Milestone Dental Clinic – Medical Information

Do not leave blanks; circle yes or no; list details; page 1/2

Date: _______________ **Patient Name:** _________________________________ **M / F** ______________ **Age**: __________ **DOB**: ____________
Height (ft' in"): ____ **Weight (lbs):** ______________________ **Self Guardian:** yes / no

Developmental Disability/Condition/Genetic Syndrome: yes / no; if yes, list diagnosis…
Diagnosis:

Behavior Challenges: yes / no
Details:

Physical Challenges: yes / no ; if yes, list challenge
Visual: **Hearing:**
Communication: **Movement:**

Breathing Trouble: yes / no
Asthma/COPD/Emphysema / Hx of Pneumonia
Inhaler/Inhaler w/ spacer / Nebulizer Tx/ Portable Oxygen
Tracheotomy/Ventilator / APNEA
Other:

Swallowing Trouble (GI): yes / no
Dysphagia / Aspiration / Silent Aspiration
Aspiration Pneumonia / Feeding Tube / NPO
Thickened Liquids / GERD / Sensitive Gag Reflex
Vomiting / -Ostomy Pouch / Swallow Study / Other:

Allergies: ***if yes, list below***
Drug Allergies: yes/no list allergies:
Other Allergy: yes/no list allergies:
Food Allergies: yes / no list allergies:
EPI PEN: yes/no

Antibiotic Premedication: yes/no ***if yes, list Rx:*** ____

Heart: yes / no ***if yes, attach, list, etc.***
Heart Defect / Artificial Valve / CHF (NYHA cl 3 or 4) — if defect, type: repair date:
Heart Attack / Angina (stable, unstable) — if MI, list date:
Arrhythmia / Prolonged QT Syndrome / Other — type:
Tachycardia/Bradycardia/Hypertension/Hypotension — if tachycardia, SVT or PSVT: yes/no Ablation: yes/no
ICD, pacemaker
Other:

Brain: yes / no
Seizure Disorder Type: ____________ Frequency: _______ Duration: ________ Last Seizure: _____________
VNS implant-magnet / Ketogenic Diet / Shunt (VA, VC, VV, VP)
Stroke (CVA / TIA) date:
Other:

Specific Medical: yes / no ***if yes, attach, list, etc.***
Diabetes (1 or 2) Type: **attach HbA1c**
Hypothyroid/Hyperthyroid controlled: yes/no
Autoimmune Disease type:
Kidney Disease/ Transplant type: **attach CBC, GFR,Creatinine** **Dialysis**: yes/no; days: _______
Liver Disease/ Transplant type: **attach CBC, PT/INR, AST, ALT**
Blood Disorder(s) type: **attach CBC**
HIV/AIDS date of dx: **attach CBC, CD4**
MRSA/TB date of tx: resolved: yes/no
Cancer (type: _____________) date of dx: location: tx type: __remission:yes/no
Artificial Joint type:
Tobacco/ Substance Abuse type: #per day: # of years:
Pregnant trimester:
Other:

Specific Medications: yes / no
Blood Thinners if yes, (Plavix, Coumadin (warfarin)) **attach PT /INR, CBC (within 2 weeks)**
Bisphosphonates / Non-bisphos. if yes, (oral or IV) O. Surgery consent needed
Non-selective Beta / Alpha Blockers
TCA's / Anti-psychotics / ADHD
Other:

Attached Medication List (may be MAR / POS): yes / no
Hospitalizations within the last 10 years: yes / no
Attached updated Contact / Insurance Information as needed: yes / no
if yes, Attached Hospital Discharge Report(s): yes / no
Person filling out this form: **Print Name:** ____________________________ **Initial:** ________________ **Date:** ________________
(DrM, 12-14-17)

Milestone Dental Clinic

Do not leave blanks; page 2/2

Patient Information

Date:________________Patient'sName:______________________________DOB:_______________SocialSecurity#_____________

Address:____Phone:____

Ethnicity:______________________________ County:______________________________ Zip Code:_________________________

Guardian Information

Legal Guardian / Guarantor Name:___________________________________Phone:______________2nd Phone:________________

Address:____FAX:________________EMAIL:___________________

Relationship to the patient:____

Agency Information: (Please indicate ICF/DD or CILA with a checkmark)ICF/DD:___________________CILA:___________________

Care Agency Name:____Phone:______________2nd Phone:_________________

Address: ____FAX:________________EMAIL:___________________

Zip Code:____________________

Case Manager Name: ____Phone:______________Extension:_________________

FAX: _________________EMAIL:__________________

Contact Person Name:____Phone:______________Extension:________________

FAX: _________________EMAIL:________________

Insurance Information:

MEDICAID (dental coverage): Yes / No ID#:_________________________

Private Dental Insurance Carrier Name:______________________________PPO / HMO / Other:______________________________

Name of Subscriber:____ DOB (of subscriber):__________ID / SSN:____________

Group #:____Phone (for benefit verification):___________________

Doctor Information:

Primary Care Physician Name:_____________________________________Phone:_______________2nd Phone:________________

Address:____FAX:_________________EMAIL:__________________

Zip Code:_________________________

MEDICATIONS (include supplements, herbal medicines etc.)- attach Medication List if more space is needed

Medication Name	Dose	Time Given	Used For

See Attached MAR / POS Sheet for Medication List: Yes / No

1.
2.
3.
4.
5.
6.
7.
8.
9.

ATTACHED COPY CHECKLIST:

Patient's Yearly Physical Exam (within 12 months):	Yes / No
MAR / POS / Medication List:	Yes / No
Medicaid Card (front and back):	Yes / No / NA
Private Dental Insurance Card (front and back):	Yes / No / NA

TO EVERY APPOINTMENT BRING:

Current Medication List / Emergency Meds

Dental Insurance Card / Medicaid Card

Please return completed forms to:

Milestone Dental Clinic
275 N. Phelps Ave
Rockford, IL 61108
(815)-484-8678
FAX(815)-484-8680

(DrM,12-14-17)

*Failure to complete/bring requested information may result in rescheduling appointment.

Acknowledgment of Privacy Practices and Personnel in Treatment Areas

Milestone Dental Clinic
275 N. Phelps Avenue
Rockford, IL 61108
815-484-8678

PATIENT NAME:________________________________ **DOB:**____________ **AGE:**___________

Privacy Practices:

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- ❑ Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- ❑ Obtain payment from third-party payers for my health care services
- ❑ Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Personnel in Treatment Areas:

It is the policy of Milestone Dental Clinic that patients and dental staff members **only** are allowed in the treatment areas during treatment. The rationale for this policy is that in order to most efficiently, effectively and safely treat our patients a minimum number of trained dental staff members *only* need to be present. Additional people in the treatment areas adds more confusion, inhibits communication between the doctor and patient, creates possible safety issues (OSHA) and does not allow for the confidentiality of other patients in the clinic (HIPPA). Staff members and family members may be present to seat the patient and then will be asked to leave the treatment area when we are ready to begin treatment. If your assistance is needed at any time during treatment, a dental staff member will come to the reception area and get you. The dentist will speak to you before and or after the appointment, if necessary. If you have specific questions for the dentist please let a staff member know. If you choose not to adhere to this policy we will request that you seek dental care elsewhere. If you would like to discuss the policy further please contact the Clinic Administrator. We appreciate your cooperation with this policy.

Name(print): ___________________________________**Signature:**_______________________________________**Date:**_________________________

Relationship to Patient: __________________________

Witness Name(print):_____________________________**Signature:**_______________________________________**Date:**_________________________

Dependent family members also covered by this acknowledgement:

____

____

Z,DrM7-'14

MILESTONE, INC. Dental Clinic
Dental Treatment and Protective Medical Immobilization Consents

PATIENT NAME: ____ **D.O.B.** ____**AGE:** ______________________________

Consent for Dental Treatment /Oral Health Care:
Consent is hereby provided for Milestone Dental Clinic and its professional staff, to provide clinical dental treatment for the above named patient. The scope of dental care may be limited by availability of resources provided by the State of Illinois, and the ability of staff and patient to proceed in a compatible fashion toward acceptable treatment. It is understood that Milestone Dental Clinic will be provided with the patient's complete medical information and that the entire patient's health care information will be safeguarded and protected according to the clinic's "Notice of Privacy Practices" under HIPAA and applicable Illinois State Laws. I hereby authorize the Milestone Dental Clinic and Staff to provide dental/oral health treatment. I understand that any health care treatment, including dental treatment, can result in untoward and unforeseen consequences.* I am aware and understand the potential serious risks of dental procedures.** I hereby consent to the dental care and authorize the appropriate health care professionals at the Milestone Dental Clinic to use their professional judgment in addressing and implementing additional or different procedures deemed necessary for completion of safe care. I consent to the use of any local anesthetic and medications deemed necessary and advisable, by the treating dentist, to successfully complete dental treatment. This local anesthetic will be administered by and supervised by the treating dentist. I certify that I have read, or had read to me, this document and have had an opportunity to review and understand risks, benefits and alternatives for routine dental care; all blanks were filled in before I signed, and that I did understand the nature of this paper at the time I signed. I understand this consent is provided voluntarily and I am legally bound by this.

Dental Disease:
Untreated dental disease leads to pain, infection, loss of teeth and loss of function. In some individuals it may progress to have potentially life threatening consequences.

Dental Treatment:
Dental treatment requires the placement of equipment and surgical instruments in the immediate proximity to delicate human tissues in the mouth as well as the head and neck. Therefore, stable positioning is of utmost importance in order to minimize the risk of adverse effects or injury to oral-facial tissues.

Protective Medical Immobilization:
In providing for each patient's right to safe care, it may be necessary to employ various patient management techniques, including the use of protective stabilization, preoperative and/or intraoperative sedation through the use of Rx Medications and Nitrous Oxide. Recommendations may also be made for intravenous (IV) sedation or general anesthesia in order to provide safe care. These management techniques are designed to help minimize the risk of self-injury to the patient from rapid body movements, grasping or dental instruments, and help to allow for the delivery of dental care.

Milestone Dental Clinic Principals for Provision of Safe Care:
The least restrictive method, which provides for safer delivery of care, shall be chosen by the Dental Professional as the means to provide treatment when absolutely necessary for the individual's protection and for the briefest time possible. Professional judgment may dictate the use of varied methods of protective immobilization for the same individual depending on the proposed treatment for that visit. (i.e. exam vs. oral surgical procedure). The use of protective stabilization, Rx medications, or nitrous oxide is never used without appropriate pain control including local anesthesia. Protective Stabilization, Medications or Nitrous Oxide are not utilized for convenience of dental staff or as a punishment for an uncooperative individual, but used to control aggression and/or destructive behaviors that place the individual or others in danger. Milestone Dental Clinic Protective Stabilization devices are of humane design and present the least physical discomfort for the patient. These include supportive and positioning devices, head stabilization, rainbow wrap, arm, leg bands and mouth prop.

Benefits vs Risks of Protective Medial Stabilization, Medications, Nitrous Oxide, etc.:
The benefit (as stated above) is to allow delivery of safe dental care while minimizing potential injury to individuals who require behavior management techniques. Risks may include but are not limited to: minor physical discomfort, postoperative skin impressions from stabilization devices, tissue trauma from placement of devices, adverse reactions to medications including but not limited to anaphylaxis, paradoxical reactions and/or side effects such as prolonged sedation, etc. Other risks can include but are not limited to *physical injury, allergic and/or anaphylaxis reactions, and possible serious life threatening conditions. I have fully reviewed the risks and benefits of Protective Medical Immobilization, Medications, etc. and **have had any and all of my questions answered, and I understand and am aware of the potential immobilization needed. I understand this consent is valid for **10 years** or as requested.

We advise calling 815-484-8678 to review prior to completion

When able, Milestone Dental Clinic utilizes the least amount or no Medical Immobilization to provide safe care. I understand that if I choose to not allow Medical Immobilization by circling "no", it may not be possible for Milestone Dental Clinic to provide care in a safe manner and may result in delayed or no care.

I agree to the implementation of the following Protective Medical Immobilization(s) as needed: *(Circle Yes or No for #1 -11)*

1. Mouth Prop	Yes No	5. Ankle Wrap	Yes No	9. Head Stabilization	Yes No
2. Rainbow Wrap	Yes No	6. Shoulder Wrap	Yes No	10. Oral Sedation	Yes No
3. Elbow Bands	Yes No	7. Wrist Bands	Yes No	11. Inhalation Sedation (Nitrous Oxide)	Yes No
4. Leg Wrap	Yes No	8. Hand Holding	Yes No		

Guardian Name (print):____**Signature:**____________________________**Date:**_______________

Relationship to Patient: ____

Witness Name (print):____**Signature:**____________________________**Date:**________________

ICF FACILITY USE ONLY:

HUMAN RIGHTS COMMITTEE
The HRC has reviewed and approved the above procedures and has determined that they are the most appropriate, safe, and least restrictive means at this time. App. Consents were also reviewed.

BEHAVIOR MANAGEMENT COMMITTEE
The BMC has reviewed the above procedures for technical adequacy. Any use of medication was also evaluated and deemed appropriate. The BMC approves their use.

HRC Representative:__________________________ **Date:**____________ **BMC Representative:**__________________________ **Date:**________________

AGENCY REPRESENTATIVE WRITTEN APPROVAL: ____ **Date:**________________

DrM 10-'17

NOTICE OF PRIVACY PRACTICES

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.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. For example, we may need to share information with other providers or specialists involved in the continuation of your care.

- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. For example, we disclose treatment information when billing a dental plan for your dental services.

- **Health Care Operations** include the business aspects of running our practice. For example, patient information may be used for training purposes, or quality assessment.

Unless you request otherwise, we may use or disclose health information to a family member, friend, or other personal representative to the extent necessary to help with your healthcare or with payment for your healthcare. In addition, we may use your confidential information to remind you of appointments by sending reminder postcards and/or leaving messages at home and/or work. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your protected health information, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to access, inspect and copy your protected health information.
- The right to request an amendment to your protected health information.
- The right to receive an accounting of disclosures of protected health information outside of treatment, payment and health care operations and outside of disclosures given on the basis of your authorization(s).
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:

Privacy Officer: Chantell Wade, Office Manager
Office Name: Milestone Dental Clinic
Address: 275 N. Phelps Avenue
City, State, Zip: Rockford, IL 61108
Phone: 815-484-8678

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
877-696-6775 (toll-free)