

Welcome to the office of Gary L. Llewellyn, D.D.S.

This form was created to help our team learn more about you, your wishes and needs.

Please read through and complete each section which pertains to you. Thank you.

CHILD REGISTRATION AND HISTORY

PATIENT INFORMATION

Today's Date _____

Child's Name _____ Nickname _____ Age _____ Birth Date _____

Home Address _____ City _____ State _____ Zip _____

School _____ Grade _____

Father's Name _____ Mother's Name _____

Father Employed By _____ Father Work # _____ Father SS# _____

Mother Employed By _____ Mother Work # _____ Mother SS# _____

Whom May We Thank For Referring You? _____

Person Responsible for this account if other than listed above _____

Birth Date _____ Male Female Address _____

City _____ State _____ Zip _____ Phone _____

Responsible Party's Employer _____ Position _____ How Long? _____

Employer's Address _____ Phone _____ SS# _____

FOR CHILDREN COVERED BY DENTAL INSURANCE

Subscriber's Name _____ Birth Date _____ SS# _____

Subscriber's Employer _____ Business Address _____

Insurance Company _____ Address _____

Group # _____ Have you used the Dental Insurance Previously? Yes No

Is the child covered by more than one Dental Plan? Yes No

SECONDARY INSURANCE

Subscriber's Name _____ Birth Date _____ SS# _____

Subscriber's Employer _____ Business Address _____

Phone _____

Insurance Company _____ Address _____ Group # _____

Relationship to Patient _____

I authorize all of the above information to be used as needed by the Dental Office to facilitate this child's dental treatment. I understand that I am financially responsible for the dental expenses of this child. I understand that I am financially responsible for all charges whether or not paid by said insurance within 60 days of service. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. The undersigned agrees that all past due accounts shall be charged a monthly billing fee on the unpaid balance commencing thirty (30) days after billing, the undersigned shall assume all responsibility for all collection agency fees charged to us, attorney fees, court costs and other costs incurred while collecting the amount due.

Signature _____ Date _____

ASSIGNMENT OF BENEFITS

I, _____ hereby assign all dental benefits to Gary L Llewellyn, D.D.S. I understand that I am financially responsible for all charges whether or not paid by said insurance within 60 days of service. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. The undersigned agrees that all past due accounts shall be charged a monthly billing fee on the unpaid balance commencing thirty (30) days after billing. The undersigned shall assume all responsibility for all collection agency fees charged to us, attorney fees, court costs and other cost incurred while collecting the amount due.

Signature _____ Date _____

MEDICAL HISTORY

Child's Physician _____ Phone _____

Date of last Exam _____ Results _____

Is this child under the care of a Physician now? Yes No Ever been hospitalized? Yes No Receiving any medication? Yes No

Allergic to Penicillin or any other drug? Yes No Have any excessive bleeding when cut? Yes No If yes, explain _____

Does this child have any history of or difficulty with any of the following:

<input type="checkbox"/> Aids	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Mononucleosis
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney	<input type="checkbox"/> Mumps
<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Liver	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Bladder	<input type="checkbox"/> Fainting	<input type="checkbox"/> Malignancies	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Hearing	<input type="checkbox"/> Mastoid	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Heart	<input type="checkbox"/> Measles	<input type="checkbox"/> Other, Explain
<input type="checkbox"/> Chronic Sinus			

Please describe any current treatment including drugs, pending surgery, recent injuries or any other information this office should be aware of.

May we request release of this child's medical records for our reference? Yes No

This information was given by _____ Relationship to Child _____

DENTAL HISTORY

Date of last visit to a Dentist _____

For what service _____

Has child complained about dental problems? Yes No

Any unhappy dental experiences? Yes No

Any injuries to mouth, teeth, or head? Yes No

Any mouth habits - thumbsucking, nail biting, nursing bottle habits, pacifier, etc.? Yes No

Any unusual speech habits? Yes No

Any lost teeth? Yes No

Have teeth been replaced? Yes No

Orthodontic appliances worn now or ever before? Yes No

Does your child brush teeth daily? Yes No

Do you assist child with tooth brushing? Yes No

How often? _____

Is Dental floss used? Yes No

How often? _____

Are disclosing tablets used? Yes No

Is fluoride taken in any form? Yes No

Child's attitude to dentistry? _____

Do you desire complete dental service? Yes No

Summary (for doctor's use) _____

Gary L. Llewellyn, D.D.S.

This form was created to help our team learn more about you and your needs.

Please list all your medications on this form. Thank you.

MEDICATION FORM

DRUG NAME	DOSAGE & FREQUENCY	REASON FOR TAKING MEDICATION
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
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19.		
20.		
21.		
22.		
23.		
24.		
25.		

MEDICAL HISTORY UPDATE

Patient Name	Telephone
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MEDICAL HISTORY UPDATE

Date: _____

Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new kind of medication at this time? Yes No

If so, what _____

Do you have any allergies or adverse reactions to any medications? Yes No

If so, what _____

Patient Signature

Hygienist or Doctor Signature

Patient Name	Telephone
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MEDICAL HISTORY UPDATE

Date: _____

Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new kind of medication at this time? Yes No

If so, what _____

Do you have any allergies or adverse reactions to any medications? Yes No

If so, what _____

Patient Signature

Hygienist or Doctor Signature

Patient Name	Telephone
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MEDICAL HISTORY UPDATE

Date: _____

Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new kind of medication at this time? Yes No

If so, what _____

Do you have any allergies or adverse reactions to any medications? Yes No

If so, what _____

Patient Signature

Hygienist or Doctor Signature

Gary L. Llewellyn, D.D.S.

6211 W. 30th Street, Suite G
Speedway, Indiana 46224
(317) 291-7550

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW 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 03-01-03, 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 effect any use or disclosures permitted by you 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 you 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 make reasonable inferences of you 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 telephone calls, voicemail messages, email, paging, postcards and/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 \$15.00 for the first 10 pages of patient records and \$.25 for additional pages, if radiographs are copied a reasonable fee will be assessed for record duplication 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 in this Notice for a full explanation of our fee structure.

Disclosing 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 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 information 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.

Contact:

Gary L. Llewellyn, DDS
6211 West 30th Street, Suite G
Speedway, Indiana 46224
(317) 291-7550

Gary L. Llewellyn, D.D.S.

6211 W. 30th Street, Suite G
Speedway, Indiana 46224
(317) 291-7550

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You May Refuse to Sign This Acknowledgement****

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

(Signature)

(Date)

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

(Please Print Name)

Relationship

(Please Print Name)

Relationship

(Please Print Name)

Relationship

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 the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)
