Registration – Children

Child's Name:	DOB:
Child's Name:	DOB:
Child's Name:	DOB:
Child's Name:	DOB:
Child's Name:	DOB:
Child's Name:	DOB:
Child's Home Address:	
City: **State:**	**Zip:**

Father's Name:		DOB:	SS#:
Home Address:			
City:	State: Zip:	Email:	
Home #:	Work #:		Cell #:
Employer:	Dental Ins. Co. Name:		
Claim Mailing Address:			
Ins. Co. Phone #:	Group#:	Member ID#:	

Mother's Name:		DOB:	SS#:
Home Address:			
City:	State: Zip:	Email:	
Home #:	Work #:		Cell #:
Employer:	Dental Ins. Co. Name:		
Claim Mailing Address:			
Ins. Co. Phone #:	Group#:	Member ID#:	

Please be advised that our office is OUT-OF-NETWORK with all insurance companies. Dr. Kacher does not participate in any PPO, DMO or HMO plans. Therefore, any benefits used in our office will be considered out-of-network with your insurance company.

As a courtesy to you, our office will bill your insurance carrier. We will collect an estimated co-payment from you on the day of your child's treatment. In any event that your insurance company does not pay for the balance of procedures performed, you are ultimately responsible for your account balance within 60 days from any treatment.

______________________________________ ______________________

Parent or Guardian Name/Signature **Date**

Health History – Children

Child's Name:	**Child's DOB:**
Child's **Physician** Name:	Physician's Phone#:
Is your child in good health? YES NO	
Is your child seen routinely by a physician? YES NO	
If YES, why?	

Name of person who referred you to our office:				
Dentist	Physician	Friend	Internet	Other:

Does your child have a health history of any of the following?		
Seizures	Rheumatic Fever	Developmental Delays
Blood Disorder	Allergies	Tuberculosis
Cerebral Palsy	Diabetes	Asthma
Heart Trouble	Kidney Disorders	Liver Disorders
Other:		

Is your child taking medicine? YES NO
If yes, what medication and why?

Has your child ever had any negative reactions or allergies to any drugs, including anesthetics? YES NO
If yes, please list medication(s) and reaction(s):

Does your child have a history of?	YES	NO	CURRENTLY
Thumb sucking			
Finger sucking			
Prolonged breast or bottle feeding			
Pacifier past age 2			

What is the chief purpose/concern of today's dental visit?
Is your child in pain now? YES NO
Has your child had any previous dental treatment? YES NO
If yes, please list:
Has your child had any negative dental/medical experiences? YES NO
If yes, please explain:

PARENT OR GUARDIAN NAME/SIGNATURE **DATE**

General Informed Consent to Perform Dentistry

1. I hereby authorize and direct the dentist(s) of Kacher Dentistry and/or dental auxiliaries of their choice, to perform the following dental treatment or oral surgery procedures(s) including the use of any necessary or advisable local anesthesia, radiographs (X-rays), or diagnostic aids:
   A. Preventive hygiene treatment (prophylaxis) and application of topical fluoride.
   B. Application of sealants to the grooves of the teeth.
   C. Treatment of diseased or injured teeth with dental restorations (fillings & crowns).
   D. Replacement of missing teeth with dental prostheses (fixed bridges, implants, removable partials or dentures).
   E. Removal (extraction) of one or more teeth.
   F. Use of sedative drugs to control apprehension.

2. I understand that there are risks involved in any treatment and hereby acknowledge that these risks will be explained to me and that I will have an opportunity to ask questions regarding the treatment and the risks and that I fully understand the same.

3. I agree to the use of local anesthesia and the use of nitrous oxide/oxygen analgesia depending on the judgment of the doctor(s). Nitrous oxide/oxygen may occasionally produce nausea and vomiting. I am also aware that the nosepiece can leave a small indentation or ring around the nose which disappears shortly after the procedure. I understand and have been informed of the above risks and complications.

4. I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request the performance of any additional procedures that are deemed necessary to oral health and well being in the professional judgment of the dentist(s).

5. There are possible risks and complications associated with the administration of local anesthesia, sedation and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, tingling and numbness of the lip and cheek biting resulting in ulceration and infection of the mucosa. I also understand that either are rare potential risks such as unfavorable reactions to medications in respiratory and cardiovascular collapse (stopping of breathing and heart function) and lack of oxygen to the brain that could result in coma or death. I understand and have been informed of the above risks and complications.

6. I also authorize the doctor(s) to use photographs, radiographs and other diagnostic materials and treatment records for the purposes of teaching, research and scientific publications.

7. I will be advised that the success of the dental treatment to be provided will require that the patient or/and the legal guardian(s) follow post-operative and post-care instructions of the dentist(s). I agree that the success of the treatment requires that all post-operative and post-care instructions be followed and that regular office visits as scheduled by my dentist and his auxiliaries must be maintained.

8. I hereby state that I have read and understand this consent and all questions about the procedures will be answered in a satisfactory manner, and I understand that I have the right to be provided answers to questions which may arise during and after the course of my treatment.

9. I further understand that this consent will remain in effect until such time that I choose to terminate it.

PATIENT NAME____**PARENT OR GUARDIAN NAME**______________________________________
SIGNATURE OF PATIENT/PARENT/GUARDIAN__________________________________**RELATIONSHIP TO PATIENT**_________________________
WITNESSED BY____**DATE**___________________________**TIME**___________________________

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.

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 takes effect (04/14/03) and will remain in effect 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 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 us using the information listed at the end of this Notice.

USES AND DISCLOSURES 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: We may use and disclose your health information to obtain payment for services we provide to 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 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 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 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 a written authorization, we cannot use or disclose your health information for any reason except those described in this 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 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 healthcare. We will also use our professional judgment and our experience with common practice 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 health 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 a serious threat to your 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 for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

APPOINTMENT REMINDERS: We may use or disclose your 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 your 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 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 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.)

DISCLOSURE ACCOUNTING: You have the right to receive a list of instances in which we or our business associates disclosed your 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 that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional requests, 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 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 of location you request.

AMENDMENT: You have the right to request that we amend your 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.

ELECTRONIC NOTICE: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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 your health information or in response to a request you made to amend or restrict the use of disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end 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.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Dr. John Kacher Telephone: 281-292-1605 Fax: 281-292-7372 E-mail: mail@kacherdentistry.com

Address: 4223 Research Forest Dr., Ste. 500 The Woodlands, TX 77381

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Kacher Dentistry

✧You May Refuse to Sign This Acknowledgment✧

I, ________________________, have reviewed/received a copy of this office's Notice of Privacy Practices.
(*print PATIENT name)*

____
Please Print PATIENT Name

____
Signature of Patient or Guardian ***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 acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify)

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