Children's Dental Clinic

WellPartners Adult & Children's Dental Clinics **Lexington County Health Department** **Red Bank Crossing** **1070 South Lake Dr., Suite B** **Lexington, SC 29073**	**WellPartners Children's Dental Clinic** **Richland County Health Department** **2000 Hampton Street, Suite 4090** **Columbia, SC 29204**

CERTIFICATION / REFERRAL FORM

Check one: □ **New** □ **Recertification**

Child's Name: _____
Last **First** **Middle**

Birth date: _____ **Social Security #:** _____

County: _____ **Name of School:** _____

Name of Parent/Guardian: _____ **Phone #:** _____

Address: _____
Street

_____
City/State/Zip

□ **Check here to certify that the above-named child is eligible and has been properly certified to receive services at the Children's Dental Clinic.**

Nurse/Staff Member: _____ **Phone#:** _____
School/Agency: _____ **Date:** _____

Parental Permission: I give my permission for the above-named child to receive full dental treatment from the Children's Dental Clinic, which includes all standard dental procedures and may involve the administering of anesthesia. I understand that a prescription for medication may be prescribed by the dentist, if needed. I further release from liability the staff and volunteers of the Children's Dental Clinic. This program is funded by the United Way of the Midlands.

*****Signature of Parent/Guardian:** _____

Appointment made for: _____, **on** _____
Time **Date**

Children's Dental Clinic

WellPartners Adult & Children's Dental Clinics **Lexington County Health Department** **Red Bank Crossing** **1070 South Lake Dr., Suite B** **Lexington, SC 29073**	**WellPartners Children's Dental Clinic** **Richland County Health Department** **2000 Hampton Street, Suite 4090** **Columbia, SC 29204**

CHILD'S HEALTH HISTORY

The following questions and answers are for our records only and will be considered confidential.

Last medical exam: _____ Physician: _____ Phone#: _____

Physician's Address: _____

Is your child now under a physician's care? □ Yes □ No
If yes, why? _____
Is your child currently taking medications? □ Yes □ No
If yes, what medications? _____
Is your child a hemophiliac (bleeder)? □ Yes □ No
Has your child been hospitalized? □ Yes □ No
If yes, reason for hospitalization: _____

Indicate if your child has, or had, any of the following
CONDITIONS—DISEASES—TREATMENTS

Anemia	**□ yes**	**□ no**	**Sinus Problems**	**□ yes**	**□ no**
Asthma	**□ yes**	**□ no**	**Thyroid Condition**	**□ yes**	**□ no**
Seasonal Allergies/Hay Fever	**□ yes**	**□ no**	**Kidney or Liver Disease**	**□ yes**	**□ no**
Diabetes	**□ yes**	**□ no**	**Fainting or Dizzy Spells**	**□ yes**	**□ no**
Hepatitis or Jaundice	**□ yes**	**□ no**	**Nervous Habits/Problems**	**□ yes**	**□ no**
Epilepsy or Seizures	**□ yes**	**□ no**	**Eating Disorders**	**□ yes**	**□ no**
Stomach or Intestinal Bleeding	**□ yes**	**□ no**	**High or Low Blood Pressure**	**□ yes**	**□ no**
Prolonged bleeding from cut/surgery	**□ yes**	**□ no**	**Stroke**	**□ yes**	**□ no**
Abnormal Heart Disease/Defect	**□ yes**	**□ no**	**Venereal Disease**	**□ yes**	**□ no**
Rheumatic Fever or Heart Disease	**□ yes**	**□ no**	**Radiation Treatment**	**□ yes**	**□ no**
Heart Murmur	**□ yes**	**□ no**	**Blood Transfusion**	**□ yes**	**□ no**
Tuberculosis (TB)	**□ yes**	**□ no**	**AIDS/HIV Positive**	**□ yes**	**□ no**
Arthritis	**□ yes**	**□ no**	**Malignancies**	**□ yes**	**□ no**

Indicate if your child has, or had, any of the following
ALLERGIES - REACTION

Local Anesthetic (Novocaine)	**□ yes**	**□ no**	**Aspirin**	**□ yes**	**□ no**
Penicillin or other Antibiotics	**□ yes**	**□ no**	**Ibuprofen**	**□ yes**	**□ no**
Sulfa Drugs	**□ yes**	**□ no**	**Codeine**	**□ yes**	**□ no**

Is your child pregnant? □ yes □ no

Is your child considered to be handicapped? □ yes □ no
If yes: □ Physical □ Mental □ Emotional

Does your child have any other condition not listed above? □ yes □ no
If yes, please describe condition and any treatment: _____ 4

_____

_____

Date of last dental care: _____ Where? _____

Child's Name: _____
Last
First Middle

□ Check Box – The above information, to the best of my knowledge, is correct.

*****Signature of Parent/Guardian: _____**

Does the above listed patient or patient's family have any special needs that must be met in order to schedule treatment? Such as:

Scheduling Difficulties: □ yes □ no _____
Transportation: □ yes □ no _____
Other: □ yes □ no _____

Children's Dental Clinic	
WellPartners Adult & Children's Dental Clinics **Lexington County Health Department** **Red Bank Crossing** **1070 South Lake Dr., Suite B** **Lexington, SC 29073**	**WellPartners Children's Dental Clinic** **Richland County Health Department** **2000 Hampton Street, Suite 4090** **Columbia, SC 29204**

ACKNOWLEDGEMENT OF RECEIPT -- NOTICE OF PRIVACY PRACTICES

You May Refuse To Sign This Acknowledgement.

I, _____ have read, and/or
(Your Name) requested a copy of the office's Notice of Privacy Practices.

_____
Print your name

_____
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.**
- □ **Communication barriers prohibited obtaining the acknowledgement.**
- □ **An emergency situation prevented us from obtaining acknowledgement.**
- □ **Other, please specify:**

_____

_____

_____

Turn page to read Notice of Privacy Practices →

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 CAREFULLY. THE PRIVACY OF YOUR HEALTH 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 is now in effect and will remain so until we replace it. We reserve the right to change our privacy practices, and the terms of the 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 well change the Notice and made 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 above.

USES AND DISCOSURES 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: Currently, the Programs provide services free of charge. We may use and disclose your health information to obtain payment for services we provide 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 qualification of healthcare professions, 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 use or disclosures 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 the Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patients' 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 disclosure. 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 toward your best interest in allowing person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of healthy 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 serious threat to your health or safety, or the health or safety of others.