

**DAVID C. METROKA, D.D.S.**  
**411 North York Road, Hatboro, Pennsylvania 19040**

(PLEASE PRINT CLEARLY)

|                    |                                 |     |        |               |
|--------------------|---------------------------------|-----|--------|---------------|
| CHILD'S FULL NAME: | NAME CHILD PREFERS TO BE CALLED | SEX | AGE    | DATE OF BIRTH |
| REASON FOR VISIT   |                                 |     | WEIGHT | HEIGHT        |

REFERRED TO THIS OFFICE BY: (WE WISH TO THANK THEM.)

|                                |                          |
|--------------------------------|--------------------------|
| FULL NAME:                     | PHONE #:                 |
| CHILD'S PHYSICIAN: (FULL NAME) | PHONE #: DATE LAST SEEN: |

|                             |                          |
|-----------------------------|--------------------------|
| FAMILY DENTIST: (FULL NAME) | PHONE #: DATE LAST SEEN: |
|-----------------------------|--------------------------|

|                                                                                                           | YES   | NO    |
|-----------------------------------------------------------------------------------------------------------|-------|-------|
| 1. IS YOUR CHILD PRESENTLY UNDER THE CARE OF A PHYSICIAN FOR ANY MEDICAL PROBLEM?<br>IF YES, WHAT?        | _____ | _____ |
| 2. WAS YOUR CHILD PREMATURE? HOW MANY WEEKS?                                                              | _____ | _____ |
| 3. DID YOUR CHILD HAVE A HISTORY OF HEALTH PROBLEMS AT BIRTH OR DURING INITIAL YEARS?<br>IF YES, EXPLAIN. | _____ | _____ |
| 4. IS YOUR CHILD PRESENTLY TAKING ANY MEDICATION? WHAT?                                                   | _____ | _____ |
| 5. HAS YOUR CHILD HAD A HISTORY OF TAKING MEDICATIONS FREQUENTLY?                                         | _____ | _____ |
| 6. HAS YOUR CHILD EVER BEEN HOSPITALIZED OR HAD SURGERY? WHAT?                                            | _____ | _____ |
| 7. IS YOUR CHILD ALLERGIC TO ANY FOOD OR MEDICINE? WHAT?                                                  | _____ | _____ |
| 8. IS YOUR CHILD ALLERGIC TO LATEX, METALS OR ACRYLICS (PLASTIC)?                                         | _____ | _____ |
| 9. HAS ANY MEMBER OF THE FAMILY HAD A PROBLEM WITH A GENERAL ANESTHETIC?                                  | _____ | _____ |
| 10. ARE IMMUNIZATIONS, INCLUDING TETANUS, CURRENT?                                                        | _____ | _____ |

HAS YOUR CHILD EVER BEEN DIAGNOSED AS HAVING ANY  
 OF THE FOLLOWING CONDITIONS? PLEASE CHECK YES OR NO:

| Y N                                                       | Y N                                                        | Y N                                                                                      |
|-----------------------------------------------------------|------------------------------------------------------------|------------------------------------------------------------------------------------------|
| <input type="checkbox"/> AIDS - HIV                       | <input type="checkbox"/> Congenital Heart Lesion           | <input type="checkbox"/> High Blood Pressure                                             |
| <input type="checkbox"/> Allergies                        | <input type="checkbox"/> Convulsions/Seizures              | <input type="checkbox"/> Hyperactivity/ADD                                               |
| <input type="checkbox"/> Anemia                           | <input type="checkbox"/> Developmentally Delayed           | <input type="checkbox"/> Kidney Disease                                                  |
| <input type="checkbox"/> Arthritis                        | <input type="checkbox"/> Diabetes                          | <input type="checkbox"/> Leukemia                                                        |
| <input type="checkbox"/> Asthma                           | <input type="checkbox"/> Drug Addiction                    | <input type="checkbox"/> Mental Disability                                               |
| <input type="checkbox"/> Autism                           | <input type="checkbox"/> Ear Stuffiness, Itching or Noises | <input type="checkbox"/> Nutritional Deficiency                                          |
| <input type="checkbox"/> Bladder Conditions               | <input type="checkbox"/> Emotional Disturbance             | <input type="checkbox"/> Oral Ulcers                                                     |
| <input type="checkbox"/> Blood Disease                    | <input type="checkbox"/> Epilepsy                          | <input type="checkbox"/> Orthopedic Problems                                             |
| <input type="checkbox"/> Blood Transfusions               | <input type="checkbox"/> Eye Problem                       | <input type="checkbox"/> Pain In Jaw Joints                                              |
| <input type="checkbox"/> Birth Defects                    | <input type="checkbox"/> Excessive Bleeding Problem        | <input type="checkbox"/> Premature Birth                                                 |
| <input type="checkbox"/> Bone or Joint Problems           | <input type="checkbox"/> Excessive Gagging                 | <input type="checkbox"/> Psychiatric Care                                                |
| <input type="checkbox"/> Brain Injury                     | <input type="checkbox"/> Fainting or Dizziness             | <input type="checkbox"/> Rheumatic Fever                                                 |
| <input type="checkbox"/> Bruising Easily                  | <input type="checkbox"/> Fever Blisters                    | <input type="checkbox"/> Scoliosis                                                       |
| <input type="checkbox"/> Cancer or Malignancies           | <input type="checkbox"/> Growth & Development Problems     | <input type="checkbox"/> Sickle Cell Anemia                                              |
| <input type="checkbox"/> Cerebral Palsy                   | <input type="checkbox"/> Heart Surgery                     | <input type="checkbox"/> Syndrome _____                                                  |
| <input type="checkbox"/> Chemotherapy/Radiation           | <input type="checkbox"/> Headaches                         | <input type="checkbox"/> Tuberculosis                                                    |
| <input type="checkbox"/> Child Abuse                      | <input type="checkbox"/> Hearing/Speech Problems           | <input type="checkbox"/> Other _____                                                     |
| <input type="checkbox"/> Chronic Adenoid/Tonsil Infection | <input type="checkbox"/> Heart Murmur/Defect               | <input type="checkbox"/> Do you wish to talk to the doctor<br>privately about a problem? |
| <input type="checkbox"/> Chronic Ear Infections           | <input type="checkbox"/> Hemophilia                        |                                                                                          |
| <input type="checkbox"/> Cleft Lip/Palate                 | <input type="checkbox"/> Hepatitis or Liver Disease        |                                                                                          |

• • • DENTAL HISTORY • • •

|                                                                                                                                                |                                                                                                                                                                   |                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| CHILD'S FIRST DENTAL VISIT?<br>YES _____ NO _____                                                                                              | PREVIOUS DENTIST _____ CITY _____                                                                                                                                 | DATE OF LAST VISIT? _____                    |
| ANY INJURIES TO YOUR CHILD'S TEETH OR JAWS?<br>WHEN? _____                                                                                     | HISTORY OF: _____ NURSING BOTTLE HABITS WHEN? _____<br>_____ THUMBSUCKING/FINGERSUCKING _____<br>_____ PACIFIER _____<br>_____ DENTAL GRINDING OR CLENCHING _____ |                                              |
| HAS YOUR CHILD EXPERIENCED ANY UNFAVORABLE REACTION FROM PREVIOUS MEDICAL OR DENTAL CARE?<br>YES _____ NO _____ (IF YES, PLEASE EXPLAIN) _____ |                                                                                                                                                                   |                                              |
| HOW DO YOU THINK YOUR CHILD WILL ACT TOWARD THE DENTIST? _____                                                                                 |                                                                                                                                                                   | HAS YOUR CHILD HAD RECENT DENTAL PAIN? _____ |

• • • PREVENTIVE DENTAL HISTORY • • •

|                                                                                    |                                                                                                                                                                                                                                  |
|------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| HOW OFTEN DOES YOUR CHILD BRUSH? _____<br>IS DENTAL FLOSS USED? YES _____ NO _____ | IS TOOTHBRUSHING SUPERVISED? YES _____ NO _____<br>BY WHOM? _____<br>DOES YOUR CHILD RECEIVE: (CHECK)<br>_____ FLUORIDE IN VITAMINS _____ FLUORIDATED WATER _____ WELL WATER<br>_____ FLUORIDE TABLETS/DROPS _____ BOTTLED WATER |
|------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

**GENERAL INFORMATION**

|                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                   |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Father's Full Name _____<br>Address _____<br>City _____ State _____ Zip _____<br>Occupation _____<br>Mother's Full Name _____<br>Address _____<br>City _____ State _____ Zip _____<br>Occupation _____<br>Child lives with: // Both parents, // mother, // father, // other. _____<br>Responsible party _____ | S S # _____ HOME PHONE: _____<br>Birthdate _____<br>Employed by _____<br>Bus Phone _____<br>S S # _____ HOME PHONE: _____<br>Birthdate _____<br>Employed by _____<br>Bus Phone _____<br>Names of any family members who have been patients here previously: _____ |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

**FOR PATIENTS COVERED BY DENTAL INSURANCE**

**PRIMARY CARRIER**

**SECONDARY CARRIER**

|                                                                                                                                                             |                                                                                                                                                             |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Insured's Name _____<br>Group/Policy Number _____<br>Employer Name _____<br>Insurance Company _____<br>How long have you had this insurance coverage? _____ | Insured's Name _____<br>Group/Policy Number _____<br>Employer Name _____<br>Insurance Company _____<br>How long have you had this insurance coverage? _____ |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|

*I HEREBY AUTHORIZE PAYMENT DIRECTLY TO DAVID C. METROKA, D.D.S. OTHERWISE PAYABLE TO ME, OR IF MY CURRENT POLICY PROHIBITS DIRECT PAYMENT TO THE DOCTOR. I HEREBY INSTRUCT THE INSURANCE COMPANY TO MAKE OUT THE CHECK TO ME AND MAIL IT IN CARE OF: DAVID C. METROKA, D.D.S., 411 NORTH YORK ROAD, HATBORO, PENNSYLVANIA 19040.*

\_\_\_\_\_  
SIGNED-INSURED PERSON

THE PERMISSION OF PARENT OR GUARDIAN IS NECESSARY FOR DENTAL TREATMENT OF A MINOR. I GIVE THE DOCTORS PERMISSION TO USE SUCH MEASURES AS DEEMED NECESSARY IN THEIR PROFESSIONAL JUDGEMENT TO RENDER A DIAGNOSIS FOR MY CHILD. THIS WOULD INCLUDE AN ORAL EXAMINATION, RADIOGRAPHS, (X-RAYS) AND OTHER DIAGNOSTIC AIDS. I HAVE GIVEN AN ACCURATE REPORT OF MY CHILD'S PHYSICAL AND MENTAL HEALTH HISTORY. I HAVE ALSO REPORTED ANY PRIOR ALLERGIC OR UNUSUAL REACTIONS TO DRUGS, FOOD, INSECT BITES, ANESTHETICS, POLLENS, DUST, BLOOD OR BODY DISEASES, GUM OR SKIN REACTIONS, ABNORMAL BLEEDING OR ANY OTHER CONDITIONS RELATED TO MY CHILD'S HEALTH OR ANY OTHER PHYSICAL CONDITIONS THAT MY CHILD'S MEDICAL DOCTOR HAS ADVISED ME SHOULD BE REPORTED TO A DENTIST.

|                                      |                             |            |
|--------------------------------------|-----------------------------|------------|
| SIGNATURE _____                      | RELATIONSHIP TO CHILD _____ | DATE _____ |
| REVIEWED BY: DOCTOR _____ DATE _____ |                             |            |

## NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.  
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

### OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 4/15/03 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. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

### USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

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

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

---

#### PATIENT RIGHTS

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$0. 20 for each page, \$ 8.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

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

---

#### QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use 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.

Contact Officer: Cathy Beiswenger

Telephone: 215-674-3080 Fax: 215-674-3063

E-mail: dcmetroka@aol.com

Address: 411 N. York Road Hatboro, Pa. 19040

DAVID C. METROKA, D.D.S.

---

# ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT"

I, \_\_\_\_\_, HAVE RECEIVED A COPY OF  
(Parent's Name)  
THIS OFFICE'S NOTICE OF PRIVACY PRACTICES.

\_\_\_\_\_  
Please print name (Child's Name)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

---

## For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
  - ☐ Communications barriers prohibited obtaining the acknowledgement
  - ☐ An emergency situation prevented us from obtaining acknowledgement
  - ☐ Other (please specify)
- 
-