gorinOrthodontics

Salud Infantil/Formulario para la Historia Dental

American Dental Association
www.ada.org

Nombre del Paciente	Apodo	Fecha de Nacimiento
Nombre del Padre/Madre/Encargado	Parentesco/Relación con el Paciente	

Dirección
DIRECCIÓN POSTAL CIUDAD ESTADO CÓDIGO POSTAL

Teléfono
Casa Trabajo

Sexo M ❑ F ❑

¿Ha tenido usted (padre/ madre/ encargado) o el paciente alguna de estas enfermedades o problemas? ..... ❑ Sí ❑ No
1. Tuberculosis activa, 2. Tos persistente que ha durado más de tres semanas, 3. Tos que produce sangre?
Si su respuesta es Sí a cualquiera de estos tres problemas, deténgase por favor y devuelva este formulario a la recepcionista.

Ha tenido el niño un historial médico, o condiciones relacionadas con lo que sigue?

❑ Anemia	❑ Cáncer	❑ Desmayos	❑ Inmunizaciones (Vacunas)	❑ Embarazo (adolescencia)	❑ Tuberculosis
❑ Artritis	❑ Parálisis Cerebral	❑ Alteraciones del crecimiento	❑ Riñones	❑ Fiebre reumática	❑ Enfermedades venéreas
❑ Asma	❑ Varicela		❑ Alergia al látex	❑ Ataques epilépticos	❑ Otras _____
❑ Vejiga	❑ Sinusitis Crónica	❑ Oído	❑ Hígado	❑ Anemia drepanocítica (drepanocitosis)	
❑ Alteraciones Hemorrágicas	❑ Diabetes	❑ Corazón	❑ Sarampión		
	❑ Dolor de oídos	❑ Hepatitis	❑ Mononucleosis	❑ Tiroides	
❑ Huesos/Articulaciones	❑ Epilepsia	❑ VIH +/SIDA	❑ Paperas (parotiditis)	❑ Uso de tabaco/ drogas	

Por favor anote el nombre y el número de teléfono del médico del niño:

Nombre del Médico _____ Teléfono _____

Historia del Niño

		Sí	No
1.	¿Está el niño tomando algún remedio recetado y/o no recetado o suplementos vitamínicos en este momento? _____ Si es así, por favor haga una lista: _____	❑	❑
2.	¿Es el niño alérgico a algunos remedios, i.e. penicilina, antibióticos o a otros fármacos? Si es así, explique for favor: _____	❑	❑
3.	¿Es el niño alérgico a alguna otra cosa, como ciertos alimentos? Si es así, explique for favor _____	❑	❑
4.	Cómo describiría los hábitos alimentarios del niño? _____		
5.	¿Ha tenido el niño una enfermedad grave alguna vez? Si es así, ¿cuándo?: _____ Descríbala por favor: _____	❑	❑
6.	¿Ha sido el niño hospitalizado alguna vez?	❑	❑
7.	¿Tiene el niño un historial clínico por alguna otra enfermedad? Si es así, haga una lista por favor: _____	❑	❑
8.	¿Ha recibido el niño alguna vez un anestésico general?	❑	❑
9.	¿Tiene el niño alguna condición hereditaria?	❑	❑
10.	¿Tiene el niño algún defecto del habla?	❑	❑
11.	¿Ha tenido el niño alguna vez una transfusión sanguínea?	❑	❑
12.	¿Tiene el niño alguna minusvalía física, mental o emocional?	❑	❑
13.	¿Sufre el niño un sangramiento excesivo cuando se corta?	❑	❑
14.	¿Está el niño recibiendo tratamiento por alguna enfermedad actualmente?	❑	❑
15.	¿Es esta la primera visita al dentista del niño? Si no es así, ¿cuál fué la fecha de su última visita al dentista? Fecha: _____	❑	❑
16.	¿Ha tenido el niño algún problema con un tratamiento dental en el pasado?	❑	❑
17.	¿Le han tomado al niño una radiografía (rayos X) alguna vez?	❑	❑
18.	¿Ha sufrido el niño alguna vez lesiones en la boca, en la cabeza o en los dientes?	❑	❑
19.	¿Ha tenido el niño algún problema con la erupción o con el recambio de dientes?	❑	❑
20.	¿Ha tenido el niño algún tratamiento de ortodoncia?	❑	❑
21.	**¿Qué tipo de agua bebe su niño? ❑ Agua doméstica ❑ Agua de pozo ❑ Agua embotellada ❑ Agua filtrada**		
22.	**¿Toma el niño suplementos fluorados?**	❑	❑
23.	**¿Usa dentífricos fluorados?**	❑	❑
24.	¿Cuántas veces al día se cepillan los dientes del niño? _____ ¿A qué horas se cepillan los dientes del niño? _____	❑	❑
25.	¿Se chupa el niño/a su dedo pulgar, otros dedos o un chupete?	❑	❑
26.	¿A qué edad dejó el niño de usar el biberón? Edad _____ ¿La lactancia materna? Edad		
27.	¿Participa el niño en actividades recreativas enérgicas?	❑	❑

NOTA: Se encarece tanto al doctor como al paciente que discutan detalladamente todos los aspectos relevantes de la salud del paciente antes de empezar el tratamiento. Certifico que he leído y comprendido lo que aparece más arriba. Reconozco que todas mis dudas sobre las preguntas de este formulario han sido respondidas satisfactoriamente. Yo no responsabilizaré a mi dentista ni a ningún otro miembro de su personal por las medidas que puedan tomar debido a los errores o a las omisiones que yo haya podido cometer al completar este formulario.

Firma del Paciente/ Apoderado _____ Fecha _____

A ser completado por el odontólogo/a

Comentarios _____

Sólo Para Uso de la Oficina: ❑ Alerta Médica ❑ Premedicación ❑ Alergias ❑ Anestesia Revisado por _____

Fecha _____

Formulario S503

Para pedir más copias llame al 1-800-947-4746
o pídalos online en el sitio web www.adacatalog.org

gorinOrthodontics

Your Information. Your Rights. Our Responsibilities.

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.**

Patient's name:

_____

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C.

20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice ("Your Information. Your Rights. Our Responsibilities")

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Other Instructions for Notice

- We never market or sell our patients personal information.
- We will never share any substance abuse treatment records without your written permission.
- Dr. Neil Gorin is the privacy official at the office. Complaints or questions should be communicated with Dr. Neil Gorin. Dr. Gorin's contact information is: drgorin@gorinortho.com 718-436-5175

I have read this notice and have been given the opportunity to ask questions regarding how my medical information may be used and how I may get access to it.

Effective date of this notice

_____

Patient, Parent, or Legal Guardian

Name:

_____

Signature:

_____