (___)_____

Why did you bring the child to the dentist today?
_____
_____
_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If my child ever has any changes in his/her health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Print name of parent or guardian Signature of parent or guardian

For office use only: Reviewed by:_____ Date_____

Welcome to Dr. David A. Paulisin's office!
To assist us in serving you, please complete the following confidential forms.

Patient Information

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Birth Date:_____Social Security # (Of Responsible Party if child) _____

Phone (Home): _____ (Cell): _____ (Work): _____ (Extention):_____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment Name_____

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID # or SS#_____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID # or SS#_____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

I accept full responsibility for all charges for services rendered by David A. Paulisin, DDS, PC. I agree to pay all costs of collection, including reasonable attorney fees. I authorize the release of medical information necessary for completion of insurance claim forms. I assign all benefits under my current health insurance policies and authorize payment directly to David A. Paulisin, DDS, PC. I understand any balance left after insurance has settled claim is my responsibility. I agree to promptly pay any outstanding balance. I understand that I will be charged a broken appointment fee without 24 hours notice. I understand that I will be charged $40 for a returned check plus any additional bank fees.
I have read all of the information on this form and agree to these policies.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

DAVID PAULISIN, DDS, PC
NOTICE OF PRIVACY PRACTICES

This Notice Describes How Health Information About You May be Used and Disclosed And How You Can Gain 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. This notice takes effect April 14, 2003.

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. Any changes will be made available to you.

You may request a copy of our privacy notice at any time.

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 to you.

Payment: We may use and disclose your 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 professionals, 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 authorization while it was in effect.

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.

N**ational 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, 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 health information, with limited exceptions.

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.

QUESTIONS AND COMPLAINTS
We support your right to the privacy of your health information. 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, you may complain to us using the contact information listed at the end of this notice.

Contact Officer: Office Manager
David Paulisin, DDS, PC
28807 Eight Mile Road, Suite 101
Livonia, MI 48152
Phone: (248) 516-5266
Fax: (248) 516-5267

DAVID PAULISIN, DDS, PC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse To Sign This Acknowledgement

I, _____, have received a copy of this office's
(Please Print Name)
Notice of Privacy Practices.

_____
Signature

_____
Date

For Office Use Only

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

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

_____

_____