Healthy Smiles

317-894-8370

**Our school has partnered with *Healthy Smiles* to offer in-school dental care.**
**Find Us On Facebook at Healthy Smiles of Indiana**
**exam ~ x-rays ~ cleaning ~ fluoride ~ sealants**

***If you would like to participate please fill out and return to school ASAP***

## 1 PATIENT INFORMATION

Child's Legal Name _____

Date of Birth _____ ☐ M ☐ F

Parent/Guardian Name _____

PARENT/GUARDIAN SIGNATURE _____ DATE

Address _____

_____ CITY _____ STATE _____ ZIP

Phone # _____ HOME _____ CELL

Parent Email _____

Employer _____

Work Phone _____

Last time child had an exam and cleaning? _____

## 2 HEALTH HISTORY

| | YES | NO |
|---|---|---|
| Heart Problems | ____ | ____ |
| Heart Murmur | ____ | ____ |
| Rheumatic Fever | ____ | ____ |
| Diabetes | ____ | ____ |
| Hepatitis | ____ | ____ |
| Lung Disease | ____ | ____ |
| HIV/AIDS | ____ | ____ |
| Organ Transplant | ____ | ____ |
| Artificial Joint | ____ | ____ |

Other Health Problems _____

Current Medications _____

Allergies (please list) Food _____

Medicine _____

## 3 INSURANCE INFORMATION

### IF CHILD HAS MEDICAID / HOOSIER HEALTHWISE

Enter Medicaid ID ⟶ _____

### IF CHILD HAS PRIVATE INSURANCE

Name of Insured Adult _____ Insured Adult Date of Birth _____

Ins. Co. _____ Phone# _____

Ins. Co. Address _____

_____ CITY _____ STATE _____ ZIP

Member ID / Policy # / Social Security # of Insured Adult

### CHILD HAS NO DENTAL INSURANCE

☐ Credit/Debit Card ($50 for Exam, X-rays, Cleaning and Fluoride)

#_____ _____ Exp ____

☐ Pay by Check ($50.00 for Exam, X-ray, Cleaning & Fluoride)
Please attach check made out to Healthy Smiles of Indiana

☐ I cannot pay for treatment and request donated care.
May be available only one time per year

**Signature in section 1 acknowledges receipt of HIPPA information and permission to file with insurance**

**Please list any service you would NOT like your child to receive:** _____

Name of Your Child's School _____ Grade ____ Teacher's Name _____

## DENTAL HEALTH RECORD – FILLED OUT BY HEALTHY SMILES DENTIST

Tx: Exam ☐ X-rays ☐ Prophy ☐ Fl2 ☐

Sealants # _____

| | Existing | Needs |
|---|---|---|

**Soft Tissue**

Healthy ☐
Lt. Plaque/Gingivitis ☐
Heavy Plaque/Tartar ☐

**Hard Tissue**

Healthy ☐
Decay ☐
Fracture ☐
Abscess ☐
Ortho ☐

Notes: _____

# Notice of Privacy Policies

The information provided below illustrates the manner your protected health information could be accessed and released and what you need to know about this process. This important document should be reviewed thoroughly. Managing the privacy of your protected health information is extremely important to Healthy Smiles of Indiana.

*Our Legal Responsibilities:* As mandated by federal and State legal requirements, your protected health information must be protected. As part of these regulations we are required to ensure you are aware of privacy policies, legal duties and your rights to our protected health information. This notice of privacy policies, outlined below, will be in effect for the duration and must be followed by our practice. This notice will be in effect until it is replaced, and becomes effective 4/14/2003.

We reserve the right to modify our privacy policies and the terms of this notice at any time and will make such modifications within the guidelines of the law. We reserve the right to make the modifications effective for all protected health information that we maintain, including protected health information we created or received before the changes were made. Changing this notice will precede all significant modifications. This notice will be available upon request.

Copies of this notice are available at your request. For your convenience, information regarding how you can contact us is at the bottom of this notice.

## PROTECTED HEALTH INFORMATION USE AND DISCLOSURE

Information regarding your health may be used and disclosed for the purpose of treatment, payment and other health care operations. Examples cited below further explain the use and disclosure process.

**TREATMENT:** Use and disclosure of your protected health information may be provided to a physician or other health care provider providing treatment to you.

**PAYMENT:** Your protected health information may be used and disclosed to obtain payment for services we provided to you.

**HEALTH CARE PROCESSES:** We may use and disclose your protected health care information in relations with our health care process. These processes include an assessment, improvement activities, reviewing the competence or qualifications of health care professionals, provider performances and evaluating practitioner, conducting training programs, accreditation, certification, licensing or credentialing activities.

**YOUR AUTHORIZATION:** At any time you may provide in writing your authorization for use and disclosure of your protected health information for any purpose. You may choose to revoke your written permission at any time. The revocation must be in writing. If you revoke your written authorization it will not affect any use or disclosure prior to revocation.

Your protected health care information may be used and disclosed to you, as described in the patient rights section of this notice. In addition, your protected health care information may be used and disclosed to a family member, friend, or other person to the extent necessary to assist you with your health care, but only with your authorization.

**PERSON INVOLVED IN CARE:** In order to accommodate the notification of your location, your general condition, or death, your protected health information may be used or disclosed to a family member, your personal representative or another person responsible for your care. If you are present and wish to object to such disclosures of your protected health information you may do so. To the extent you are incapacitated or emergency circumstances exist, we will disclose protected health information using our professional judgement, disclosing only protected health information that is directly relevant to the persons involvement in your health care. We will use our professional judgement and our experience with common practices 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 protected health information.

**MARKETING HEALTH-RELATED SERVICES:** The use of your protected health information for the purpose of marketing communications is prohibited without your written authorization.

**REQUIRED BY LAW:** Your protected health information may be used or disclosed if required by law.

**ABUSE OR NEGLECT:** As required by law, if we have reason to believe that you are the victim of possible abuse, neglect or domestic violence or other possible crimes, your protected health information may be disclosed to the appropriate authorities. If we have reason to believe the use or disclosure of your protected health information will prevent a serious threat to your health or safety or the health or safety of others, we may have to provide the necessary protected health information.

**NATIONAL SECURITY:** Under some circumstances the military may require disclosure of health care information for armed forces personnel. For the purpose of national securities activities, counter intelligence and lawful intelligence, authorized federal authorities may require disclosure of protected health information. Protected health care information disclosure may be made to the correctional facilities or law enforcement authorities with the lawful authority requiring custody of such information.

**APPOINTMENT REMINDERS:** Your protected health care information may be used to assist you with appointment reminders in the form of voicemail messages, postcards or letters.

## PATIENT RIGHTS

**ACCESS:** At all times you have the right to review your protected health information, with limited exceptions. At your request, we will provide your information in a format other than photocopies. If we are able to do so, we will accommodate your request.

Your request to obtain access to your information must be in writing. You may obtain a *Protected Health Information Access Form* by using the contact information at the end of this notice. We may need to charge you a reasonable, cost-based fee for expenses including copies and staff time. You may also request access for submitting a letter using the information at the bottom of this notice. If you request copies, we will charge you 25¢ per each page and $10.00 per hour for staff time to locate and copy your protected health information. Postage will be included if you wish to have your information mailed. If you request a format option, which is different, we will charge a cost-based fee for that format. An explanation of fees can be made available.

**DISCLOSURE ACCOUNTING:** Your rights include the choice to receive a review of every time we or our business associates disclosed your protected health information for reasons other than treatment, payment, health care information and certain other activities for the last six years but not before April 14, 2003. Additional reasonable cost-based fees may be extended if your requests for such information are more than one time per year.

**RESTRICTIONS:** You may request we apply additional restrictions to any disclosure of your health care information. We are not required to respond to the application of these additional restrictions. If we agree to follow your request regarding additional restrictions, we will follow the agreed restrictions unless an emergency situation dictates otherwise.

**ALTERNATIVE COMMUNICATION:** Your rights include the instruction to request how you are communicated to regarding your protected health information. Your request must be in writing and can spell out other ways or other locations regarding your protected health information communication. You must identify agreed upon explanations of payment arrangements under alternative communications.

**AMENDMENT:** You can initiate a written request to amend your protected health information. Included in the amendment must be an explanation why information should be amended. Certain conditions may exist where we may reject your request.

**ELECTRONIC NOTICE:** If you receive a notice electronically, you are entitled to receive the notice in writing as well.

## QUESTIONS AND COMPLAINTS

More information is available to you regarding our privacy policies. Please contact us.

If at any time you are unsure or concerned that your protected health information has not been protected or if you believe an error was made in the decision we made about accessing your protected health information; or in the response to a request you made to amend the use or disclosure of your protected health information; or to have us communicate to you by an alternative means or at an alternative location, you have the right to bring the issue forward. You may make a 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 at your request.

Privacy of your protected health information remains extremely important; we are committed to ensure your privacy. If you file a concern with the U.S. Department of Health and Human Services, we will not retaliate in any way. We are available to assist you with any questions, concerns or complaints.

**CONTACT PERSON'S NAME:** Chad Matchett, D.D.S.

**TELEPHONE:** 317-894-8370

**FAX:** 317-894-8370

**EMAIL:** info@indysmiles.org

**ADDRESS:** 11710 E. Prospect Street

**CITY, STATE, ZIP:** Indianapolis, IN 46239