



4728 S. Campbell Ave. Suite 120 • Springfield, MO 65810 • 417-300-9424 • [www.LittleGrinsDental.com](http://www.LittleGrinsDental.com)

### Patient Form Instructions

Our new patient forms allow you to type directly into them. You can also print the forms and fill them out by hand. If you are using the free version of Adobe Reader, you will not be able to save the forms. Here are your options for returning the new patient forms to us:

- **Email:** Once your forms are filled out, you can print the forms, sign them and then email them back to us at [office@littlegrinsdental.com](mailto:office@littlegrinsdental.com)
- **Fax:** Once your forms are filled out, you can print the forms, sign them and then fax them to us at [855-673-2198](tel:855-673-2198)
- **Mail:** Once your forms are filled out, you can print the forms, sign them and then mail them to:

Little Grins Dental  
4728 S. Campbell Suite 120  
Springfield, MO 65810

- **Hand Deliver:** You can drop completed forms by our office anytime in advance of your appointment, or you can bring them with you on your appointment day. (Dropping them off in advance will save you time on the day of your appointment as you will not have to wait for us to enter your information into our system.) Our office hours are 8am to 5pm Tuesday through Friday.



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### Patient Registration

Child's First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Child's SSN: \_\_\_\_\_

Child's Gender:  Male  Female Age: \_\_\_\_\_ Child's Date of Birth: \_\_\_\_\_

Reason for seeking dental care?  Routine check-up  Toothache  Cavities  First Dental Visit  
 Other: \_\_\_\_\_

**Responsible Party**  Responsible Party is also the Primary Insurance Holder  
 Responsible Party is also the Secondary Insurance Holder

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cellular Phone: \_\_\_\_\_  I would like to receive Text Message Appt. Reminders

E-mail: \_\_\_\_\_  I would like to receive e-mail correspondence

### Primary Dental Insurance

Policy Holder's First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Policy Holder's Date of Birth: \_\_\_\_\_ Policy Holder's SSN: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer Phone #: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Ins. Company: \_\_\_\_\_ Ins. Co. Phone #: \_\_\_\_\_

Ins. Group #: \_\_\_\_\_ Member ID #: \_\_\_\_\_

### Secondary Dental Insurance

Policy Holder's First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Policy Holder's Date of Birth: \_\_\_\_\_ Policy Holder's SSN: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer Phone #: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Ins. Company: \_\_\_\_\_ Ins. Co. Phone #: \_\_\_\_\_

Ins. Group #: \_\_\_\_\_ Member ID #: \_\_\_\_\_

## Medical History

Primary Care Provider (Medical Doctor): \_\_\_\_\_ Phone: \_\_\_\_\_

Previous Dentist: \_\_\_\_\_ Referring Doctor: \_\_\_\_\_

Is your child presently under the care of a physician for any medical condition?  Yes  No  Unknown

If yes, please explain: \_\_\_\_\_

Has your child ever had a serious illness or operation?  Yes  No  Unknown

If yes, please explain: \_\_\_\_\_

Is your child currently taking any medications?  Yes  No  Unknown

If yes, please list all medications including over the counter and herbal according to dose and frequency:

Medication	Dose	Frequency	Reason (Behavior, Asthma, etc)

Is your child allergic to any of the following?  None

Aspirin  Penicillin  Codeine  Local Anesthetics  Acrylic  Metal  Latex  Sulfa Drugs

Does your child have a food allergy?  Yes  No If yes: \_\_\_\_\_

Does your child have an allergy not listed above?  Yes  No If yes: \_\_\_\_\_

Does your child have, or have had, any of the following?

(Many of these don't apply to children; however, we are required to ask.)

AIDS/HIV Positive	<input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine	<input type="radio"/> Yes <input type="radio"/> No	Hemophilia	<input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments	<input type="radio"/> Yes <input type="radio"/> No
Sickle Cell Trait	<input type="radio"/> Yes <input type="radio"/> No	Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis A	<input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss	<input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis	<input type="radio"/> Yes <input type="radio"/> No	Drug Addiction	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C	<input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis	<input type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input type="radio"/> No	Easily Winded	<input type="radio"/> Yes <input type="radio"/> No	Herpes	<input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever	<input type="radio"/> Yes <input type="radio"/> No
Angina	<input type="radio"/> Yes <input type="radio"/> No	Emphysema	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Rheumatism	<input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout	<input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures	<input type="radio"/> Yes <input type="radio"/> No	High Cholesterol	<input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever	<input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve	<input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding	<input type="radio"/> Yes <input type="radio"/> No	Hives or Rash	<input type="radio"/> Yes <input type="radio"/> No	Shingles	<input type="radio"/> Yes <input type="radio"/> No
Artificial Joint	<input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst	<input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia	<input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease	<input type="radio"/> Yes <input type="radio"/> No
Asthma	<input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness	<input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat	<input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble	<input type="radio"/> Yes <input type="radio"/> No
Blood Disease	<input type="radio"/> Yes <input type="radio"/> No	Frequent Cough	<input type="radio"/> Yes <input type="radio"/> No	Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No	Spina Bifida	<input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion	<input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea	<input type="radio"/> Yes <input type="radio"/> No	Leukemia	<input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease	<input type="radio"/> Yes <input type="radio"/> No
Breathing Problems	<input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches	<input type="radio"/> Yes <input type="radio"/> No	Liver Disease	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No
Bruise Easily	<input type="radio"/> Yes <input type="radio"/> No	Genital Herpes	<input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Lung Disease	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Chemotherapy	<input type="radio"/> Yes <input type="radio"/> No	Hay Fever	<input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse	<input type="radio"/> Yes <input type="radio"/> No	Tonsillitis	<input type="radio"/> Yes <input type="radio"/> No
Chest Pains	<input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure	<input type="radio"/> Yes <input type="radio"/> No	Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters	<input type="radio"/> Yes <input type="radio"/> No	Heart Murmur	<input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints	<input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths	<input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder	<input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker	<input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease	<input type="radio"/> Yes <input type="radio"/> No	Ulcers	<input type="radio"/> Yes <input type="radio"/> No
Convulsions	<input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease	<input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care	<input type="radio"/> Yes <input type="radio"/> No	Yellow Jaundice	<input type="radio"/> Yes <input type="radio"/> No
ADHD	<input type="radio"/> Yes <input type="radio"/> No	Autism	<input type="radio"/> Yes <input type="radio"/> No	Learning Disability	<input type="radio"/> Yes <input type="radio"/> No	Down's Syndrome	<input type="radio"/> Yes <input type="radio"/> No
Behavior Concerns	<input type="radio"/> Yes <input type="radio"/> No	Autistic Tendencies	<input type="radio"/> Yes <input type="radio"/> No	Speech Delayed	<input type="radio"/> Yes <input type="radio"/> No	Special Needs (Other)	<input type="radio"/> Yes <input type="radio"/> No

If yes to any of the above, please explain: \_\_\_\_\_

Has your child had any illness not listed above?  Yes  No If yes, please list: \_\_\_\_\_

To help better serve your child, are there any additional thoughts or concerns about your child? \_\_\_\_\_

**To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform Little Grins Dental of any changes in medical status.**

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

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## Dental History

How long has it been since your child's last dental check-up? \_\_\_\_\_

Has your child had any unpleasant experiences in a dental office?  Yes  No  Unknown

If yes, please explain: \_\_\_\_\_

Is your child complaining of any teeth, gums or mouth pain?  Yes  No  Unknown

If yes, please explain: \_\_\_\_\_

Does your child drink Soda Pop / Soft Drinks?  Yes  No  Unknown If yes, how often: \_\_\_\_\_

How often does your child brush their teeth?

Once a day  Twice a day  Three times a day  When remembered  Unknown

Is teeth brushing supervised?  Yes  No  Unknown If yes, by whom: \_\_\_\_\_

Does your child have a history of prolonged pacifier use (past 18 months)?  Yes  No

Does your child have a history of prolonged finger or thumb sucking (past 18 months)?  Yes  No

Is your child currently nursing?  Yes  No

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## Emergency Contact

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_ E-mail: \_\_\_\_\_

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## Referring Family or Friend

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ E-mail: \_\_\_\_\_

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## Consent for Examination

I hereby authorize an initial examination by Dr. Craig Rechkemmer, DDS. An initial examination will include dental x-rays, cleaning, fluoride and diagnosis of oral health problems. I understand that the practice of dentistry is not an exact science. I acknowledge that no guarantees have been made to me as to the results of treatment or examination at Little Grins Dental, LLC.

I understand that after the examination, cleaning, fluoride and x-rays have been evaluated by the dentist; I will receive a Treatment Plan for my child. If I agree with the Treatment Plan; I will need to complete the Treatment Plan consent form before any additional dental treatment can be provided.

I hereby and on behalf of above listed child who is under the age of eighteen (18) years, consent that said child may participate in the dental services provided by Dr. Craig Rechkemmer (d/b/a/ Little Grins Dental, LLC).

The undersigned further hereby consents and authorizes the agents and employees of Little Grins Dental to file and collect reimbursement for dental services performed.

Yes No

1. Are you currently the legal guardian for this child?  
  2. Can you sign for Medical/Dental Treatment?

PARENT/GUARDIAN ACKNOWLEDGEMENT I acknowledge that I have read (or have had read to me) and fully understand the above consent, any explanations requested were explained, and all blanks requiring completion were filled in before I affixed my signature.

Print Parent/Guardian Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Signature Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_



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**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

*You may refuse to sign this acknowledgement.*

I acknowledge that I have received the Notice of Privacy Practices for Little Grins Dental, LLC.

**Parent /Guardian of:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_

**Date:** \_\_\_\_\_

This document will become a permanent part of the patient's Medical/Dental Record.

I refuse to sign this acknowledgement.

**Print Name:** \_\_\_\_\_

**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 the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement



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## **Appointment Policy**

Little Grins Dental strives to be on-time, efficient and respectful of your time. When your appointment is scheduled, a room is reserved, your records are reviewed and special instruments are prepared before your arrival. You can expect Little Grins Dental to be prompt unless we are providing emergency treatment for another patient.

Due to our limited number of available appointments, we ask that you contact us before your scheduled appointment to reschedule or cancel. If we are given enough notice, we can offer your appointment time to a family that is on the waiting list.

If you miss or reschedule within 24 hours of your scheduled appointment, Little Grins Dental will require a \$60 deposit in order to reschedule your appointment. The \$60 deposit will be refunded at the next appointment. If a consecutive appointment is missed or is rescheduled with less than a 24 hour notice, then an additional \$60 deposit will be required to reschedule. In that situation, only \$60 total will be refunded at the next appointment and not \$120. If a third appointment is missed or rescheduled with less than a 24 hour notice, then it will be necessary to categorize that patient as inactive and will only be scheduled from the waiting list.

I hereby certify that I understand the appointment policy and the reasons for the rescheduling appointment deposit. I acknowledge that every effort will be made to arrive promptly for appointments and that I will contact Little Grins Dental with any schedule changes before the scheduled appointment.

Print Parent/Guardian Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Signature Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_



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## Payment Policy

Little Grins Dental is a general dental practice where dental insurance is welcomed and accepted. Payment for professional services is due at the time dental treatment is provided. Every effort will be made to provide a treatment plan which fits your timetable and budget and gives your child the best possible care. If payment is not received from your dental insurance company within 45 days from the date of service then you will be responsible for payment for all dental services provided. All balances over 60 days are subject to a 5% service charge. Delinquent accounts over 90 days will be forwarded to a collection service and you will be responsible for all related costs.

### Insurance Plans

Little Grins Dental will process insurance forms electronically which enables the claim to be paid within 30 days of receipt. We recommend you verify your annual maximum with your insurance company. Once you exceed your annual maximum, payment in full is expected at the time of service. Co-payments are collected at the time of visit.

We are currently a dental provider for:

Aetna PPO	Assurant PPO	Cigna	Delta Dental Premier & PPO
Humana PPO	MetLife (MetDental)	United Healthcare	-

Payment for services from the above listed dental insurance companies will go directly to Little Grins Dental. Any overpayment or refunds will be handled accordingly on a case-by-case basis.

### Families with other Dental Insurance Plans

Little Grins Dental can file an electronic claim for most dental insurance companies not listed above. In those situations, full payment is collected at the time of visit and the reimbursement money from your insurance company is sent directly to you. Please keep in mind that we file those dental insurance claims as a courtesy to our families. We do not have a contract with dental insurance companies that are not listed above and therefore are not responsible for what benefits they pay on a claim. The insurance reimbursement that is sent directly to you may not cover the entire cost of treatment provided at Little Grins Dental since we are not enrolled in their dental insurance program.

### Families without Dental Insurance

Little Grins Dental offers a payment plan through CareCredit. CareCredit is a GE Money Company card that allows you to finance treatments with special financing, low monthly payment options, no up-front costs and no-prepayment penalties. This payment plan is accepted by over 90,000 providers and will allow you to continue treatment without delay due to financial constraints. You can apply for CareCredit online, or the Little Grins Dental team can help process your application in person.

We accept cash, checks, Visa, MasterCard, Discover, and American Express. Personal checks are processed electronically and will withdraw from your checking account on the date of service.

### Child Custody Agreements and Court Orders

Little Grins Dental understands that many families may have child custody agreements or court orders regarding the fiduciary responsibility of a child's medical and dental care. However, Little Grins Dental will not become involved in any custody or financial responsibility disputes. The parent or guardian that brings the child to Little Grins Dental is legally responsible for the payment of all fees regardless of any custody agreements or court orders.

Print Parent/Guardian Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Signature Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_



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## Playground & Play Area Consent

I, the parent/legal guardian of the child, am aware that participation in the indoor Little Grins Dental, LLC playground and/or use of the play area creates a risk of injury, and I, on behalf of myself and child, knowingly and freely assume all such risks, both known and unknown, even if arising from the negligence of others; and

I agree that the child and I shall comply with the rules and conditions for the indoor Little Grins Dental, LLC playground. In addition, if I observe any hazard during our participation, I will bring it to the attention of the Little Grins Dental staff.

I, for myself and the child, hereby release and hold harmless Little Grins Dental, LLC, their affiliates, officers, members, agents, employees, and other participants from and against any and all claims, injuries, liabilities or damages arising out of or related to participation with the indoor Little Grins Dental, LLC playground and play area.

**PARENT/GUARDIAN ACKNOWLEDGEMENT** I acknowledge that I have read and fully understand the above consent and any explanations requested were made - before I affixed my signature.

Print Parent/Guardian Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Signature Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_



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### **Dental Patient Consent and Release Regarding COVID-19**

Novel Coronavirus (“COVID-19”) has had wide-ranging impacts on our everyday lives, including here at Little Grins Dental, LLC (“The Practice”). As we transition back to providing dental care, the health and safety of staff and patients remains our top priority.

**Precautions.** The Practice has implemented, as appropriate, the Center for Disease Control’s (“CDC”) Guidance on Returning to Work as well as guidance by state and local health departments, and applicable state licensing agencies (“the Precautions”). Some of the Precautions may include: regular screening of employees and pre-appointment screening of patients for respiratory illness indicators; limiting non-patient visitors to essential ones such as suppliers and barring family members and friends of patients as appropriate; practicing social distancing with staff and patients where possible; expanding the wearing of masks and other Personal Protective Equipment (“PPE”); rigorous cleaning and sanitizing of our work space, tools, and instruments; responding quickly and effectively to isolate exposed areas and people when a staff member or patient becomes sick; and, making reasonable efforts to assist with contact tracing and notifications where appropriate. Additionally, because dental procedures which use dental instruments such as handpieces, ultrasonic scalers, and air-water syringes create a spray which may contain contaminated droplets and aerosols, some of the Precautions may include transmission-based precautions published by the CDC and/or state licensing agencies, in addition to standard precautions. As guidance and circumstances change so may The Practice’s Precautions.

**Consent.** By signing this form, I acknowledge and understand that the implementation of some of the Precautions may change as circumstances warrant and that due to the nature of COVID-19, The Practice does not guarantee that I or my child will not be exposed to COVID-19 or expose others if I unknowingly have COVID-19. Despite the risk that I could unintentionally be exposed to COVID-19 at The Practice, I agree and consent to receiving dental care for my child at The Practice. If I have questions about the Precautions in place, I understand The Practice will answer them to the best of its ability.

**Release.** In consideration for the Precautions taken by The Practice to reduce the risk of possible exposure to COVID-19, in consideration for receiving dental care for my child at The Practice, and in consideration of the risk posed to The Practice and its staff in providing me dental care if I or my child unknowingly have COVID-19, **I hereby knowingly and voluntarily RELEASE AND FOREVER DISCHARGE (for myself, my heirs, executors, administrators, and assigns) The Practice (its present and former owners, officers, directors, providers, employees, agents, and representatives (including volunteers), successors and assigns, any affiliates, and its direct or indirect owners), from any and all**

**liability, claims, suits, actions, causes of action, crossclaims, counter-claims, compensatory damages, liquidated damages, punitive or exemplary damages, other damages, claims for costs and attorney's fees, or liabilities or any nature whatsoever and demands of whatever kind or nature, either in law or in equity, for or because of any illness and injury I might incur from unintended exposure to COVID-19 while I or my child is at The Practice and because of any negligence or fault The Practice arising directly or indirectly from the Precautions.**

**In executing this document, IT IS MY INTENT to release all claims of any kind or character, including negligence claims, which I might have now or in the future against The Practice arising out of any illness or injury I or my child might incur from unintended exposure to COVID-19 at The Practice and from any because of any negligence or fault of The Practice arising directly or indirectly from the Precautions.**

I have read the above. I fully understand it, and my questions have been answered to my satisfaction.

Print Parent/Guardian Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Signature Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_



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### **COVID-19 Pandemic Dental Treatment Consent Form**

Even after following protocols set by the American Dental Association and our state's dental association, it is still possible to contract COVID-19 while at a dental office. We are following all guidelines to minimize the risk of transmission.

- I knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic for my child. I understand that the COVID-19 virus has a long incubation period during which carriers of this virus may not show symptoms and may still be highly contagious. \_\_\_\_\_ (Initial)
- I understand that due to the frequency of visits of other dental patients, the characteristics of the COVID-19 virus, and the characteristics of dental procedures I and/or my child have an elevated risk of contracting the COVID-19 virus simply by being in a dental office. \_\_\_\_\_ (Initial)
- I confirm that I am, nor my child, is not presenting any of these COVID-19 symptoms: \_\_\_\_\_ (Initial)
  - Fever
  - Shortness of breath
  - Dry cough
  - Runny nose
  - Sore throat
- I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus. And the CDC recommends social distancing of at least six feet for a period of 14 days to anyone who has recently traveled, and this is not possible with dentistry. \_\_\_\_\_ (Initial)
- I verify that I, nor my child, have not traveled outside the United States in the past 14 days. \_\_\_\_\_ (Initial)
- I verify that I, not my child, have not traveled domestically within the United States by commercial airline, bus or train within the past 14 days. \_\_\_\_\_ (Initial)

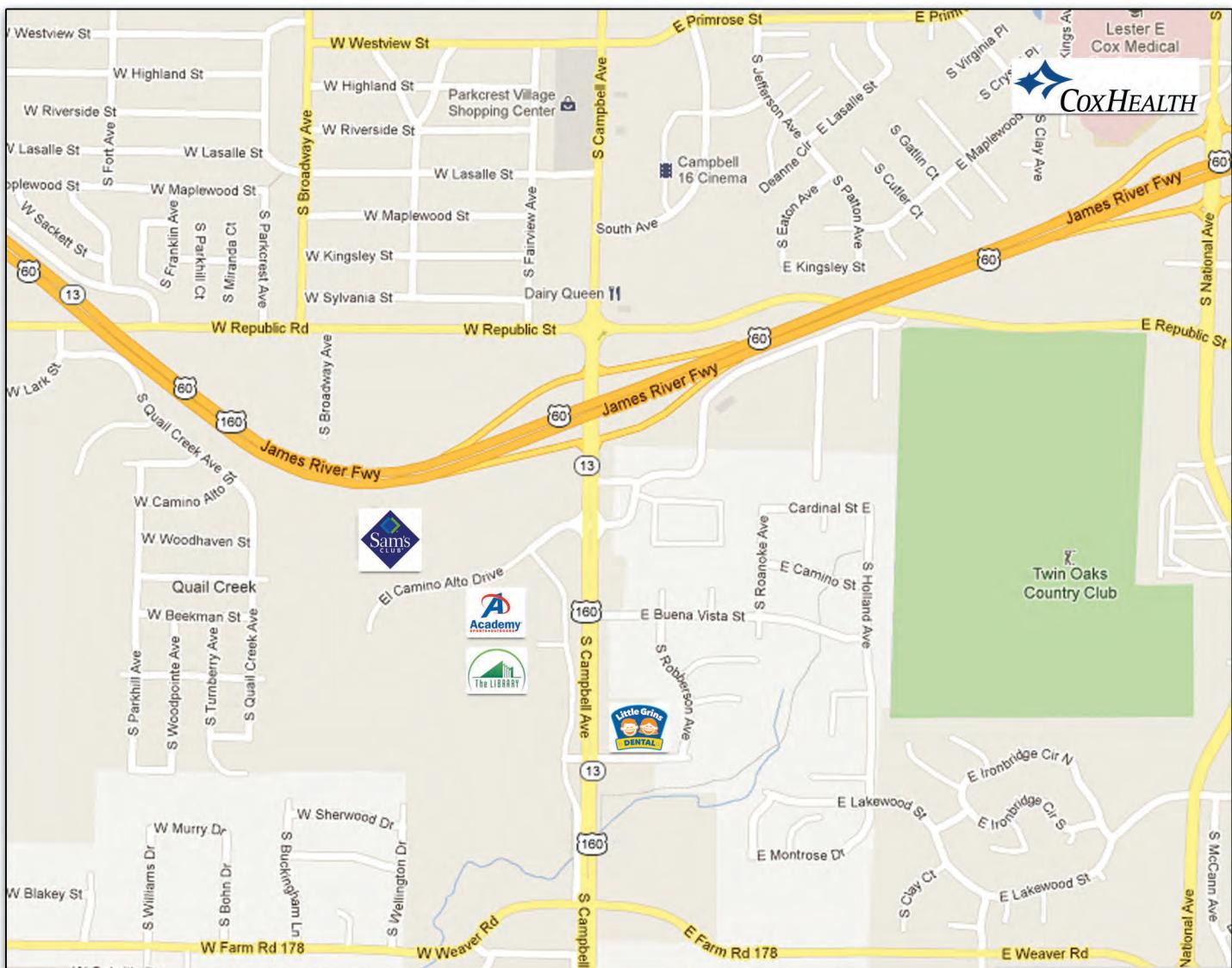
Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Today's Date: \_\_\_\_\_



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## 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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect February 16, 2026 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

#### **HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU**

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance use disorder treatment records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

**Treatment.** We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

**Payment.** We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

**Healthcare Operations.** We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

**Individuals Involved in Your Care or Payment for Your Care.** We may disclose your health information to your family or friends or any other individual identified by you when they participate in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

**Disaster Relief.** We may use or disclose your health information to assist in disaster relief efforts.

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

**Public Health Activities.** We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

**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 the protected health information of an inmate or patient.

**Secretary of HHS.** We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

**Worker's Compensation.** We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

**Law Enforcement.** We may disclose your P-II for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

**Health Oversight Activities.** We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Judicial and Administrative Proceedings.** If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

**Research.** We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

**Coroners, Medical Examiners, and Funeral Directors.** We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to perform their duties.

**Fundraising.** We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

**SUD Treatment Information.** If we receive or maintain any information about you from a substance use disorder treatment program that is covered by 42 CFR Part 2 (a "Part 2 Program") through a general consent you provide to the Part 2 Program to use and disclose the Part 2 Program record for purposes of treatment, payment or health care operations, we may use and disclose your Part 2 Program record for treatment, payment and health care operations purposes as described in this Notice. If we receive or maintain your Part 2 Program record through specific consent you provide to us or another third party, we will use and disclose your Part 2 Program record only as expressly permitted by you in your consent as provided to us.

In no event will we use or disclose your Part 2 Program record, or testimony that describes the information contained in your Part 2 Program record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against you, unless authorized by your consent or the order of a court after it provides you notice of the court order.

#### **OTHER USES AND DISCLOSURES OF PHI**

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already acted in reliance on the authorization.

#### **YOUR HEALTH INFORMATION RIGHTS**

**Access.** You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

**Disclosure Accounting.** With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

**Right to Request a Restriction.** You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

**Alternative Communication.** You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested, we may contact you using the information we have.

**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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

**Right to Notification of a Breach.** You will receive notifications of breaches of your unsecured protected health information as required by law.

**Electronic Notice.** You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

#### **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 if 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 or 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.

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#### **PRIVACY OFFICIAL NAME AND CONTACT INFORMATION:**

Privacy Official Name: **Little Grins Dental, LLC**

Telephone: **417-300-9427**

Fax: **855-673-2193**

Address: **4728 S. Campbell Ave. Suite 120 Springfield, MO 65810**

Email: **Office@LittleGrinsDental.com**

**Craig Rechkemmer, DDS**