WELCOME TO HENNIKER FAMILY DENTISTRY

Please answer the following questions as thoroughly as possible. With detailed information about your routine, we can provide a high-quality dental experience for you and your child. Please include any questions or concerns you may have. Depending on your child's age, some topics may not apply. In this case, please move on to the next applicable topic.

Please answer the following questions in reference to your child.

Name: _____Nickname: _____
Hobbies, interests, sports: _____
Special needs with regards to healthcare or treatment: _____
_____
When does your child brush? _____
Who brushes the child's teeth? _____
What kind of brush is used? _____
What kind of toothpaste is used? _____
Does your child floss? _____Who helps? _____
Do you use any mouth wipe or rinses? _____
Does your child sleep with a cup or bottle? _____
How many snacks per day does your child eat? _____
What kinds of snacks? _____

Please circle all beverages your child may drink (even if it is only occasionally)

milk	coffee	smoothies
juice	flavored water	flavored milk
water	sports drinks	other: _____

Has your primary water source been tested for fluoride? YES NO
Do you use prescription vitamins or fluoride supplements?
_____
Does the rest of your family receive regular dental care?
every six months as needed not at this time
_____
Is there a parent or caregiver with untreated decay (cavities)? _____
Is there a family history of significant dental treatment or problems?
_____
Does your child experience chronic ear infections? YES NO
Do you have any questions?
_____
_____

Medical History: Children and Young Adults

Child's Name: _____ **DOB:** _____

Nickname: _____ M / F SSN: _____

Child's Home Address: _____

Child's Home Phone #: _____ Primary Parent's Cell Phone #: _____

Child's Physician – Name and Phone #: _____

Mother's Name and Address: _____

Home Phone: _____ Work Phone: _____

Father's Name and Address: _____

Home Phone: _____ Work Phone: _____

Person Responsible for Account: _____ SSN: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Primary Dental Insurance
Ins. Co. Name: _____
Address: _____
Phone #: _____
Group#: _____
Policy Owner's Name: _____
Policy Owner's DOB: _____
Policy Owner's SSN: _____
Employer: _____

Secondary Dental Insurance
Ins. Co. Name: _____
Address: _____
Phone #: _____
Group #: _____
Policy Owner's Name: _____
Policy Owner's DOB: _____
Policy Owner's SSN: _____
Employer: _____

Please list all medications that the child is currently taking:

_____

_____

Please list all medications/things that the child is allergic to:

_____

_____

Has the child ever had any of the following medical problems?

Y N Autism Spectrum Disorder

Y N	Abnormal Bleeding	*Y N*	Convulsions	*Y N*	Hives / Skin Rash
Y N	Allergies to any Drugs	*Y N*	Diabetes	*Y N*	HIV/AIDS
Y N	Anemia	*Y N*	Epilepsy	*Y N*	Kidney/Liver Problems
Y N	Any Hospital Stays	*Y N*	Handicaps/disabilities	*Y N*	Measles
Y N	Any Operations	*Y N*	Hearing Impairment	*Y N*	Mononucleosis
Y N	Asthma	*Y N*	Heart Murmur	*Y N*	Rheumatic fever
Y N	Cancer	*Y N*	Hemophilia	Y *N*	Tuberculosis (TB)
Y N	Chicken Pox	*Y N*	Hepatitis	Y N	COVID-19
Y N	Congenital Heart Defect				

I have been made aware of this office's privacy policy.

Parent's/Guardian's Signature: _____ *Date:* _____

HENNIKER FAMILY DENTISTRY

Appointment Cancellation Policy

At Henniker Family Dentistry, we schedule individual time with each patient to deliver the quality personal care that each person deserves. Our office policy requires that you give at least **48 hours'** notice when changing an appointment. Available appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely care.

Because your appointment time is a guaranteed reservation for you, a **$60 charge** will be required for the following conditions:

- Less than **48 hours'** notice for cancelling or rescheduling an appointment
- Missing an appointment without giving notice to our office

By signing below, you acknowledge that you have read and understand the cancellation policy for Henniker Family Dentistry

Thank you for your understanding.

Patient Signature: _____

Date:_____

HENNIKER FAMILY DENTISTRY

NOTICE OF PRIVACY PRACTICES

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.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates, and their subcontractors may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

Records & Communication

- You can ask for an electronic or paper copy of your records and other health information we have about you. We will provide a copy or summary of your health information within 60 days of your request. We may charge a reasonable, cost-based fee.
- You can ask us to correct health information about you that you think is incorrect or incomplete. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.
- You can ask us not to use/share certain health information for treatment, payment, or our operations. We are not required to agree to your request,we may say "no" if it will affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
- You can ask for a list of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Choose someone to act for you:

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care.
- Share information in a disaster relief situation
- Include your information in a hospital directory.

If you are not able to tell us your preference, for example if you are unconscious, we may share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

We typically use or share your health information in the following ways:

- *We can use your health information and share it with other* professionals who are treating you.
- We can use/share your information to run our practice, improve your care, and contact you when necessary.
- We can use and share your health information to bill and get payment from health plans or other entities.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes.

Help with public health and safety issues-

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety.

Work with a medical examiner or funeral director or respond to organ and tissue donation requests-

We can share health information with a coroner, medical examiner, or funeral director when an individual dies. We can share health information about you with organ procurement organizations.

Address workers' compensation, law enforcement, and other government requests-

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes/with a law enforcement official (If state or federal laws require it, including with the Dept. of Health & Human Services if it wants to see that we're complying with federal privacy law.)
- With health oversight agencies for activities authorized by law.
- For special government functions such as military, national security, and presidential protective services.
- In response to a court/administrative order or in response to a subpoena.

Our Responsibilities

- We will not use or share your information other than as described here unless you tell us we can in writing. If you change your mind at any time, let us know in writing.
- We are required by law to maintain the privacy and security of your protected health information.
- We will inform you if a breach occurs that may have compromised the privacy of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- *We will never share any substance abuse treatment records without your written permission.*

Complaints

You may complain to us if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint.

We will not retaliate against you for filing a complaint.

Jessica Bonenfant (603) 428-3419
hygiene@hennikerfamilydental.com

HIPAA Compliance Officer phone email

You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to: 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting ***www.hhs.gov/ocr/privacy/hipaa/complaints/.***

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions about this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Acknowledgment of Receipt of the Notice of Privacy Practices

Name of patient or representative **Date**