DAVID C. METROKA, D.D.S.

411 North York Road, Hatboro, Pennsylvania 19040

(PLEASE PRINT CLEARLY)

CHILD'S FULL NAME:	NAME CHILD PREFERS TO BE CALLED	SEX	AGE	DATE OF BIRTH

REASON FOR VISIT	WEIGHT	HEIGHT

REFERRED TO THIS OFFICE BY: (WE WISH TO THANK THEM.)

FULL NAME: PHONE #:

CHILD'S PHYSICIAN: (FULL NAME) PHONE #: DATE LAST SEEN:

FAMILY DENTIST: (FULL NAME) PHONE #: DATE LAST SEEN:

	YES	NO
1. IS YOUR CHILD PRESENTLY UNDER THE CARE OF A PHYSICIAN FOR ANY MEDICAL PROBLEM? IF YES, WHAT?	____	____
2. WAS YOUR CHILD PREMATURE? HOW MANY WEEKS?	____	____
3. DID YOUR CHILD HAVE A HISTORY OF HEALTH PROBLEMS AT BIRTH OR DURING INITIAL YEARS? IF YES, EXPLAIN.	____	____
4. IS YOUR CHILD PRESENTLY TAKING ANY MEDICATION? WHAT?	____	____
5. HAS YOUR CHILD HAD A HISTORY OF TAKING MEDICATIONS FREQUENTLY?	____	____
6. HAS YOUR CHILD EVER BEEN HOSPITALIZED OR HAD SURGERY? WHAT?	____	____
7. IS YOUR CHILD ALLERGIC TO ANY FOOD OR MEDICINE? WHAT?	____	____
8. IS YOUR CHILD ALLERGIC TO LATEX, METALS OR ACRYLICS (PLASTIC)?	____	____
9. HAS ANY MEMBER OF THE FAMILY HAD A PROBLEM WITH A GENERAL ANESTHETIC?	____	____
10. ARE IMMUNIZATIONS, INCLUDING TETANUS, CURRENT?	____	____

HAS YOUR CHILD EVER BEEN DIAGNOSED AS HAVING ANY OF THE FOLLOWING CONDITIONS? PLEASE CHECK YES OR NO:

Y N

☐ ☐ AIDS - HIV
☐ ☐ Allergies
☐ ☐ Anemia
☐ ☐ Arthritis
☐ ☐ Asthma
☐ ☐ Autism
☐ ☐ Bladder Conditions
☐ ☐ Blood Disease
☐ ☐ Blood Transfusions
☐ ☐ Birth Defects
☐ ☐ Bone or Joint Problems
☐ ☐ Brain Injury
☐ ☐ Bruising Easily
☐ ☐ Cancer or Malignancies
☐ ☐ Cerebral Palsy
☐ ☐ Chemotherapy/Radiation
☐ ☐ Child Abuse
☐ ☐ Chronic Adenoid/Tonsil Infection
☐ ☐ Chronic Ear Infections
☐ ☐ Cleft Lip/Palate

Y N

☐ ☐ Congenital Heart Lesion
☐ ☐ Convulsions/Seizures
☐ ☐ Developmentally Delayed
☐ ☐ Diabetes
☐ ☐ Drug Addiction
☐ ☐ Ear Stuffiness, Itching or Noises
☐ ☐ Emotional Disturbance
☐ ☐ Epilepsy
☐ ☐ Eye Problem
☐ ☐ Excessive Bleeding Problem
☐ ☐ Excessive Gagging
☐ ☐ Fainting or Dizziness
☐ ☐ Fever Blisters
☐ ☐ Growth & Development Problems
☐ ☐ Heart Surgery
☐ ☐ Headaches
☐ ☐ Hearing/Speech Problems
☐ ☐ Heart Murmur/Defect
☐ ☐ Hemophilia
☐ ☐ Hepatitis or Liver Disease

Y N

☐ ☐ High Blood Pressure
☐ ☐ Hyperactivity/ADD
☐ ☐ Kidney Disease
☐ ☐ Leukemia
☐ ☐ Mental Disability
☐ ☐ Nutritional Deficiency
☐ ☐ Oral Ulcers
☐ ☐ Orthopedic Problems
☐ ☐ Pain in Jaw Joints
☐ ☐ Premature Birth
☐ ☐ Psychiatric Care
☐ ☐ Rheumatic Fever
☐ ☐ Scoliosis ____
☐ ☐ Sickle Cell Anemia
☐ ☐ Syndrome ____________ ____
☐ ☐ Tuberculosis ____
☐ ☐ Other ________________
☐ ☐ Do you wish to talk to the doctor privately about a problem?

* * * DENTAL HISTORY * * *

CHILD'S FIRST DENTAL VISIT? YES ________ NO ________	PREVIOUS DENTIST	CITY	DATE OF LAST VISIT?

ANY INJURIES TO YOUR CHILD'S TEETH OR JAWS? WHEN?

HISTORY OF:
- ______ NURSING BOTTLE HABITS WHEN? ________
- ______ THUMBSUCKING/FINGERSUCKING ________
- ______ PACIFIER ________
- ______ DENTAL GRINDING OR CLENCHING ________

HAS YOUR CHILD EXPERIENCED ANY UNFAVORABLE REACTION FROM PREVIOUS MEDICAL OR DENTAL CARE?
YES ________ NO ________ *(IF YES, PLEASE EXPLAIN)*

HOW DO YOU THINK YOUR CHILD WILL ACT TOWARD THE DENTIST?	HAS YOUR CHILD HAD RECENT DENTAL PAIN?

* * * PREVENTIVE DENTAL HISTORY * * *

HOW OFTEN DOES YOUR CHILD BRUSH?	IS TOOTHBRUSHING SUPERVISED? YES ________ NO ________ BY WHOM?

IS DENTAL FLOSS USED?
YES ____________
NO ____________

DOES YOUR CHILD RECEIVE: *(CHECK)*
- ______ FLUORIDE IN VITAMINS
- ______ FLUORIDATED WATER
- ______ WELL WATER
- ______ FLUORIDE TABLETS/DROPS
- ______ BOTTLED WATER

GENERAL INFORMATION

Father's Full Name ____________ S S # ____________ HOME PHONE: ____________

Address ____________ Birthdate ____________

City ____________ State ______ Zip ______ Employed by ____________

Occupation ____________ Bus Phone ____________

Mother's Full Name ____________ S S # ____________ HOME PHONE: ____________

Address ____________ Birthdate ____________

City ____________ State ______ Zip ______ Employed by ____________

Occupation ____________ Bus Phone ____________

Child lives with: / /Both parents, / /mother, / /father, / /other.

Names of any family members who have been patients here previously: ____________

Responsible party ____________

FOR PATIENTS COVERED BY DENTAL INSURANCE

PRIMARY CARRIER	SECONDARY CARRIER
Insured's Name ____________	Insured's Name ____________
Group/Policy Number ____________	Group/Policy Number ____________
Employer Name ____________	Employer Name ____________
Insurance Company ____________	Insurance Company ____________
How long have you had this insurance coverage? ________	How long have you had this insurance coverage? ________

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO DAVID C. METROKA, D.D.S. OTHERWISE PAYABLE TO ME, OR IF MY CURRENT POLICY PROHIBITS DIRECT PAYMENT TO THE DOCTOR. I HEREBY INSTRUCT THE INSURANCE COMPANY TO MAKE OUT THE CHECK TO ME AND MAIL IT IN CARE OF: DAVID C. METROKA, D.D.S., 411 NORTH YORK ROAD, HATBORO, PENNSYLVANIA 19040.

____

SIGNED-INSURED PERSON

THE PERMISSION OF PARENT OR GUARDIAN IS NECESSARY FOR DENTAL TREATMENT OF A MINOR.
I GIVE THE DOCTORS PERMISSION TO USE SUCH MEASURES AS DEEMED NECESSARY IN THEIR PROFESSIONAL JUDGEMENT TO RENDER A DIAGNOSIS FOR MY CHILD. THIS WOULD INCLUDE AN ORAL EXAMINATION, RADIOGRAPHS, (X-RAYS) AND OTHER DIAGNOSTIC AIDS.
I HAVE GIVEN AN ACCURATE REPORT OF MY CHILD'S PHYSICAL AND MENTAL HEALTH HISTORY. I HAVE ALSO REPORTED ANY PRIOR ALLERGIC OR UNUSUAL REACTIONS TO DRUGS, FOOD, INSECT BITES, ANESTHETICS, POLLENS, DUST, BLOOD OR BODY DISEASES, GUM OR SKIN REACTIONS, ABNORMAL BLEEDING OR ANY OTHER CONDITIONS RELATED TO MY CHILD'S HEALTH OR ANY OTHER PHYSICAL CONDITIONS THAT MY CHILD'S MEDICAL DOCTOR HAS ADVISED ME SHOULD BE REPORTED TO A DENTIST.

SIGNATURE	RELATIONSHIP TO CHILD	DATE
REVIEWED BY: DOCTOR ____________	DATE ____________	

DAVID C. METROKA, D.D.S.
{NAME OF PRACTICE}

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 4/15/03 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 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. 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 judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment 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 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. 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 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 will charge you $0.20 for each page, $8.00 per hour for staff time to locate and copy your health information, 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.)

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 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 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 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 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 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: Nancy Phillips

Telephone: 215-674-3080 Fax: 215-674-3063

E-mail: staff@hatboropediatricdentistry.com

Address: 411 N. York Road Hatboro, Pa. 19040

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DAVID C. METROKA, D.D.S.

ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT"

I, ______________________________________, HAVE RECEIVED A COPY OF
(Parent's Name)
THIS OFFICE'S NOTICE OF PRIVACY PRACTICES.

____

Please print name (Child's Name)

____

Signature

____

Date

<u>For Office Use Only</u>

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)**

____

____