Kathleen Ellsworth DDS PC

www.doctorkat.com

60 N. Bridge Street, Saranac, MI 48881

616-642-3500 • Fax 616-642-3600

Welcome!

Thank you for choosing our practice for your dental care. Our goal is to provide quality dentistry in a fun and friendly setting. We will do everything we can to make your dental experience a positive one.

Please fill out the enclosed medical and dental health history forms and bring them to the appointment along with your insurance card and information. We have enclosed a brochure for you with a map and information regarding our practice.

If your child has an appointment, please bring your picture ID. If you are not the legal guardian or custodial parent, please bring any legal documentation necessary (a signed note from the legal guardian or court documents will suffice). Parents must remain in the office while their children are undergoing dental treatment.

If you/your child have any medical conditions requiring pre-medication or antibiotics, please notify us so we may prescribe the appropriate medication before your appointment.

Please feel free to call our office if you have any questions or concerns.

We look forward to meeting you!

Sincerely,

Dr. Kathleen Ellsworth

Dr. Kathleen Ellsworth and Staff
Kathleen Ellsworth, D.D.S., P.C.

Patient Information

Patient Name_____ Phone:(____) _____ DOB _____

Your Name_____ Relationship to Patient_____ Email_____

Address _____City _____ State _____ Zip _____

If Patient is Under age 18, Who Does the Patient Live With? _____

If Patient is Under age 18, Who is the Patient's Legal Guardian? _____

Mother's Information: Name _____ Drivers Lic. # _____

Street Address_____ City _____ State _____ Zip_____

SS # _____ Phone (____)_____ Cell (____) _____

Father's Information: Name _____ Drivers Lic. # _____

Street Address_____ City _____ State _____ Zip_____

SS # _____ Phone (____)_____ Cell (____) _____

Do You Give Consent/Permission to Any Other Person to Accompany Your Minor Child to the Dentist?

*Name of Person_____ Relationship to Minor Patient _____

*Name of Person_____ Relationship to Minor Patient _____

*The above listed may give consent for treatment in the absence of the legal guardian

Emergency Contact:_____ Phone: (____)_____ Relationship _____

Patient's Physician:_____ Phone: (____) _____

Primary Dental Insurance:_____ Employer _____

Subscriber Name _____ Subscriber ID/SS# _____ DOB _____

Subscriber Address_____

Subscriber Phone _____

Secondary Dental Insurance:_____ Employer _____

Subscriber Name _____ Subscriber ID/SS# _____ DOB _____

Subscriber Address_____

Subscriber Phone _____

Coverage and benefits are subject to the provisions and limitations of the plan and are not guaranteed. Copays are an estimate only. Further payment may be required after insurance has been processed.

I give permission to Kathleen Ellsworth DDS PC to provide dental care for myself or minor/child which may include: X-rays, Exam, Prophylaxis, Fluoride Application, and Sealants. If any emergency treatment is required, I will be informed of the procedures before any treatment is rendered. I understand that I must provide 24-48 hours notice if I need to cancel an appointment, and that two or more NO SHOWS/Cancel PER FAMILY without 24 hour notice will result in dismissal. There is a $25 charge per NO SHOW or cancel without 24 hours notice. I agree to abide by all policies as stated in the office brochure that I received. I will pay any copay or uninsured portion of my balance at the time of service. I understand there is a 2% monthly service charge on all balances.

_____ _____ _____

Signature of Mother (Parent/Guardian) Signature of Father (Parent/Guardian) Date

(I certify that I am the Legal Guardian or Custodial Parent of the Above Listed Minor Patient)

All balances overdue 90 days will be sent to a collection agency.

Kathleen Ellsworth DDS PC

Kids Love Us. Parents Trust Us.

❑ Yes ❑ No Congenital Heart Defects*

❑ Yes ❑ No Rheumatic Fever*

❑ Yes ❑ No Heart Murmur*

❑ Yes ❑ No Heart Valve Damage*

❑ Yes ❑ No Mitral Valve Prolapse*

❑ Yes ❑ No Heart Arrythmias/ Rapid or Slow Heart Beat

❑ Yes ❑ No Pacemaker

❑ Yes ❑ No Heart Surgeries Type/Date _____

❑ Yes ❑ No Heart Disease

❑ Yes ❑ No Heart Attack Date_____

❑ Yes ❑ No Stroke Date_____

❑ Yes ❑ No Diabetes Type_____

❑ Yes ❑ No Any Syndromes or Diseases? Please List

_____

❑ Yes ❑ No Any Form of Cancer Type_____

❑ Yes ❑ No Organ Transplant*

❑ Yes ❑ No Asthma

❑ Yes ❑ No Hay Fever

❑ Yes ❑ No Allergies

❑ Yes ❑ No Sinus Problems

❑ Yes ❑ No Tuberculosis, Emphysema, or Lung Disorder

❑ Yes ❑ No Skin Problems Type_____

❑ Yes ❑ No Epilepsy or Seizure Disorder

Last Seizure _____

❑ Yes ❑ No Any Kidney Problems or Disease

❑ Yes ❑ No Any Mental Health Issues

Type/Diagnosis_____

❑ Yes ❑ No Depression

❑ Yes ❑ No Bipolar Disorder

❑ Yes ❑ No Manic Depression

❑ Yes ❑ No Autism

❑ Yes ❑ No OCD

❑ Yes ❑ No Cerebral Palsy

❑ Yes ❑ No Schizophrenia

❑ Yes ❑ No ADD

❑ Yes ❑ No ADHD

❑ Yes ❑ No ODD

❑ Yes ❑ No Bone Marrow Transplant

❑ Yes ❑ No Disease of Bones

❑ Yes ❑ No Hepatitis Type____

❑ Yes ❑ No Hemophilia Type_____

❑ Yes ❑ No Jaundice

❑ Yes ❑ No Liver Problems

❑ Yes ❑ No Allergic Reaction to:

LATEX Dental Anesthesia General Anesthesia

Nitrous Oxide Sedative Drugs Food _____

❑ Yes ❑ No High Blood Pressure

❑ Yes ❑ No Low Blood Pressure

❑ Yes ❑ No Joint Replacement* Date_____

❑ Yes ❑ No VSD*

❑ Yes ❑ No Heart Transplant*

❑ Yes ❑ No Artificial Joints/Joint Surgery*

❑ Yes ❑ No Compromised Immune System*

❑ Yes ❑ No AIDS/HIV*

Medications, please list:

_____

_____

Has the patient ever been hospitalized or had any surgery? Explain.

_____

_____

What is the patients chief concern regarding their teeth/mouth?

_____

_____

Does the Patient Drink ANY of the Following Products Between Meals? (please circle)

Juice Pop/Soda Kool-Aid Milk Soy Water Coffee/Tea Lemonade Sweet Drinks

Effective date of notice: August 1,2005

NOTICE OF PRIVACY PRACTICES

Kathleen Ellsworth, D.D.S., P.C.
60 N. Bridge Street
Saranac, Mi 48881
(616) 642-3500
(616) 642-3600
Office Contact: Robin

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons we usually will not ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;

- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- Iincidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

- The law gives you many rights regarding your health information. You can:
- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address,.We will

accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to

us, send a written complaint to the office contact person at the address or fax shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

I acknowledge that I fully understand Dr. Ellsworth's Notice of Privacy Practices.

Signature & Date: