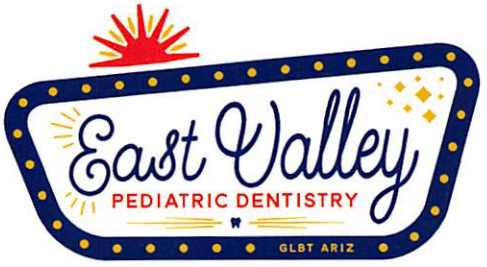

James C. Johnson DMD
Blake R. Schow DDS
1355 South Higley Road, Suite 117, Gilbert, AZ 85296
480-632-7500 o 480-632-8900 F kidstoothdr.com

PATIENT REGISTRATION FORM

Child's Name: _____ Preferred Name: _____ ✧Male ✧Female
Child's birth date: _____ Child's age: _____ School: _____ Grade: _____
Child's home address: _____ City: _____ State: _____ Zip: _____
Child's home number: _____

WHO IS ACCOMPANYING THE CHILD TODAY?

Name: _____ Relation: _____ Do you have legal custody of the child? _____ ✧Yes ✧No
In case of emergency, contact (name and phone#): _____
Whom may we thank for this referral? _____

PERSON RESPONSIBLE FOR ACCOUNT

Father's information: _____
Marital status ✧S ✧M ✧D ✧Other: _____
Name: _____ DOB_____
Address: _____
Employed by:_____
Occupation: _____
SS#: _____
Business Phone: _____
Home Phone: _____
Mobile Phone: _____
Email: _____

Mother's Information: _____
Marital status ✧S ✧M ✧D ✧Other: _____
Name: _____ DOB_____
Address: _____
Employed by: _____
Occupation: _____
SS#: _____
Business Phone: _____
Home Phone: _____
Mobile Phone: _____
Email: _____

DENTAL INSURANCE COMPANY

Insurance Co. Name: _____ Insurance Co. Phone: _____
Insurance Co. Address: _____
Group# (Plan, Local or Policy#) _____ Member# or ID# _____
Insured's Name: _____ Relationship to Child: _____
Insured's birthday: _____ SS#: _____ Insured's employer _____
Do you have secondary insurance Yes No If yes, with whom? _____

AUTHORIZATION

I certify the truth of all information given. I also authorize the release of pertinent information to those requiring it for the treatment of my child or for the purpose of payment of the account or credit reference. Under certain circumstances, I authorize payment of insurance benefits directly to EVPD, otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I understand I am financially responsible for payment of the services not paid, in whole or in part, by my dental care payor.

Signature of Parent/Guardian_____ Date _____

MEDICAL HISTORY

1. Is your child under care of a physician? ..... ◇Yes ◇No
   If yes, since when and why? _____
2. Name of physician? _____
3. Is your child receiving any medication? ..... ◇Yes ◇No
   List current medications: _____
4. Is your child allergic to any drugs, such as Penicillin? ..... ◇Yes ◇No
5. Does your child have any other allergies? ..... ◇Yes ◇No
6. Has your child had any serious illness? ..... ◇Yes ◇No
7. Has your child ever had surgery or been hospitalized? ..... ◇Yes ◇No

Has your child had a history of any of the following?

Please select a response to each question.

Heart trouble, murmur, or surgery ..... ◇Yes ◇No
Rheumatic fever or scarlet fever ..... ◇Yes ◇No
Asthma, TB, or lung problems ..... ◇Yes ◇No
HIV infection or AIDS ..... ◇Yes ◇No
Hemophilia, Sickle Cell Disease or other bleeding problems ..... ◇Yes ◇No
Hepatitis or liver problems ..... ◇Yes ◇No
Kidney Infection ..... ◇Yes ◇No
Diabetes ..... ◇Yes ◇No
Cancer, tumor, or leukemia ..... ◇Yes ◇No
Thyroid or other glandular problems ..... ◇Yes ◇No
Latex or rubber allergy ..... ◇Yes ◇No
Epilepsy, seizures, fainting ..... ◇Yes ◇No
Cerebral palsy or developmental delay ..... ◇Yes ◇No
Autism Spectrum Disorder or sensory sensitivities ..... ◇Yes ◇No
Vision problems ..... ◇Yes ◇No
Speech or hearing problems ..... ◇Yes ◇No
Emotional or psychological problems ..... ◇Yes ◇No
Congenital birth defects ..... ◇Yes ◇No
Cleft lip or palate ..... ◇Yes ◇No
Malignant hyperthermia ..... ◇Yes ◇No
Other medical condition ..... ◇Yes ◇No
Is parent or patient pregnant ..... ◇Yes ◇No

Comments
(For office use only)

Med. Alert

PURPOSE OF TODAY'S VISIT _____

DENTAL HISTORY

1. When and where was your child's last dental visit? _____
   _____
2. What was the purpose of that visit? _____
3. Were x-rays taken at your child's last dental visit? ..... ◇Yes ◇No
4. Did your child have difficulty cooperating? ..... ◇Yes ◇No
5. Was/is your child bottle fed? ..... ◇Yes ◇No
6. Was/is your child breast fed? ..... ◇Yes ◇No
7. If you child has been weaned please indicate at what age: _____
8. When does your child brush his/her teeth? ..... ◇ Upon rising ◇ After eating any food ◇ Right after meals ◇ Before going to bed
9. Do you assist/supervise your child's brushing? ..... ◇Yes ◇No
10. Does your child take fluoride supplements? ..... ◇Yes ◇No
11. Have any cavities been noted in the past? ..... ◇Yes ◇No
12. Were any teeth (baby or permanent) removed by extraction? ..... ◇Yes ◇No
13. Have there been any injuries to teeth, such as falls, blows, chips, etc.? ..... ◇Yes ◇No
14. Has anyone in the family, including parents, had orthodontics? ..... ◇Yes ◇No
15. Has your child had a toothache recently? ..... ◇Yes ◇No
    If yes, explain why: _____
16. Do you expect your child to be cooperative? ..... ◇Yes ◇No
17. Does your child have other siblings seen by us? ..... ◇Yes ◇No

CONSENT

I understand that the information I have given is correct and to the best of my knowledge, and that it will be held in the strictest of confidence. Because my child is a minor, it is necessary that signed permission be obtained from a parent or legal guardian before any dental services can be rendered. I give my consent to Dr. James C. Johnson, Dr. Blake R. Schow and their staff to perform such treatments, services, medication, behavior management techniques, local anesthesia, and/or analgesia necessary to treat any dental/oral deficiency, abnormality, and/or infection.

Signature of Parent/Guardian _____ Date _____

Protecting Your Confidential Health Information is Important to Us

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.

Our Promise

Dear Patient:
This notice is not meant to alarm you. Quite the opposite! It is our desire to communicate to you that we are taking seriously Federal law (HIPAA—Health Insurance Portability and Accountability Act) enacted to protect the confidentiality of your health information. We never want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside our office.

Why do we have a privacy policy? Very good question!

The Federal government legally enforces the importance of the privacy of health information largely in response to the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we follow to protect your health information when we use it.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.
We will use and communicate your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment, conducting health care operations, and as otherwise described in this notice.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an Electronic or Paper Copy of Your Medical Record

You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you, and we will provide a copy or a summary of your health information, usually within 30 days of your request.
We may charge a reasonable, cost-based fee.

Ask Us to Correct Your Medical Record

You can ask us to correct health information about you that you think is incorrect or incomplete. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request Confidential Communications

You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. You may, for example, request that we only communicate your health information to you privately with no other family members present or through mailed communications that are sealed. We will say "yes" to all reasonable requests.

Ask Us to Limit What We Use or Share

You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Accounting of Disclosures of Your Health Information to Receive a List of Those Whom We've Shared Information

You have the right to ask us for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
We will include all disclosures except for those about treatment, payment, and health care operations and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Obtain a Copy of This Privacy Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time, even if you have agreed to receive the notice electronically.
We will provide you with a paper copy promptly.

Choose Someone to Act on Your Behalf

If you give someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a Complaint if You Feel Your Rights Are Violated

You can complain if you feel we have violated your rights by contacting us using the information on page 1. You can file a complaint with the U.S. Department of Health and Human Services office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

YOUR CHOICES

For certain health information, you can tell us your choices about what we can share.
If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want, we will use our best judgment when sharing your health information only when it will be important to those participating in providing your care.

Authorization to Use or Disclose Health Information

We are required to obtain your written authorization in the following circumstances: (a) to use or disclose psychotherapy notes (except when needed for payment purposes or to defend against litigation filed by you); (b) to use your Protected Health Information (PHI) for marketing purposes; (c) to sell your PHI; and (d) to use or disclose your PHI for any purpose not previously described in this Notice. We also will obtain your authorization before using or disclosing your PHI when required to do so by (a) state law, such as laws restricting the use or disclosure of genetic information or information concerning HIV status; or (b) other federal law, such as federal law protecting the confidentiality of substance abuse records. You may revoke that authorization in writing at any time.

Protecting Your Confidential Health Information is Important to Us

OTHER USES AND DISCLOSURES

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways:

Treat You
We can use your health information and share it with other professionals (for example, pharmacies or other health care personnel who are treating you).

Run Our Organization
We can use and share your health information to run our practice, improve your care, and contact you when necessary. For example, we use your health information to manage your treatment and services.

Bill For Your Services
We can use and share your health information to bill and get payment from health plans and other entities. For example, we give information about you and your health insurance plan so it will pay for your services.

How Else Can We Use or Share Your Health Information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

In Patient Reminders

Because we believe regular care is very important to your health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best care. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

To Business Associates

We have contracted with one or more third parties (referred to as a business associate) to use and disclose your health information to perform services for us, such as billing services. We will obtain each business associate's written agreement to safeguard your health information.

To Avert a Serious Threat to Health or Safety

We may disclose your health information to reduce a risk of serious and imminent harm to another person or to the public including preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence as well as preventing or reducing a serious threat to anyone's health or safety.

Help With Public Health and Safety Issues

We can share health information about you for certain situations such as preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect or domestic violence and preventing or reducing a serious threat to anyone's health or safety.

Abuse or Neglect

We may disclose your health information to the responsible government agency if (a) the Privacy Official reasonably believes that you are a victim of abuse, neglect, or domestic violence, and (b) we are required or permitted by law to make the disclosure. We will promptly inform you that such a disclosure has been made unless the Privacy Official determines that informing you would not be in your best interest.

Do Research

We may use or disclose your health information for research, subject to conditions. "Research" means systemic investigation designed to contribute to generalized knowledge.

Comply With the Law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to Organ and Tissue Donation Requests

We can share health information about you with organ procurement organizations.

Work With a Medical Examiner or Funeral Director

We can share information with a coroner, medical examiner, or funeral director when an individual dies.

Address Workers' Compensation, Law Enforcement, and Other Government Requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Workers' Compensation Purposes

We may disclose your health information as required or permitted by State or Federal workers' compensation laws.

For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

To The U.S. Department of Health and Human Services (HHS)

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to Lawsuits and Legal Actions

We may disclose your health information in an administrative or judicial proceeding in response to a subpoena or a request to produce documents. We will disclose your health information in these circumstances only if the requesting party first provides written documentation that the privacy of your health information will be protected.

Incidental Uses and Disclosures

We may use or disclose your health information in a manner which is incidental to the uses and disclosures described in this Notice.

OUR RESPONSIBILITIES

- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We are required by law to maintain the privacy and security of your protected health information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Notice

We are required by law to maintain the privacy of your health information and to provide to you or your personal representative with this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices, we will be sure all of our patients receive a copy of the revised Notice.

Effective Date: 9/01/23

Patient Acknowledgment

Patient Name(s): _____

_____
Patient Signature

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions, we want to hear from you. If not, we would greatly appreciate your acknowledging the receipt of our policy by signing this form.

Date _____ / _____ / _____

For additional information about the matters discussed in this notice, please contact our Privacy Officer.