Welcome Aboard!

STARSHIP M

Your Galactic Dental Journey Starts Here

Please complete this new patient questionnaire so our clinical and administrative staff can provide high quality service to your child and make the experience more exciting. Please review your completed document and then submit it at the reception desk.

We appreciate the time that you spend providing this information
and helping us prepare for you and your child's dental journey!

1118 N. BROOKHURST ST., ANAHEIM, CA 92801 | 714.533.0303 | WWW.MDENTALGROUP.COM
Family Dentistry: M DENTAL GROUP (FULLERTON) 714.526.5200 | M BRACES (ANAHEIM) 714.533.0303

HERO APPLICATION

The Little Hero

Little Hero's Name First: _____ Last: _____

Nickname: _____

Date of Birth: MM / DD / YYYY

Sex: ☐ Female ☐ Male

Is this your child's first dental visit? ☐ Yes ☐ No

Last dentist visit: MM / YYYY

Have we seen other children in your family? ☐ Yes ☐ No (If yes, please write name: _____)

Preferred Pharmacy and Phone: _____

Who may we thank for referring your hero? _____

Emergency Contact <Primary>	Name:	Relation to the patient:
	Phone:	
Emergency Contact <Secondary>	Name:	Relation to the patient:
	Phone:	

Parent / Guardian

Full Name (First Last): _____ Relation to the Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Contact & Phone: _____ □ Home Phone □ Cell Phone □ Work Phone

Secondary Contact & Phone: _____ □ Home Phone □ Cell Phone □ Work Phone

Birth Date: _____ / _____ / _____ Social Security #: _____ Driver's License: _____
MM DD YYYY

Email Address: _____ □ I would like to confirm appointments via e-mail

Sex: □ Female □ Male Marital Status: □ Married □ Single □ Divorced □ Separated □ Widowed

If you have insurance, are you the policy holder? □ Yes □ No

INSURANCE

PRIMARY DENTAL INSURANCE INFORMATION

Name of Subscriber to Policy:	Relationship to Subscriber:
Subscriber Soc. Sec.:	Subscriber Birth Date:
Employer:	Employer Address:
Insurance Co.:	Insurance Co. Phone:
Subscriber ID#:	Group #:

☐ I don't have a dental insurance

SECONDARY DENTAL INSURANCE OR MEDICAL INSURANCE INFORMATION

Name of Subscriber to Policy:	Relationship to Subscriber:
Subscriber Soc. Sec.:	Subscriber Birth Date:
Employer:	Employer Address:
Insurance Co.:	Insurance Co. Phone:
Subscriber ID#:	Group #:

☐ I don't have a second dental insurance or medical insurance

Medical History

Please ONLY write the name and birth date of the child receiving treatment

Patient Name: **Date of Birth (MM/DD/YYYY):**

Is your child under a physician's care now? ☐ No ☐ Yes (If yes, please explain: _____)

Has your child ever been hospitalized or had an operation? ☐ No ☐ Yes (If yes: _____)

Is your child on a special diet? ☐ No ☐ Yes (If yes, please explain: _____)

Is your child allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex

☐ Amoxicillin ☐ Local Anesthetics ☐ Other (Please explain:_____)

Does your child have any of the following medical conditions?

☐ ADHD/ADD	☐ Ear Aches/Infection	☐ Heart Trouble/Disease	☐ Mumps
☐ Asthma	☐ Eczema	☐ High Blood Pressure	☐ Rheumatic fever
☐ Autism	☐ Enlarged Tonsils	☐ Hives or Rash	☐ Sickle Cell disease
☐ Bleeding Disorder	☐ Epilepsy/Seizures	☐ HIV+/AIDS	☐ Skin Trouble/Disease
☐ Bone Disorder	☐ Fainting	☐ Hyperactivity	☐ Snoring
☐ Cancer	☐ Growth Problems	☐ Irregular Heartbeat	☐ Speech/Hearing Trouble
☐ Cerebral Palsy	☐ Headaches	☐ Kidney Disease	☐ Stomach Disease
☐ Chicken Pox	☐ HHT	☐ Liver Disease	☐ Thyroid
☐ Cold Sores/Fever Blisters	☐ Hepatitis A	☐ Measles	☐ Tuberculosis
☐ Developmental Delays	☐ Hepatitis B or C	☐ Minor speech impediment	☐ Vision Disorders
☐ Diabetes	☐ Herpes	☐ Mono-cleosis	☐ Frequent Cough

Any other serious health conditions not listed above?

☐ No ☐ Yes (If yes, please explain: _____)

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in medical status.

Parent/Guardian Name: **Date:**

Dental History

Please ONLY write the name and birth date of the child receiving treatment

Patient Name: **Date of Birth (MM/DD/YYYY):**

What is your primary concern about your child's oral health?

How would you describe your child's oral health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Is there a family history of cavities? ☐ No ☐ Yes

Please indicate if your child has a history of any of the following:

☐ Fluoride treatment in the dental office ☐ Fluoride varnish by pediatrician/other practitioner

☐ Prescription drops/tablets/vitamins ☐ Prescription rinse/gel

☐ Over-the-counter rinse

Dietary Habits:

Sippy cup use? ☐ No ☐ Yes

Bottle use? ☐ No ☐ Yes

Breast-feeding? ☐ No ☐ Yes

Does your child regularly eat 3 meals each day? ☐ No ☐ Yes

Is your child on a special or restricted diet? ☐ No ☐ Yes

Does your child have a diet high in sugars or starches? ☐ No ☐ Yes

Do you have any concerns regarding your child's weight? ☐ No ☐ Yes

Please select how frequently your child has the following:

Candy or other sweets	☐ Daily	☐ 1-2 times a week	☐ Rarely/Never
Juice (including sweet tea, Gatorade, lemonade, etc.)	☐ Daily	☐ 1-2 times a week	☐ Rarely/Never
Carb-rich snacks	☐ Daily	☐ 1-2 times a week	☐ Rarely/Never
Sticky foods (i.e. dried fruits, fruit snacks, etc)	☐ Daily	☐ 1-2 times a week	☐ Rarely/Never
Soda	☐ Daily	☐ 1-2 times a week	☐ Rarely/Never

Other significant dietary habits (if yes, please explain: _____)

Sports and Activities:

Does your child participate in any sports or similar activities? ☐ No ☐ Yes

Does your child wear a mouthguard during these activities? ☐ No ☐ Yes

Previous Dental Treatment:

Has your child been examined or treated by another dentist? ☐ No ☐ Yes

Were X-rays taken of the teeth or jaws? ☐ No ☐ Yes

Has your child ever had orthodontic treatment (braces, spacers, or other appliances)? ☐ No ☐ Yes

Has your child ever had a difficult dental appointment? ☐ No ☐ Yes

How do you expect your child will respond to dental treatment? ☐ Very well ☐ Fairly well ☐ Poorly ☐ Very poorly

Is there any other mouth or health related issues not covered in the questionnaire that we should know before treating your child?

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in medical status.

Parent/Guardian Signature: **Date:**

HIPAA Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly
- Obtain payment from designated third-party payers.
- Conduct normal health care operations such as quality assessments or evaluations, and physician certifications.
- I have been informed by you of your Notice of Privacy Practices that contains a more complete description of the uses and disclosures of my health information.

I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that Starship M Pediatric Dentistry has the right to change its Notice of Privacy Practices from time to time and that I may contact Starship M Pediatric Dentistry at any time to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that Starship M Pediatric Dentistry restricts how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand Starship M Pediatric Dentistry is not required to agree to my requested restrictions, but if Starship M Pediatric Dentistry does agree, then it is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that Starship M Pediatric Dentistry has taken action relying on this consent.

By checking the box I acknowledge that

☐ I read this organization Notice of Privacy Practices

Please sign **Date**

General Consent

1. I hereby authorize and give consent to **Starship M**, the dentist and his/her staff to administer treatment on my child, including but not limited to local anesthesia and other such treatment, which, in their judgment, may be necessary for the prudent exercise of the medical care. I understand that the use of medications, esthetics and some procedures embody a certain risk.
2. I have been informed most insurance plans do not cover oral sedation. I agree that in case of sedation, the sedation fee will be due in full along with estimated dental co-payments on the day of service.
3. I acknowledge that no guarantee or assurance has been given by anyone as to the results that may be obtained.
4. I understand that during the procedure(s) unforeseen conditions may arise that necessitate different procedures from those planned. I consent to the performance of additional procedures that are deemed necessary in the professional judgment of the dentists and I understand that payment for these additional procedures is my responsibility.
5. I consent to the disposal of any tissues or body parts that may be removed.
6. The attached medical and dental history was completed fully and accurately to the best of my knowledge.
7. I understand and agree that a routine credit check for my care credit will be processed at the discretion of Starship M. **If you would prefer to pay on the date of service and not have a credit check performed, please initial here: _____** We will request payment in full **(cash or credit).**
8. I acknowledge and understand that I am responsible for all of the charges for all of the services rendered to me or any member of my family where I am listed as the responsible party. Unless other arrangements are made prior to treatment, accounts are to be paid on the day services are provided. I have read and I understand Starship M financial policy. (**Minor Parents:** In the case of separated or divorced patents, the parent accompanying the child is responsible for payment at the time of service).
9. I hereby authorize payment of my group insurance benefits, otherwise payable to me, to Starship M. In the event of legal action of this account, I agree to pay any and all costs of such suit, collection and attorney fees. I have reviewed the treatment plan and authorize the release of any information relative to this claim.
10. A service charge of 1.5% per month (18% per annual) will be added to the unpaid balance of all accounts not paid in full within 90 days of the treatment date.
11. I grant my permission to you or your assignees to telephone me at home or at my work to discuss matters related to the consent, my treatment or my account.
12. I have the opportunity to review Starship M notice of privacy practices.
13. I understand that if I am unable to keep my appointment, I need to let Starship M know at least 48 hours in advance. **I also understand STARSHIP M reserves the right to assess a minimum $40.00 fee for cancellation and/ or missed appointments.**
14. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges of dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment in connection with any of the insurance claims.
15. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Starship M.

Patient Name	**Parent Name and Signature)**	**Date**

Effective Date of Notice: 09/23/2013

Notice of Privacy Practices

Starship M Pediatric Dentistry by M Dental Group
1118 N. Brookhurst St., Anaheim, CA 92801
714-533-0303

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.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use of discloses your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills and claims; collecting unpaid amounts (either ourselves or through a collection agency or attorney). “Health care operations” mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we will ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose;
- For public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- Disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- Uses and disclosures for health oversight activities, such as for the licensing of

doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;

- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- Disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- Uses or disclosures for health related research;
- Uses and disclosures to prevent a serious threat to health or safety;
- Uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of member of the foreign service;
- Disclosures of de-identified information;
- Disclosures relating to worker's compensation programs;
- Disclosures of a "limited data set" for research, public health, or health care operations;
- Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- Disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form". The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours. If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- Ask us to restrict our uses and disclosures for purposes of treatment (expect emergency treatment), payment or health care operations. We do not have to agree to do this; but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this notice.
- Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E Mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this notice.
- Ask to see or to get photocopies of your health information. By law, there are few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one if legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this notice.
- Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E Mail shown at the beginning of this notice.
- Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E Mail shown at the beginning of this notice.
- Get additional paper copied of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E Mail shown at

the beginning of this notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web Site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E Mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.