

# Child Health/Dental History Form



American Dental Association  
www.ada.org

Patient's Name LAST FIRST INITIAL			Nickname	Date of Birth
Parent's/Guardian's Name			Relationship to Patient	
Address PO OR MAILING ADDRESS CITY STATE ZIP CODE				
Phone Home Work			Sex M <input type="checkbox"/> F <input type="checkbox"/>	
Have you (the parent/guardian) or the patient had any of the following diseases or problems? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No 1. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3. Cough that produces blood? <b>If you answer yes to any of the three items above, please stop and return this form to the receptionist.</b>				
<b>Has the child had any history of, or conditions related to, any of the following:</b>				
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cancer	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> HIV +/-AIDS	<input type="checkbox"/> Mononucleosis
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Fainting	<input type="checkbox"/> Immunizations	<input type="checkbox"/> Mumps
<input type="checkbox"/> Asthma	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Growth Problems	<input type="checkbox"/> Kidney	<input type="checkbox"/> Pregnancy (teens)
<input type="checkbox"/> Bladder	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/> Hearing	<input type="checkbox"/> Latex allergy	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Bleeding disorders	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart	<input type="checkbox"/> Liver	<input type="checkbox"/> Seizures
<input type="checkbox"/> Bones/Joints	<input type="checkbox"/> Ear Aches	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Measles	<input type="checkbox"/> Sick cell
<input type="checkbox"/> Thyroid				
<input type="checkbox"/> Tobacco/Drug Use				
<input type="checkbox"/> Tuberculosis				
<input type="checkbox"/> Venereal Disease				
<input type="checkbox"/> Other _____				
<b>Please list the name and phone number of the child's physician:</b>				
Name of Physician _____			Phone _____	

## Child's History

	Yes	No
1. Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? ..... If yes, please list: _____	1. <input type="checkbox"/>	<input type="checkbox"/>
2. Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____	2. <input type="checkbox"/>	<input type="checkbox"/>
3. Is the child allergic to anything else, such as certain foods? If yes, please explain: _____	3. <input type="checkbox"/>	<input type="checkbox"/>
4. How would you describe the child's eating habits? _____		
5. Has the child ever had a serious illness? If yes, when: _____ Please describe: _____	5. <input type="checkbox"/>	<input type="checkbox"/>
6. Has the child ever been hospitalized? .....	6. <input type="checkbox"/>	<input type="checkbox"/>
7. Does the child have a history of any other illnesses? If yes, please list: _____	7. <input type="checkbox"/>	<input type="checkbox"/>
8. Has the child ever received a general anesthetic? .....	8. <input type="checkbox"/>	<input type="checkbox"/>
9. Does the child have any inherited problems? .....	9. <input type="checkbox"/>	<input type="checkbox"/>
10. Does the child have any speech difficulties? .....	10. <input type="checkbox"/>	<input type="checkbox"/>
11. Has the child ever had a blood transfusion? .....	11. <input type="checkbox"/>	<input type="checkbox"/>
12. Is the child physically, mentally, or emotionally impaired? .....	12. <input type="checkbox"/>	<input type="checkbox"/>
13. Does the child experience excessive bleeding when cut? .....	13. <input type="checkbox"/>	<input type="checkbox"/>
14. Is the child currently being treated for any illnesses? .....	14. <input type="checkbox"/>	<input type="checkbox"/>
15. Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: _____	15. <input type="checkbox"/>	<input type="checkbox"/>
16. Has the child had any problem with dental treatment in the past? .....	16. <input type="checkbox"/>	<input type="checkbox"/>
17. Has the child ever had dental radiographs (x-rays) exposed? .....	17. <input type="checkbox"/>	<input type="checkbox"/>
18. Has the child ever suffered any injuries to the mouth, head or teeth? .....	18. <input type="checkbox"/>	<input type="checkbox"/>
19. Has the child had any problems with the eruption or shedding of teeth? .....	19. <input type="checkbox"/>	<input type="checkbox"/>
20. Has the child had any orthodontic treatment? .....	20. <input type="checkbox"/>	<input type="checkbox"/>
21. What type of water does your child drink? <input type="checkbox"/> City water <input type="checkbox"/> Well water <input type="checkbox"/> Bottled water <input type="checkbox"/> Filtered water		
22. Does the child take fluoride supplements? .....	22. <input type="checkbox"/>	<input type="checkbox"/>
23. Is fluoride toothpaste used? .....	23. <input type="checkbox"/>	<input type="checkbox"/>
24. How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____	24. <input type="checkbox"/>	<input type="checkbox"/>
25. Does the child suck his/her thumb, fingers or pacifier? .....	25. <input type="checkbox"/>	<input type="checkbox"/>
26. At what age did the child stop bottle feeding? Age _____ Breast feeding? Age _____		
27. Does child participate in active recreational activities? .....	27. <input type="checkbox"/>	<input type="checkbox"/>

**NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.**

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

**For completion by dentist**

Comments \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**For Office Use Only:**  Medical Alert  Premedication  Allergies  Anesthesia Reviewed by \_\_\_\_\_  
Date \_\_\_\_\_

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Kevin M. Lacour, DDS, P.C.

# NOTICE OF PRIVACY PRACTICES

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**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.**

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## 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 July 1, 2006, 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.

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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 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. For adult patients who claim someone other than them self as financially responsible, our practice policy is to inform the financially responsible party of your health information for consent of treatment and payment.

**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. Our practice policy is to use an outside mailing company for the purpose of mailing newsletters and calendars.

**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, Patient Surveys/Newsletters/Calendars:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, messages left at home or work, postcards, or letters), patient surveys/newsletters/calendars.

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#### 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 \$0.10 for each page, \$10.00 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.

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## **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: Barbara Hartsfield

Telephone: 770-921-6606

Fax: 770-921-6919

E-mail: kevinlacourdds@bellsouth.net

Address: 5400 Lawrenceville Highway, Lilburn, GA 30047

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**This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).**

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Kevin M. Lacour, DDS, P.C.

# CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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## SECTION A: PATIENT GIVING CONSENT

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Patient Number: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

## SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Barbara Hartsfield

Telephone: 770-921-6606

Fax: 770-921-6919

E-mail: \_\_\_\_\_

Address: 5400 Lawrenceville Highway, Lilburn, GA 30047

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

## SIGNATURE

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.  
Include completed Consent in the patient's chart.**

## REVOCACTION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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Kevin M. Lacour, DDS, P.C.

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**\*\*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}

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## For Office Use Only

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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)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
  
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**This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).**

Kevin M. Lacour, DDS, P.C.  
5400 Lawrenceville Highway  
Lilburn, GA 30047

Welcome to our office! We are pleased to have you as a patient and look forward to caring for your dental health. We sincerely hope that the quality of your treatment will exceed your expectations. We do appreciate your time in completing the paperwork. It is important for us to know about your medical and dental histories to set up your personal records in our office, and we would like you to know what to expect of us in regard to office policies. We will be happy to answer any questions you may have. Thank you for your help.

1. Our goal is to see you promptly at your scheduled time. Please inform us as soon as possible in the event that you will need to change an appointment.
2. Payment is due when services are rendered (this includes any insurance deductibles and/or co-pays). We accept cash, checks, Visa, Mastercard, and Discover. In regard to minors: the parent requesting services for a minor child is financially responsible for those services provided.
3. For patients with dental insurance: We will be happy to assist you in filing your insurance claim, although you are ultimately responsible for your bill. We will file your insurance form for you after you have supplied us with a copy of your insurance card and the required information. This form must be signed on both sides to allow us to release the necessary information and allow the insurance company to remit payments to our office. Any co-payments and/or deductibles are due at the time services are rendered.
4. **FEMALE PATIENTS: Before each dental visit, please inform us if you are pregnant or may possibly be pregnant before x-rays are taken or anesthesia (including nitrous oxide or “gas”) is administered.**
5. **Medicare does not cover most procedures performed in this office.** Please see the “Advance Medicare Directive” published by the American Dental Association posted in the office – it offers more information on this subject. We will be happy to provide a copy of this information.
6. We have provided you with a copy of our “Notice of Privacy Practices”. Please sign both sides of the form titled “Consent for Use and Disclosure of Health Information” and “Acknowledgement of Receipt of Notice of Privacy Practices” and return it to the Front Desk along with the rest of your paperwork.

I have read and understand these Office Policies. I acknowledge that any questions I had in reference to the above have been answered to my satisfaction. **I, the undersigned (Patient or Legally Responsible Party), authorize treatment to be rendered and assume full financial responsibility. I acknowledge that all accounts over sixty (60) days old will be charged a service fee of 1.5% per month (18% annually) on the unpaid balance. Any collection and/or attorney fees incurred to collect this account will be borne by the account.**

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Patient Name (please print)

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Signature of Patient/Guardian

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Date

*Please complete both sides of this form. Thank you.*

Kevin M. Lacour, DDS, P.C.  
5400 Lawrenceville Highway, Lilburn, GA 30047

Please fill in the following information completely. If you have dental insurance, please provide a copy of your insurance card so that we can assist in filing your insurance claims.

Whom may we thank for referring you to our office? \_\_\_\_\_

**Financial Responsibility Information:**

Date: _____	SS#: _____		
Name: _____	_____	Date of Birth: _____	
<i>Last</i>	<i>First</i>	<i>Middle Initial</i>	
Address: _____	City: _____	State: _____	Zip: _____
Home Phone: _____	Cell Phone: _____	Business Phone: _____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Email address: _____			
Employer: _____	Employer Address: _____	Occupation: _____	
Marital Status: <input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Widowed	<input type="checkbox"/> Divorced <input type="checkbox"/> Separated
Spouse's Name: _____	Birthdate: _____	SS#: _____	Occupation: _____
Spouse's Employer: _____	Spouse's Employer Address: _____	Phone: _____	

**Dental Insurance Information:**

Insurance Company: _____	Phone: _____
Insurance Company Address: _____	City: _____ State: _____ Zip: _____
Employer: _____	Group #: _____
Subscriber (Employee)Name: _____	ID#: _____
SS#: _____	DOB: _____
Address: _____	City: _____ State: _____ Zip: _____
Home phone: _____	Work Phone: _____ Cell Phone: _____

**Secondary Insurance Information: (Please complete only if you have secondary insurance coverage.)**

Is patient covered by additional insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Insurance Company: _____	Phone: _____
Insurance Company Address: _____	City: _____ State: _____ Zip: _____
Employer: _____	Group #: _____
Subscriber (Employee)Name: _____	ID#: _____
SS#: _____	DOB: _____
Address: _____	City: _____ State: _____ Zip: _____
Home phone: _____	Work Phone: _____ Cell Phone: _____

**Assignment and Release: (Please read and sign.)**

I certify that I, and/or my dependent(s) have insurance coverage with _____ and assign directly to Dr. Kevin M. Lacour all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions. The above-named Dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.	
_____ Signature of Patient/Responsible Party	_____ Date

*Please complete both sides of this form. Thank you.*