Mark A. Ellis, D.D.S.,MSD

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www.ellispediatricdentistry.com

Health History Form

For your convenience... Print this form, complete all information, and bring it with you on your first visit to our office. The parent or Guardian who accompanies the child is responsible for payment at the time of service.

1. Tell Us About Your Child

Child's Name ______________________________
Last First MI

Nickname______________________ Male Female

Siblings that we treat ______________________________

Child's Birthdate _____/_____/_____ Child's Age ___________

Child's Home # (__________)________________________

SS#____

Child's Home Address:_____________________________
APT. /

____
City State Zip

2. Mother's Information

Name ____

Stepmother Guardian Birthdate _____/_____/_____

Address (if different from the patient)______________________

____
City State Zip

Employer ____

Work # (_________)__________________ Ext. __________

Home # (_________)_________________________________

Cellular Phone # (_________)__________________________

SS # ____________________ DL# ____________________

3. Father's Information

Name ____

Stepfather Guardian Birthdate _____/_____/_____

Address (if different from the patient)______________________

____
City State Zip

Employer ____

Work # (_________)__________________ Ext. __________

Home # (_________)_________________________________

Cellular Phone # (_________)__________________________

SS # ____________________ DL# ____________________

Marital Status Single Married Separated Widowed Divorced

4. Who is Accompanying the Child Today?

Name ____

Relationship_______________________________________

Do you have legal custody of this child? Yes No

5. Person Responsible for Account

Name____

Relationship_______________________________________

Billing Address _____________________________________

____
City State Zip

Home # (___________)_______________________________

Work # (___________)_______________________________

E-mail ____

6. Primary Dental Insurance

Insurance Co. Name ________________________________

Insurance Co. Address ______________________________

____

Insurance Co. Phone # (___________)__________________

Group # (Plan, Local, or Policy #) ____________________

Policy Owner's Name ________________________________

Relationship to Patient______________________________

Policy Owner's Birthdate ______/ ______/ ______

Social Security # ___________________________________

Policy Owner's Employer _____________________________

7. Secondary Dental Insurance

Insurance Co. Name ________________________________

Insurance Co. Address ______________________________

____

Insurance Co. Phone # (___________)__________________

Group # (Plan, Local, or Policy #) ____________________

Policy Owner's Name ________________________________

Relationship to Patient______________________________

Policy Owner's Birthdate ______/ ______/ ______

Social Security # ___________________________________

Policy Owner's Employer _____________________________

8. Dental History

Is this your child's first visit to the dentist? ________________

If not, how long since the last visit to the dentist? ____________

Were any x-rays taken at previous dental visits? ____________

Have there been any injuries to the teeth, face or mouth? _____

____

If yes, please explain ________________________________

____

____

Why did you bring the child to the dentist today? ____________

____

____

Does the child have any of the following habits?

Y N Lip Sucking / Biting   Y N Nail Biting

Y N Nursing Bottle Habits   Y N Thumb / Finger Sucking

Has the child ever had a serious or difficult problem associated with previous dental work? Yes No

If yes, please explain ________________________________

____

Is the child's water fluoridated? Yes No

Is the child taking fluoride supplements? Yes No

Has the child ever had any pain or tenderness in his/her jaw/joint? (TMJ/TMD)? Yes No

Does the child brush his/her teeth daily? Yes No

Floss his / her teeth daily? Yes No

9. Health History

Has the child ever had any of the following conditions?

Y N Abnormal Bleeding	Y N Handicaps/Disabilities
Y N Allergies to any Drugs	Y N Hearing Impairment
Y N Any Hospital Stays	Y N Heart Murmur / Heart Prob
Y N Any Operations	Y N Cerebral Palsy
Y N ADHD / ADD	Y N Diabetes
Y N Autism / Asperger	Y N Hemophilia
Y N Asthma	Y N Hepatitis
Y N Cancer	Y N HIV + / AIDS
Y N Congenital Heart Disease	Y N Kidney/Liver Conditions
Y N Convulsions/Epilepsy	Y N Rheumatic/Scarlet Fever
Y N Pregnancy	Y N Allergies to Latex Product
Y N Tuberculosis	Y N Tobacco Use

Please discuss any serious medical conditions the child has had

____

____

Please list all drugs the child is currently taking ______________

____

Please list all drugs the child is allergic to __________________

____

Child's Physician _____________________________________

Phone (_____________)______________________________

Is the child currently under the care of a physician? Yes No

Please describe the child's current physical health...

Good Fair Poor

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA the CDC, and the ADA.

Who may we thank for referring you to our office? ____________

____

10.

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

______________________________________ ______________________________

Signature of Parent or Guardian   Date   Relationship to Patient

For Office Use Only

I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein.

Initials _____________ Date ______________

Insurance Verification: Effective Date ______/______/_______

Preventive __________%   Deductible $_________

Basic ______________%   Maximum $_________

Major ______________%   Electronic Claims **Yes** **No**

Doctor's Comments ____________________________________

____

____

____

Does insurance cover sealants (1351)? **Yes** **No**

If yes, what do they fall under? ___________________________

FINANCIAL POLICY

Payment is expected at the time services are rendered.

We accept cash, check, or credit cards (Visa, MasterCard, and Discover) as forms of payment.

If we have received all of your insurance information on the day of the appointment, we will be happy to file your claim for you. You must be familiar with your insurance benefits, as we will collect from you the estimated amount insurance is not expected to pay. By law your insurance company is required to pay each claim within 30 days of receipt. We file all insurance electronically so your insurance company will receive each claim within days of the treatment. You are responsible for any balance on your account after 30 days, whether insurance has paid or not. If you have not paid your balance within 60 days a finance charge of 1.5% will be added to your account each month until paid. We will be glad to send a refund to you once insurance has paid us.

PLEASE UNDERSTAND that we file dental insurance as a courtesy to our patients. We are not responsible for how your insurance company handles its claims or for what benefits they pay on a claim. We can only assist you in estimating your portion of the cost of treatment, we at no time guarantee what your insurance will or will not do with each claim. We also can not be responsible for any errors in filing your insurance; once again we file claims as a courtesy to you.

Medicaid

Our office is a participating provider for Medicaid and Hoosier Healthwise.

Delta Dental

Our office is a participating provider with Delta Preferred and Delta Premier. There are many types of Delta Dental insurance plans so we encourage parents to call ahead to verify that we are on **"their"** particular list. Being a participating provider means we voluntarily, as a courtesy to our patients, write-off an amount that is dictated to us by Delta Dental.

Self Pay Patients

You are considered a self-pay patient if you fall into one of the following categories:

No insurance coverage
Involved in a liability case
Incomplete insurance coverage information

In these instances, you are responsible for payment of your bill at the time of service.

Missed appointments

Unless cancelled at least 24 hours in advance, you will be charged the fee for a normal office visit. Please help us serve you better by keeping scheduled appointments. New appointments for non-emergency care will not be accepted until past due amounts for missed appointments are settled. **The practice reserves the right to dismiss patients with excessive cancelled appointments.**

Thank you for understanding our Financial Policy. If you have any problems or questions, please ask our staff. They are well informed and up-to-date. Please call if you have any questions or concerns regarding your visit with our office.

I have read, understand, and agree to comply with this Financial Policy for payment of the professional fees. I authorize the office of Mark A. Ellis, DDS to release any medical or dental information required in the course of examination and treatment and permit payment directly to Mark A. Ellis, DDS for any benefits due for services rendered. **I understand that I am ultimately responsible for all fees including any collection fees, returned check fees, attorney fees, and court costs incurred by our office in the collection of all sums due.**

____ ______________________

Signature of Patient or Responsible Party (must be 18 or older) Social Security Number

____ ______________________

Address Phone Number

____ ______________________

City, State, Zip Code Date

Mark A. Ellis, D.D.S., 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 Patient Name(s)}

____
{Signature of Parent}

____
{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 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).

Notice of privacy practices

Mark A. Ellis, D.D.S., P.C.

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your individually identifiable health information.

Please review this notice carefully.

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 01/01/2008, 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, provide 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.

USES AND DISCLOSURE 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 operation. 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 disclosure 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 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 authorizations.
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 voicemail messages, postcards, 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 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 retrieval fee, .25 fee each page after ten, .25 for paper copy of x-ray or $1.05 for duplicate, plus 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 3 years but not before July 1, 2005. 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.)
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 may also 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: Melissa Walker
Telephone: 317.859.9450 Fax: 317.859.9475
Address: 910 Averitt Rd. Greenwood, IN 46143

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