

CHILDREN'S DENTISTRY

EDWARD M. MATSUISHI, D.D.S., INC

7001 Stockton Avenue, El Cerrito, CA 94530 Telephone (510) 524-4633

PATIENT INFORMATION

Patients Name _____
Last First Middle
Address _____
Street City State Zip
Whom may we thank for referring you to our office? _____

RESPONSIBLE PARTY INFORMATION

Parent Guardian _____
Last First M Marital Status
Residence _____
Street City State Zip
Mailing Address _____
Street City State Zip
How long at this address? _____ Home Phone _____ Work Phone _____ Cell/Pgr _____
Previous Address (if less than 3 yrs.) _____
Street City State Zip
Email Address _____
Social Security # _____ Birthdate ____/____/____ Relationship to Patient _____
Employer _____ Occupation _____ No. Years Employed _____
Spouse's Name _____ Relationship to Patient _____
Last First M
Email Address _____
Employer _____ Occupation _____ No. Years Employed _____
Social Security # _____ Birthdate ____/____/____ Work Phone _____ Cell/Pgr _____
Who does child reside with? _____

Dental Insurance Information

Insured's Name _____ Insured's Soc. Sec. # _____
Insurance Company _____ Group No. _____
Insurance Co. Address _____ Phone No. _____
Do you have dual coverage? Yes or No If yes:
Insured's Name _____ Insured's Soc. Sec. # _____
Insurance Company _____ Group No. _____
Insurance Co. Address _____ Phone No. _____
Assignment of Benefits: I hereby authorize payment directly to Dr. Edward Matsuishi the dental benefits otherwise payable to me but not to exceed the charges shown on any claim. I understand that I am financially responsible for any charges not covered by this authorization. I authorize release of any information relating to any claim.
Signature _____ Date _____

Emergency Information

Name of nearest relative not living with you _____
Complete Address _____ Phone No. _____

I GIVE MY PERMISSION TO DR. EDWARD MATSUISHI, TO RENDER ALL NECESSARY DENTAL SERVICES, including diagnostic X-rays, medication and anesthetics as he sees fit.

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____ Date _____

Office use only:
UPDATES _____

CHILDREN'S DENTISTRY

EDWARD M. MATSUISHI, D.D.S., INC

7001 Stockton Avenue, El Cerrito, CA 94530 Telephone (510) 524-4633

GETTING TO KNOW YOUR CHILD

Please fill out this form completely. This information will allow us to better understand your child and provide quality dental care.

Child's Name _____ Nickname _____
First Last Middle

Sex: Female / Male Age _____ Birthdate _____

What is the reason for this visit? _____

Is this your child's first dental visit? _____ Date of last visit _____ Purpose _____

What is your child's attitude toward previous dental care? _____

Have we seen other children in your family? _____

Name(s) and age(s) of brother(s) and sister(s) _____

Name of child's pet _____ Child's interests _____

Name of family dentist _____ Child's previous dentist _____

HEALTH HISTORY

Child's Pediatrician _____ Phone number _____

Date of last physical exam _____ Is your child under a doctor's care now? _____

For what reason? _____ Kaiser Medical # _____

Is your child taking any medications? _____ What Kind? _____

Have your child ever been hospitalized? _____ For what reason _____

Is your child allergic to any medications? _____ Please list _____

_____ Reaction _____

Does your child have any allergic reactions to food _____ What Kind? _____ animals _____ pollen _____ dust _____

Does your child have good physical coordination? _____ Has your child received all immunizations? _____

Has your child taken fluoride? _____ In what form and when? _____

Does your child brush regularly? _____ Does an adult assist with brushing? _____

Does your child use dental floss? _____ Does an adult assist with flossing? _____

Has either parent or child been treated orthodontically? _____

How would you expect your child to behave in our office? _____

Has your child had a history of or difficulty with:

| YES | NO | | YES | NO | |
|-------|-------|------------------------|-------|-------|------------------------|
| _____ | _____ | Premature birth | _____ | _____ | Speech disorder |
| _____ | _____ | First year of life | _____ | _____ | Hearing |
| _____ | _____ | Heart | _____ | _____ | Gag Reflex |
| _____ | _____ | Brain Injury | _____ | _____ | Bladder |
| _____ | _____ | Bruising | _____ | _____ | Seizures |
| _____ | _____ | Cancer or malignancies | _____ | _____ | Fainting or dizziness |
| _____ | _____ | Diabetes | _____ | _____ | Nosebleeds |
| _____ | _____ | Hepatitis | _____ | _____ | Asthma |
| _____ | _____ | Earaches | _____ | _____ | Liver |
| _____ | _____ | Kidney | _____ | _____ | Bone disorder |
| _____ | _____ | Cerebral Palsy | _____ | _____ | Rheumatic fever |
| _____ | _____ | Kidney | _____ | _____ | Developmental problems |
| _____ | _____ | Anemia | _____ | _____ | Other _____ |
| _____ | _____ | Motion Sickness | | | |

COMMENTS/DETAILS _____

Does your child have any phobias? _____ Any emotional or school problems? _____

How would you describe your child's learning: slow _____ average _____ accelerated _____

Was your child bottle fed? _____ breast fed? _____ Until what age _____

Does your child have any oral habits, such as: finger/thumb sucking _____ pacifier _____ nail biting _____

Lip sucking _____ mouth breathing _____ other _____

Has your child ever had any injuries to his/her teeth, mouth or head? _____

If so, please describe _____

Describe your child: outgoing _____ shy _____ stubborn _____ anxious _____ frightened _____ regular kid _____

Date _____ Signature _____

| |
|-----------------------------------|
| Office use only: UPDATES _____ |
|-----------------------------------|

Thank you for completing this detailed information so that we may become better acquainted with your child.

CHILDREN'S

DENTISTRY

EDWARD M. MATSUISHI, D.D.S., INC.

INFANT ORAL HEALTH RISK ASSESSMENT

Patient Name: _____

DOB: _____

Date: _____

HEALTH HISTORY

| | YES | NO |
|---|-----|----|
| Did birthmother have any problems during pregnancy? | | |
| Was child premature? | | |
| Was child's birth weight low? | | |
| Were there any complications at birth? | | |
| Has your infant been ill? | | |
| Is your child on any medications? | | |

DIET AND NUTRITION

| | | |
|--------------------------------------|--|--|
| Is/was your child breastfed? | | |
| Does your child sleep with a bottle? | | |
| Does your child drink from a cup? | | |
| Is your child on a special diet? | | |

FLUORIDE ADEQUACY

| | | |
|--|--|--|
| Do you know the fluoride level of your water? | | |
| Do you have well water? | | |
| If yes, has the water been tested? | | |
| Do you use bottled water? | | |
| Do you use a water conditioner or filtration system? | | |
| If yes, please list: | | |
| Do you use fluoridated toothpaste for your child? | | |

ORAL HABITS

| | | |
|---|--|--|
| Does your child use a pacifier? | | |
| Does your child suck a thumb or fingers? | | |
| Does your child grind teeth day or night? | | |

INJURY PREVENTION

| | | |
|---|--|--|
| Is your child walking? | | |
| Is your home childproofed? | | |
| Do you use a car seat for your child? | | |
| Has your child had an oral/facial injury? | | |

ORAL DEVELOPMENT

| | | |
|---|--|--|
| Does your child have any teeth? | | |
| If yes, child's age (in months) when first tooth erupted: | | |
| Has your child experienced teething problems? | | |
| Have you noticed any oral problems in your child? | | |

ORAL HYGIENE

| | | |
|--|--|--|
| Do you clean your child's teeth/gums? | | |
| Do you use a toothbrush to clean your child's teeth? | | |
| Do you use toothpaste to clean your child's teeth? | | |

CHILDREN'S DENTISTRY

EDWARD M. MATSUISHI, D.D.S., INC

7001 Stockton Avenue, El Cerrito, CA 94530 Telephone (510) 524-4633

This worksheet is designed to help identify your concerns to assure a positive dental visit when your family meets with us. Please feel free to use it in any way which is helpful, and bring it with you when you come to meet us. Thanks!

What prompted you to phone our office?

What do you hope to accomplish from your meeting with us?

What things, from previous dental experience, would you like to find in our office?

What experiences would you hope to avoid or eliminate?

Are there any problems, issues, or challenges you'd like us to help you with? Please explain.

How may we help to make this visit a positive experience for your child?

Notice of Privacy Practices

OUR LEGAL DUTY

We are required by federal and state law to maintain the privacy of your child's health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your child's health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003 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 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. 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 listed at the end of this Notice.

Uses and disclosures of Health Information

We use and disclose health information about your child for treatment, payment, and health care operations. For example:

Treatment: We may use or disclose your child's health information to another healthcare provider providing treatment to your child.

Payment: We may use and disclose your child's health information to obtain payment for services we provide to your child.

Healthcare Operations: We may use and disclose your child's health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of health-care professionals, evaluating practitioners and provider performance, conducting training programs, accreditations, certification, licensing or credentialing activities.

Incidental Disclosure: In order to create a relaxed atmosphere for your child, we work in an open environment, therefore, there may be occasional, incidental information disclosed to persons transiting the area.

Your Authorizations: In addition to your use of your child's health information for your treatment, payment or healthcare operations, you may give us written authorization to use your child'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.

To Your Family and Friends: We must disclose your child's health information to you as described in the Patient Rights section of this Notice. We may disclose your child's health information to a family member, friend, or other person to the extent necessary to help with your child's healthcare or with payment for your child's healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may 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 child's care, of your child's location, your child's general condition, or death. If you are present, then prior to use or disclosure of your child'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 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 child's healthcare. We will also use our professional judgment and our experience with our common practice to make reasonable inferences of your child's best interest in allowing a person to pick up files, prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services

We will not use your child's health information for marketing without your written authorization.

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

Abuse or neglect: We may disclose your child's health information to appropriate authorities if we reasonably believe that your child is a possible victim of abuse, neglect or the possible victim of other crimes. We may disclose your child's information to the extent necessary to avert a serious threat to their health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of armed forces personnel under certain circumstances. We may disclose to authorized federal officials health information required of lawful intelligence, counter intelligence, and other national security activities. We may disclose to correctional institution or the law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders We may use or disclose your child's health information to provide you with appointment reminders (such as voice mail messages, postcard, or letters.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclose your health information for purposes, other than treatment, payment, health care operations, and certain other activities for the last six years, but not before April 14, 2003. If you request this accounting more than once in a twelve month period, we may charge you a reasonable cost based

fee for responding to these additional requests.

Access: You have the right to look at or get copies of your child's health information, with limited exceptions. You may request that we provide copies in a format other than photo copies in a format other than photo copies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this notice. 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 at the end of this notice. If you request copies, we reserve the right to charge you \$0.10 for each page \$1.00 for each sheet of x-rays duplicated, 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 your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Restrictions: you have the right to request that we place additional restrictions on our use or disclosure of your child's health information. We are not required to agree to those 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 your child's health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative mean or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendments: You have the right to request that we amend your child'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: Sally Matsuishi

7001 Stockton Ave.
El Cerrito, Ca. 94530
(510) 524-4633

In order to comply with the privacy notification requirements of the Health Insurance Portability and Accountability Act we are providing you with a copy of our privacy practices

I, _____ the parent / legal guardian
(circle one)

Of _____

acknowledge I have received, from Dr. Matsuishi, a copy of their privacy practice.

Date _____ Signature _____

CHILDREN'S

DENTISTRY

EDWARD M. MATSUISHI, D.D.S., INC.

7001 Stockton Avenue El Cerrito, CA 94530 (510) 524-4633

