Health History

Michael Stoker, D.D.S.
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Richard Adams, D.M.D.

***THESE QUESTIONS ARE OF GREAT VALUE IN AIDING US TO A BETTER UNDERSTANDING OF YOUR CHILD.**

CHILD'S NAME	NICKNAME	LAST NAME	AGE	DATE OF BIRTH	SEX

SCHOOL	GRADE	REASON FOR VISIT

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

MEDICAL HISTORY

CHILD'S PHYSICIAN	CITY	DATE LAST SAW PHYSICIAN MONTH/YEAR

	YES	NO
1. IS YOUR CHILD PRESENTLY UNDER THE CARE OF A PHYSICIAN FOR ANY MEDICAL PROBLEM? WHAT?	❑	❑
2. IS YOUR CHILD CURRENTLY TAKING ANY MEDICATION? WHAT?	❑	❑
3. HAS YOUR CHILD EVER BEEN HOSPITALIZED OR HAD SURGERY? FOR WHAT?	❑	❑
4. IS YOUR CHILD ALLERGIC TO ANY FOOD OR MEDICINE? WHAT?	❑	❑
	❑	❑

HAS YOUR CHILD A HISTORY OF? (CHECK)

❑ HEART TROUBLE OR MURMURS	❑ BRAIN INJURY	❑ KIDNEY/LIVER INVOLVEMENT
❑ RHEUMATIC FEVER	❑ DIABETES	❑ HEPATITIS
❑ ALLERGIES	❑ ASTHMA	❑ BLEEDING PROBLEMS
❑ DRUG SENSITIVITIES	❑ EPILEPSY	❑ BLOOD DISORDERS
❑ IMMUNE DEFICIENCIES	❑ SEIZURES/CONVULSIONS	❑ NONE
	❑ DEVELOPMENTAL DELAY	❑ BLOOD TRANSFUSIONS

MEDICAL HISTORY REVIEW

DENTAL HISTORY

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

ANY INJURIES TO YOUR CHILD'S TEETH OR JAWS? (FALLS, BLOWS, CHIPS, ETC.) ❑ YES ❑ NO	HISTORY OF? ❑ THUMBSUCKING ❑ LIP SUCKING ❑ PACIFIER ❑ FINGER SUCKING ❑ NAIL BITING AGE WHEN HABIT DISCONTINUED _____

HOW DO YOU THINK YOUR CHILD WILL ACT TOWARD THE DENTIST?

NAME OF FAMILY DENTIST CITY

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 ❑ FLUORIDE TABLETS/DROPS ❑ FLUORIDATED WATER ❑ NONE

OVER PLEASE

775-825-1000

3701 Baker Lane, Suite 1
Reno, NV 89509

6360 Mae Anne Ave., Suite 3
Reno, NV 89523

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FAMILY INFORMATION

RESIDENCE ADDRESS		ZIP CODE	PHONE ( )
FATHER'S FULL NAME	ADDRESS IF DIFFERENT		OCCUPATION S.S. #
EMPLOYED BY	BUSINESS ADDRESS	CITY	BUS. PHONE
MOTHER'S FULL NAME	ADDRESS IF DIFFERENT		OCCUPATION S.S. #
EMPLOYED BY	BUSINESS ADDRESS	CITY	BUS. PHONE

FIRST NAMES OF ALL BROTHERS AND SISTERS AND THEIR AGES:

HAS ANY MEMBER OF YOUR FAMILY BEEN A PATIENT IN THIS OFFICE BEFORE? ❑ YES ❑ NO IF YES, NAME

EMERGENCY CONTACT: PHONE ( )

NEAREST RELATIVE RELATIONSHIP

NAME ADDRESS PHONE ( )

AUTHORIZATION AND FINANCIAL RESPONSIBILITY

IS YOUR CHILD COVERED BY A DENTAL PLAN? ❑ YES ❑ NO		RECEIVED PREVIOUS CARE UNDER THIS PLAN? ❑ YES ❑ NO	
NAME OF PARENT INSURED	SOCIAL SECURITY NO.	NAME OF INSURANCE / ADDRESS	GROUP OR POLICY NO.
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IS YOUR CHILD ELIGIBLE FOR STATE/COUNTY AID?
❑ YES ❑ NO

IF FAMILY NOT LIVING TOGETHER, PERSON TO BE RESPONSIBLE FOR CHILD'S ACCOUNT:

I HEREBY AUTHORIZE PAYMENT OF THE GROUP INSURANCE BENEFITS DIRECTLY TO THE DENTIST

X _____
SIGNED (INSURED PERSON) DATE

I hereby authorize Dr. Michael Stoker, Dr. Nicole Stoker, Dr. Richard Adams and/or their associates to perform any and all treatment for my above named child and consent to such methods, drugs and agents as may be indicated in connection with his/her dental care. This consent shall remain in effect until cancelled.

SIGNATURE	RELATIONSHIP TO CHILD	DATE
X		

PLEASE NOTE: PAYMENT IS EXPECTED FOR SERVICE RENDERED AT THE TIME OF THE FIRST VISIT. FINANCIAL ARRANGEMENTS FOR SUBSEQUENT TREATMENT MAY BE MADE FOLLOWING THE DIAGNOSIS. DELINQUENT ACCOUNTS MAY BE SUBJECT TO FINANCE CHARGES AND/OR COLLECTION FEES.

THANK YOU.

Acknowledgement of Privacy Practices
(Our Privacy Practices begin on the next page)

Michael Stoker, D.D.S.
Nicole Stoker, D.D.S.
Richard Adams, D.M.D.

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
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 obtained because:

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify)

_____

_____

_____

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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 duty, 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 04/15/03, 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 policy 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. (continued…)

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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 and 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 effect 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 to notify, as described in the Patient Rights sections 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 judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgement 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 safety or the health of 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 officials 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 RIGHTSAccess: 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._____ for each page, $_____ 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 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 you 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:
Kristie Kinder
Telephone: 775-825-1000 Fax: 775-826-3030
Address: 3701 Baker Lane, Suite 1, Reno, NV 89509