

# Welcome



**My Children's Dentist**  
Professional Corporation  
**Conelius Dyson, D.D.S.**

Phone: (908) 835-3500

## Health History Form

Today's Date: \_\_\_\_\_

NOTE: 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

Goes by: \_\_\_\_\_  Male  Female

Siblings that we treat \_\_\_\_\_

Child's Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Child's Age \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_

Child's Home # (\_\_\_\_\_) \_\_\_\_\_

SS# \_\_\_\_\_

Child's Home Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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

### 2. Who may we thank for referring you to our office?

\_\_\_\_\_

### 3. Mother's Information

Name \_\_\_\_\_

Mother Stepmother Guardian Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer \_\_\_\_\_

Work # (\_\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_

Home # (\_\_\_\_\_) \_\_\_\_\_

Cellular Phone # (\_\_\_\_\_) \_\_\_\_\_

SS # \_\_\_\_\_ DL# \_\_\_\_\_

### 4. Father's Information

Name \_\_\_\_\_

Father Stepmother Guardian Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer \_\_\_\_\_

Work # (\_\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_

Home # (\_\_\_\_\_) \_\_\_\_\_

Cellular Phone # (\_\_\_\_\_) \_\_\_\_\_

SS # \_\_\_\_\_ DL# \_\_\_\_\_

### 5. Who is Accompanying the Child Today?

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Do you have legal custody of this child?  Yes  No

### 6. Person Responsible for Account

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Billing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home # (\_\_\_\_\_) \_\_\_\_\_

Work # (\_\_\_\_\_) \_\_\_\_\_

Cellular # (\_\_\_\_\_) \_\_\_\_\_

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

### 7. 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 \_\_\_\_\_

### 8. 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 \_\_\_\_\_

**9. Dental History**

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

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

Previous Dentist's Name \_\_\_\_\_

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

**10. Health History**

Has the child ever had any of the following conditions?

Y  N Abnormal Bleeding       Y  N Disabilities/Special Needs

Y  N Allergies to any Drugs       Y  N Hearing Impairment

Y  N Any Hospital Stays       Y  N Heart Disease/Murmur

Y  N Any Operations       Y  N Hemophilia/Blood Disorders

Y  N Asthma       Y  N Hepatitis

Y  N Cancer       Y  N HIV + / AIDS

Y  N Congenital Birth Defects       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 Diabetes

Y  N ADD/ADHD       Y  N Autism

Please discuss any serious medical conditions the child has had

\_\_\_\_\_

\_\_\_\_\_

Please list all drugs the child is currently taking \_\_\_\_\_

\_\_\_\_\_

Please list all allergies \_\_\_\_\_

\_\_\_\_\_

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.***

**11.** 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 \_\_\_\_\_

Doctor's Comments \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**My Children's Dentist Professional Corporation**  
**134 Belvidere Avenue**  
**Washington, NJ 07882**  
**(908) 835-3500**

**Waiver of Liability**

Your insurance company will only pay for a service that is determined to be “reasonable and necessary.” If your insurance company determines that a particular service, although it would otherwise be covered is “not reasonable and necessary” under your insurance company’s program standards, your insurance will deny payment for that service.

Our staff will make every reasonable effort to comply with your insurance company’s procedures and protocol but is the patient’s ultimate responsibility.

If for any reason your insurance company denies payment for the dental procedures rendered by our doctors, you will be fully responsible for payment of those services.

Possible Responsible Reasons for Denial:

1. Insurance determination
2. Failure to acquire pre-authorization
3. Not medically necessary
4. Pre-existing condition
5. Failure to acquire pre-authorization or referral
6. Failure to provide correct/updated primary insurance information

If you are not sure of the payment guidelines of your insurance company program standards you can choose to reschedule your appointment.

I have read the above statement and understand that if my claim is denied for any reason, I agree to be fully responsible.

---

Print Your Name

---

Sign Your Name

---

Date

**My Children's Dentist Professional Corporation**  
**134 Belvidere Avenue**  
**Washington NJ 07882**

---

**CONSENT FOR CARE**

1. I consent to the release of information provided to Dr. Cornelius L. Dyson and discovered during the examination, diagnostic procedures, and treatment to my insurance company for billing purposes, or to my physician for coordination of my medical and dental care.

2. I request the consultation services of Cornelius L. Dyson, DDS. I authorize the doctor and staff to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of treatment needs. I understand this may include consultation with my physician, or other practice specialists. I authorize and consent that the doctor choose and employ such assistance as deemed fit to provide recommended treatment.

3. I understand that all responsibility for payment of services provided by Dr. Cornelius L. Dyson and staff for myself or my dependent(s) is mine, due and payable at the time service is rendered unless otherwise arranged.

4. In event payments are not received by the agreed date, I understand collection action will begin and additional collection charges may be accrued. I understand and agree that information to assist in the collections of this account, should I default, may be given to an attorney, collection agency, or other professional contracted by the office.

5. I understand it is my responsibility to advise your office of changes in information contained on this form.

6. I understand that a parent or legal guardian must accompany the minor to the office.

I have read and understand the above financial policy and consent for care information.

---

**Date**

---

**Patient**

---

**Signature (Parent if under 18)**

**Privacy Policy Notice**  
**For My Children's Dentist Professional Corporation**  
**134 Belvedere Avenue – Washington, NJ 07882**

**This notice describes how medical information about you may be used and disclosed and how you can access to this information. Please review it carefully.**

**Uses and Disclosures**

Our office must provide you, the patient, a description and at least one example of the type of uses and disclosure that our office is permitted to make for the purpose of treatment, payment and health-care operations ( all uses and disclosure by the way, that are permitted by the law without authorization by the patient).

**Treatment** – Our office will use and disclose your protected health information (PHI) for purpose of treatment, meaning the provision, coordination and management of your health care and related services. For instance, we will use and disclose your health information to coordinate benefits with a third-party payer, or for consultation between our office and a specialist if required for your care.

**Payment** – Our office may use and disclose the minimum necessary amount of you Phi for health-care operations, such as business planning and development that involves conducting, cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development and improvement of methods of payment or coverage policies.

This section of our policy also must describe other purposes for which our office is permitted or required to use or disclose your PHI without your written authorization. No example of each of the following instances is required by law.

**Required by Law** – Our office may use and disclose your PHI only to the extent that such use is required by law.

**Public health activities** – Our office may use and disclose the minimum necessary amount of your PHI to appropriate public health authorities for reasons such as, but not limited to, preventing or controlling disease, injury or child abuse or neglect.

**Reporting abuse, neglect or domestic violence** – Our office may sue and disclose the minimum necessary amount of your PHI to the extent necessary to inform the appropriate government authority if we reasonably believe you to be a victim of abuse, neglect or domestic violence.

**Health oversight activities** – Our office may use and disclose oversight agency for oversight activities authorized by law, such as for, but not limited to, audits.

**Judicial and administrative proceedings** – Our office may use and disclose the minimum necessary amount of your in the course on any Judicial or administrative proceeding if required by law to do so.

**Law enforcement agencies** – Our office may use and disclose the minimum necessary amount of your PHI to a law enforcement agency is required by law to do so.

**Deceased patients** – Our office may use and disclose the minimum necessary amount of your PHI to a coroner or medical examiner for the purpose of identifying a deceases person, determining cause of death of another matter authorized by law, or to funeral directors to carry out their duties with respect to the deceased individual.

**Research purposes** – Our office may use and disclose the minimum necessary amount of your PHI for research purposes without your written authorization only if we have obtained one of the following documented institutional review board of privacy board approval, either written or verbal representations that the information being sought is solely for research on the PHI of decedents, or a limited data Use agreement.

**Specialized government functions** – if you are a member of the Armed Forces, our office will use and disclose the minimum necessary amount of your PHI for military and veteran and activities. Our office also will use and disclose nativities for protective services for the U.S. Presidents and others. Our office also will use and disclose the minimum necessary amount of your PHI to a correctional institution or law enforcement agency if you are an inmate and that agency or institution indicates the information is necessary.

**Safety** – Our office may use and disclose the minimum necessary amount of your PHI if we believe doing so is necessary to prevent or lessen a serious and imminent threat to the health of safety of a person r the public and other special circumstances.

**Workers' compensation proceedings** – Our office may use and disclose the minimum necessary amount of you PHI as authorized by and to the extent necessary to comply with laws related to worker's compensation or similar programs.

**Patient directory** – Excepts when an objection is expressed by you, our office may use and disclose the minimum amount of you PHI to maintain directory of patients in the office. Said information includes your name , your location in the office, your condition described in general terms. We will inform you in advance of such need and give you an opportunity to object, except in sases of emergencies when we must exercise professional judgment to determine whether us and disclosure of this information is in your best interest.

**Friend, family and personal representatives** – Our office may use and disclose the minimum amount of your PHI that is directly relevant to the involvement of a family member, other relative, a close personal friend or someone else identified by you. Involvement could be in relation to care or payment for service. Our office also will use and disclose the minimum necessary amount of your PHI regarding your location, general condition or death to a family member, a personal representative of yours or another person responsible for your care. Such uses and disclosures will be made only with your permission if you are present, unless you are incapacitated or there is an emergency circumstance where our office must exercise professional judgment.

**Federal Investigation** – Our office may use and disclose the minimum necessary amount of you PHI for an investigation by the U.S. Department of Health and Human Services Secretary to determine if our office is in compliance with the HIPAA privacy regulation that requires us to protect your individually identifiable health information.

**Business Associates** – Our office may use and disclose the minimum necessary amount of you PHI to a business associate that has agreed in writing to appropriately safeguard the information.

**Appointment reminders** – Our office may use and disclose the minimum necessary amount of your PHI when contacting you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

**Marketing** – Our office will obtain written authorization from you if we would like to use your PHI for marketing purposes, except for face-to-face communication or promotional gift of nominal value provided to you while visiting the office. This office will inform you via the written authorization form if this office is to receive remuneration in connection with any marketing purpose. You have the right to revoke any authorization as long as you do so in writing.

**General authorization statement** – For any purpose not stated in this notice, our office will not use or disclose your PHI without your written authorization.

#### **PATIENT RIGHTS**

**The patient** – You have the right to inspect or obtain a copy of your PHI from our office. Our office requires you submit such requests in writing to our privacy director. Our office must act on your request no later than 30 days after receipt of your request, unless the PHI request is not maintained or accessible to our office on site. In the latter case, our office must respond to your request within 60 days of your request, and we must inform your request, and we must inform you of any such delay in writing within the initial 30 day timeframe. If further delays are required, our office may extend the time needed to respond to your request an additional 30 days provided that our office informs you in writing of the reasons for the delay and offers a date by which our office will respond to your request. Our office will provide you with access to your PHI to inspect or to obtain a copy, or both, in the form requested, if reasonable. If you agree to receive a summary of your PHI our office will supply you with access to the summary. Our office will charge you a cost-based fee for the provision of any copies provided to you.

**Denial of access appeals** – If our office denies your request for access to your PHI in whole or in part, we must provide you with access to any other PHI for which access is not denied. For the information that is denied, our officer must inform you in writing of this denial within 30 days of the original request, and the statement must provide the basis for the denial. Reasons for denial may include the following circumstances: The doctor has determined, using his professional judgment, that access to the information is reasonably likely to endanger the life or physical safety of your or another person; the information requested makes reference to another person (unless the other person is a health-care provider) and the doctor has determined, using his professional judgment, that granting your request is reasonably likely to cause substantial harm to this other person; and when the request for information is made by your personal representative and the doctor, using his professional judgment, has decided that the provision of the information to the personal representative is reasonably likely to cause substantial harm to your or another person. If access to your PHI is denied for these reasons, you have the right to have the denial reviewed by \_\_\_\_\_, who has agreed to serve in this capacity for your office. \_\_\_\_\_ cannot be involved in the original decision to deny access to your PHI. Our office will inform you in writing as to the decision by them within a reasonable period of time.

**Restrictions** – You have the right to request restrictions on certain uses and disclosures of your PHI, though our office is not required to grant such requests.

**Confidential communication** – You have the right to request, and our office must accommodate reasonable requests to receive confidential communication of PHI from our office by alternative means or at alternate locations.

**Accounting and disclosures** – You have the right to receive an accounting of disclosures of your PHI made by our office for the six years prior to the date on which the accounting is requested. The following disclosures are exempted from this accounting. Disclosures to carry out treatment, payment and healthcare operations; to you the patient; for incidental uses or disclosures to carry out treatment, payment and healthcare operation, to you, the patient; for incidental uses of disclosures; disclosure

**My Children's Dentist Professional Corporation  
134 Belvidere Avenue  
Washington, NJ 07882**

**Patient Acknowledgement Form**

I acknowledge that I have received and reviewed the office Privacy Policy Notice from My Children's Dentist Professional Corporation.

Parent/Guardian Signature \_\_\_\_\_

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

In case you do not agree to sign this form, our office must indicate why you declined to do so. This office will not refuse treatment to anyone based solely on the patient's refusal to sign the acknowledgement form.

Reason for patient's refusal:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Privacy Director's Signature: \_\_\_\_\_

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