



THE SMILE CENTRE

PLEASE COMPLETE AND BRING WITH YOU

309 South Second Street • Leavenworth, Kansas 66048 • (913) 651-9800

THE FOLLOWING INFORMATION AND HISTORY ARE NECESSARY FOR ADEQUATE TREATMENT AND UNDERSTANDING OF YOUR CHILD. THANK YOU FOR COMPLETING IT.

Patient's Name _____ Preferred Name _____ Age _____

Sex _____ Date of Birth _____ Place of Birth _____ Family E-Mail Address _____

Patient's Address _____ Street _____ City _____ State _____ Zip _____ Home Phone _____

Father/Guardian's Name _____ Date of Birth _____ Social Security # _____

His Address _____ Street _____ City _____ State _____ Zip _____ Home Phone _____

Where Employed _____ Work Phone _____

Father/Guardian's Dental Insurance _____ Company _____ Address _____ Policy # _____

Father/Guardian's Major Medical Insurance _____ Company _____ Address _____ Policy # _____

Mother/Guardian's Name _____ Date of Birth _____ Social Security # _____

Her Address _____ Street _____ City _____ State _____ Zip _____ Home Phone _____

Where Employed _____ Work Phone _____

Mother/Guardian's Dental Insurance _____ Company _____ Address _____ Policy # _____

Mother/Guardian's Major Medical Insurance _____ Company _____ Address _____ Policy # _____

With whom does patient live _____

Other Children in family – names and ages _____

Child's Physician _____

Whom may we thank for referring you to our office? Doctor Parent Patient _____

HEALTH HISTORY			Med	NM	PCS	ETS	RM	
	Yes	No	Yes	No	Check any of the following that may pertain to your child			
Is your child in good health?	_____	_____	Has your child experienced: chronic cough? _____ recurrent mouth sores? _____		_____	_____	_____	_____
Does your child have regular medical exams?	_____	_____			_____	_____	_____	_____
Is your child up to date with immunizations?	_____	_____	Has your child ever had: blood transfusions? _____ chemotherapy? _____ transplant surgery? _____		_____	_____	_____	_____
Is your child presently undergoing medical treatment? If so, what? _____	_____	_____			_____	_____	_____	_____
Has your child been hospitalized since birth or had any operations? Date _____ Reason _____	_____	_____	Health history reviewed (initials & date) _____ _____		_____	_____	_____	_____
Does your child have any infectious diseases? If yes, list _____	_____	_____			_____	_____	_____	_____
Is your child presently taking medicine? If so, what? _____	_____	_____	_____	_____	_____	_____	_____	_____
Is your child allergic to latex?	_____	_____	_____	_____	_____	_____	_____	_____
Does your child have any other allergies? If so, what? _____	_____	_____	_____	_____	_____	_____	_____	_____
Has your child experienced any unfavorable reaction to medicine? If so, what? _____	_____	_____	_____	_____	_____	_____	_____	_____

What is your water source? Private Well? Bottled Water Public System? Name of system: _____

	Yes	No		Yes	No
Is this your child's first dental visit?	_____	_____	Does your child have a toothache?	_____	_____
Has your child had an unfavorable experience in a dental office?	_____	_____	Purpose of this visit _____		

Thank you for your help. If there is any information that you think might be of value to us in treating your child, please feel free to comment:

FINANCIAL AGREEMENT: Payment is required for services rendered at the time the treatment is performed.
 Method of Payment: Cash Check Credit Card (MasterCard, Visa, Discover)
 I agree to diagnostic and cleaning procedures as found necessary by The Smile Centre for the patient named above. I will accept responsibility for this account or any part thereof should named responsible party fail or insurance benefit be denied or insufficient to pay the full fee.

Date _____ Signature of person legally responsible _____

_____ Dental Assistant reviewing history prior to Dr.'s review of history. _____ Dr.'s Review



NEW CHILD SCREENING
ONLY FOR CHILDREN UNDER 4 YEARS OF AGE
PLEASE FILL OUT AND BRING WITH YOU!

CHILD'S NAME: _____ DATE OF BIRTH: _____ DATE: _____

Please answer each of the following questions concerning your child and **BRING TO FIRST EXAM APPT.**

What age did your child first get teeth?	Before 6 mon.	6-12 Mon.	After 12 Mon.	
Have parents or siblings had cavities?	Yes	No		
Who brushes your child's teeth?	Parent	Child	No One	
What type of toothpaste is used for your child?	Fluoride	No Fluoride	Don't Know	None
Who flosses your child's teeth?	Parent	Child	No One	
Does your child cooperate for brushing/flossing?	Yes	No		
Is your water fluoridated?	Yes	No	Don't Know	
Does your pediatrician paint fluoride varnish on your child? Yes	Yes	No	Don't Know	
Do you use bottled water?	Yes	No	Formula	
What oral habits does your child have?.	None	Thumb	Pacifier	Finger
When and how often does this habit occur?	All Day	Nap Time	Bed Time	Stress Time
Does your child drink from a: (circle one)	Regular Cup	Sippy Cup	Bottle	
What liquid does your child mostly drink?	Water	Milk	Juice	Other
Does your child eat between meals?	No	Occ.	Frequently	
Does your child drink between meals?	No	Occ.	Frequently	
Is your child breast fed?	Yes	No		
Does your child sleep well?	Yes	No		
Does your child snore?	Yes	No	Don't Know	
Have parents had braces?	Yes	No		
Has your child had any injuries to their mouth?	Yes	No		

What age and severity

Does your child take any medications?

Yes No

If so, what medications and why

What are your special concerns?

INSURANCE AUTHORIZATION
Dr. Paul E. Kittle, D.D.S.
Dr. Jennifer Kirwan, D.D.S.
The Smile Centre
309 S. Second Street
Leavenworth, KS 66048

SIGNATURE ON FILE

- I authorize use of this form on all of my insurance submissions.
- I authorize release of information to all of my insurance carriers.
- I understand that I am responsible for my bill.
- I authorize my doctor to act as my agent in helping me obtain payment from my insurance carriers.
- I authorize payment directly to my doctor.
- I permit a copy of this authorization to be used in place of the original.
- I understand there is a minimal charge for duplicated xrays.
- I understand there is a \$40 fee for failed or cancelled appts (without 24 hr notice)

Parent/Patient Name _____

Signature _____

Date _____

THE SMILE CENTRE

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.

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 the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (Please Specify)

Paul E. Kittle, DDS, PA
Pediatric Specialist



Jennifer A. Kirwan, DDS
General Dentist

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about our patients may be used and disclosed and how you can get access to this information.

Please review it carefully. The privacy of our patients' 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 our patients' health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 4/14/03, 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 our office.

Uses and Disclosures of Health Information:

We use and disclose health information about our patients for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose our patient's health information to a physician, a dentist, or other healthcare provider providing treatment to our patients.

Payment: We may use and disclose our patient's health information to obtain payment for services we provide to our patients.

Healthcare Operations: We may use and disclose our patient's 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 our patient's health information for treatment, payment or healthcare operations, you may give us written authorization to use our patient's 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 written authorization, we cannot use or disclose our patient's health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose our patient's health information to you, as described in the Patient Rights Section of this Notice. We may disclose our patient's health information to a family member, friend or other person to the extent necessary to help with our patient's healthcare or with payment for our patient's 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 our patient's care, of our patient's location, or our patient's general condition. If you are present, then prior to use or disclosure of our patient's 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 our patient's health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in our patient's healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of our patient's best interest in allowing a person to pick up filled prescriptions, dental supplies, x-rays, or other similar forms of health information.

309 South Second Street
Leavenworth, Kansas 66048

Phone: 913-651-9800
Fax: 913-651-8559

pedident@aol.com
smilecentre@earthlink.net

Marketing Health-Related Services: We will not use our patient's health information for marketing communications.

Required by Law: We may use or disclose our patient's health information when we are required to do so by law.

Abuse or Neglect: We may disclose our patient's health information to appropriate authorities if we reasonably believe that he/she is a possible victim of medical or dental abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose our patient's health information to the extent necessary to avert a serious threat to our patient's health or safety or the health or safety of others.

Appointment Reminders: We may use or disclose our patient's 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 our patient's 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 our patient's health information. 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 on the front of this Notice. If you request copies, we will charge you \$1.00 for each page, \$10.00 per hour for staff time to locate and copy our patient's 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 our patient's health information in that format. If you prefer, we will prepare a summary or an explanation of our patient's health information for a fee.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed our patient's 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, in writing, that we place additional restrictions on our use or disclosure of our patient's 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 our patient's 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. Our practice does not initiate communication with patients via e-mail. At this time, we do not have encryption capabilities.

Amendment: You have the right to request that we amend our patient's 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.

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 our patient's health information or in response to a request you made to amend or restrict the use or disclosure of our patient's health information or to have us communicate with you by alternative means or at alternative locations, you may contact us using the address listed on the front 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.

The Smile Centre will do its best to provide privacy for your and your child. However, due to the open bay treatment area, this is not always possible. We will make every effort to keep our patients health information private.

We support your right to the privacy of our patients health information.