FIRST CLASS PEDIATRIC DENTISTRY

Thank you for allowing us to care for your child's dental health. Our goal is to have every child and parent that visits our practice leave with a better understanding of their dental health. We promise to do our best to provide your child with the finest care available for both the treatment and prevention of dental disease.

YOUR CHILD'S INFORMATION __ Male __ Female

Name: _____ Nickname :_____ Date of Birth: _____
Address: _____ City: _____ _____State:____ ZIP: _____
School Name: _____ Age: ____ Grade: ____ Interests: _____
Pediatrician Name: _____ Pediatrician Phone # _____
Pediatrician Address: _____ City: _____ State:____ ZIP: _____

GENERAL INFORMATION

How did you hear about our practice?_____
Who is accompanying the child today? _____What is your relation to this child?_____
Will you be accompanying this child to all of their visits? __yes__no Do you have legal custody of this child? __yes__no
Does this child have siblings in this practice? __yes__no
Name of person responsible for this child's account: _____

PARENT'S INFORMATION

1) Name: _____ SSN :_____ Date of Birth: _____
Address: _____ City: _____ _____State:____ ZIP: _____
Driver's License # _____ Work # _____ Home# _____ Cell #_____
E-mail Address: _____Employer: _____
Maritial Status: __Single__Married__Partnered__Widowed/Widower__Divorced__Separated
Relation: __Mother__Father__Guardian_ _Step Mother__Step Father
2) Name: _____ SSN :_____ Date of Birth: _____
Address: _____ City: _____ _____State:____ ZIP: _____
Driver's License # _____ Work # _____ Home# _____ Cell #_____
E-mail Address: _____Employer: _____
Maritial Status: __Single__Married__Partnered__Widowed/Widower__Divorced__Separated
Relation: __Mother__Father__Guardian_ _Step Mother__Step Father

INSURANCE INFORMATION

Name of Insured: _____ Insurance Company Name: _____
Insurance Company Address: _____ City: _____ State:____ ZIP: _____
Group # _____ Union/Local/Policy # _____ Deductible: _____ Max annual benefit: _____

DENTAL HISTORY

Reason for today's visit:_____Is this your child's first dental visit?__yes__no
Check (√) if you child has problems with any of the following

__ Bad breath	__ Grinding teeth	__ Poor past dental experience
__ Bleeding gums	__ Injury to mouth or teeth	__ Sensitive while biting
__ Broken fillings	__ Loose teeth	__ Sensitive to sweet /temp
__ Clicking/Popping jaw	__ Mouth breather	__ Sores/growths in mouth
__ Crowded teeth	__ Pacifier user	__ Sucks thumb/fingers
__ Food collection between teeth	__ Periodontal treatment	__ Toothache

How many times a day are your child's teeth brushed/flossed? _____/_____
Are there any other dental concerns: _____

Please fill out and sign health history

MEDICAL HISTORY

Check (√) if your child has ever had any of the following diseases/disorders:

y__n__ ADD/ADHD – What type of therapy is effective at treating condition? _____

y__n__ Adenoid/Tonsil Problems - If yes, explain: _____

y__n__Anemia – Frequency of crisis: _____Date of last hosp/crisis: _____/_____

y__n__Asthma - Frequency of episodes: _____Date of last hosp/episode :_____/_____

y__n__ Autism – At what age does your child function?____ What oral textures does your child dislike?_____

y__n__Bronchitis – Chronic or Acute?_____Frequency/Duration: _____/_____Triggers: _____

y__n__ Cancer - If yes, explain: _____

y__n__Cerebral Palsy - What type?_____Any mental disability? _____Any Physical Restrictions?_____

y__n__ Congenital Heart Disease - If yes, explain: _____

y__n__ Cystic Fibrosis - What type of therapy is being used?_____

y__n__ Developmental Delay - If yes, explain: _____

y__n__ Diabetes – Type: _____ Frequency of crisis: _____Date of last hosp/crisis: _____/_____

y__n__Down Syndrome – At what age level does your child function?___Any heart conditions?_____

y__n__ Ear/Eye Problems - If yes, explain: _____

y__n__Fainting - If yes, explain: _____

y__n__Gastro-esophageal Reflux Disease (GERD) – Frequency:____Exacerbating Foods/Events:_____

y__n__Head Injury/Brain Injury - If yes, explain: _____

y__n__Heart Murmur - If yes, explain: _____

y__n__Hemophilia/Von Willebrand Disease - Type:_____Port?____Measures to prevent bleeding:_____

y__n__Hepatitis – Type:_____Date of last hosp:_____Type of therapy:_____

y__n__HIV/AIDS – What type of ongoing care does your child receive?_____

y__n__Kidney /Liver Problems - If yes, explain: _____

y__n__Muscular Dystrophy – What type of therapy does your child receive?_____

y__n__Obstructive Sleep Apnea - If yes, explain: _____

y__n__ Seizure Disorder – Type: _____ Frequency/Duration: _____/_____Triggers: _____

y__n__Sickle Cell – Frequency of crisis: _____Date of last hosp/crisis: _____/_____

y__n__ Snoring - If yes, explain: _____

y__n__Spina Bifida – What type?_____ Any physical disability? _____Latex Allergy?____

y__n__Stomach Problems - If yes, explain: _____

y__n__ Thalassemia – Frequency of crisis: _____Date of last hosp/crisis: _____/_____

y__n__Tuberculosis – How long has your child had the disease? _____Is the disease active?_____

Are your child's immunizations up to date? y__n__If no please explain:_____

Is there a chance that your child could be pregnant ?y__n__If yes please explain:_____

Describe any episodes where your child required surgery: _____

Describe any episodes where your child required a sedative: _____

Describe any episodes where your child required hospitalization: _____

List any medications, materials, or foods that your child is allergic to: _____

_____

List any medications that your child is currently or has formerly taken and the correlating diagnosis:_____

_____

Is there anything else that you would like to tell us about your child's medical history? _____

_____

To the best of my knowledge the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my child ever has a change in health.

I (We) the undersigned parent, parents, or legal guardian of_____

DOB ___/___/___, a minor, do hereby authorize and consent to x-rays which may be taken along with a head and neck examination, dental cleaning, dental diagnosis, and performance of all recommended treatment which is deemed advisable by and is to be rendered under the general or special supervision of any dentist at First Class Pediatric.

Signature of parent/guardian:_____Date:_____

Notice of Privacy Practices for
Protected Health Information

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!

With your consent, the practice is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Example of uses of your health information for treatment purposes:
The doctor obtains your treatment information and records it in a health record. During the course of your treatment, the doctor determines a need to consult with another specialist in the area. The doctor will share the information with such specialist and obtain input.

Example of use of your health information for payment purposes:
We submit a request for payment to your health insurance company. The health insurance company requests information from us regarding dental care given. We will provide information to them about you and the care given.

Example of Use of Your Information for Health Care Operations:
We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

Your Health Information Rights

The health record we maintain and billing records are the physical property of the practice. The information in it, however, belongs to you. You have a right to:
• Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request granted;
• Obtain a paper copy of this Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our office;
• Request that you be allowed to inspect and copy your health record and billing record—you may exercise this right by delivering the request in writing to our office;
• Appeal a denial of access to your protected health information except in certain circumstances;
• Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office;
• File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
• Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care;
• Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office; and,
• Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you want to exercise any of the above rights, please contact our office director at 770-469-4192 in person or in writing, during normal hours. Will provide you with assistance on the steps to take to exercise your rights.

PLEASE READ AND SIGN LAST PAGE

You have the right to review this Notice before signing the consent authorizing use and disclosure of your protected health information for treatment, payment, and health care operations purposes.

Our Responsibilities

The practice is required to:

• Maintain the privacy of your health information as required by law;
• Provide you with a notice of our duties and privacy practices as to the information we collect and maintain about you;
• Abide by the terms of this Notice;
• Notify you if we cannot accommodate a requested restriction or request; and
• Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact office director @ 770-469-4192.

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to You may also file
complaint by mailing it or e-mailing it to the Secretary of Health and Human Services whose street address is

•We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the practice.
•We cannot, and will not, retaliate against you for filing a complaint with the Secretary.

Other Disclosures and Uses

Notification

Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Communication with Family

Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Food and Drug Administration (FDA)

We may disclose to the FDA your protected health information relating to adverse events with respect to products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation

If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health

As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse & Neglect

We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Correctional Institutions

If you are an inmate of a correctional institution, we may disclose to the institution, or its agents, your protected health information necessary for your health and the health and safety of other individuals.

PLEASE READ AND SIGN LAST PAGE

Law Enforcement

We may disclose your protected health information for law enforcement purposes as required by law,

such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

Health Oversight
Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings
We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.

Other Uses
Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided.

Website
If we maintain a website that provides information about our entity, this Notice will be on the website.

BY SIGNING BELOW YOUR SIGNATURE INDICATES YOU HAVE COMPLETELY READ AND THOROUGHLY UNDERSTAND THE PATIENT PROTECTED PRIVACY HEALTH FORM.

Effective Date: 01/09/2015 RECEIVED BY: _____DATE:_____

PRINT NAME: _____

FIRST CLASS PEDIATRIC DENTISTRY

Welcome to our practice! We are excited you have chosen our team of professionals to create positive smiles for your child(ren). To better serve you, we have prepared our office policies so that you may have an understanding of how our practice functions. If you have any questions, please feel free to ask.

PATIENTS

- We are **PEDIATRIC DENTAL SPECLALISTS!** That means, we specialize in comprehensive dental treatment for children. From the appearance of an infant's very first tooth until that same child graduates from high school, we want to be personally involved in maintaining a dazzling smile! Most children should be seen for the first time at around one year old; however we are happy to see infants and children of all ages. Our professional staff is skilled in making sure each child has a positive dental experience in our office!

APPOINTMENTS

- Dental decay is the number one disease among children. Many children in the Atlanta area suffer from tooth decay. As a result, we have a list of children who are waiting just to be seen for an initial appointment. We have specifically scheduled an appointment for your child. We ask that you please be on time (preferably early!) for your appointment as we try to see each patient within 10 minutes of his/her appointment time. Because the appointment time has been specifically created for your child, we reserve the right to reschedule your child's appointment to another time if you are 15 or more minutes late. Please understand that there are instances when your child's appointment may run longer than anticipated. We ask that if your child's appointment runs longer than anticipated that you be patient so that we can give your child the quality care and attention that he/she deserves.
- It is the policy of this practice to exclusively treat children and the special needs person. Each child that we see is evaluated on an individual basis to determine the treatment situation that will lead to them having the best possible dental experience. Children tend to react to the fears and concerns of their parents and it is our experience that some children are more responsive and cooperative to treatment if their parent(s) are not present during treatment. If a child's parent is present during the dental procedure we ask that they are a silent observer so that 100% of our attention can be on the child receiving treatment. If asked to remain in the waiting room during treatment we respectfully require that you remain in the waiting room while your child is being treated. **Parents should NOT LEAVE the dental office during the child's treatment**. This will enable us to have immediate access to you should we need additional information regarding your child. Once your child's treatment is complete, the dentist, hygienist, and/or assistant will speak with you to outline the treatment performed and necessary follow-up, if any. During the appointment, your child will be supervised at **all times** by a member of our staff. They will be encouraged to play at the play table, read a book, play with puzzles and games, or watch TV. We want their time in our office to be remembered as a FUN time!
- We understand that there will be times when you will not be able to keep the appointment time that has been reserved specifically for your child. As a courtesy to the other children needing dental attention, **we request that you notify our office at least 24 hours in advance if you will be unable to keep your scheduled appointment**. For your convenience, an answering machine is maintained to allow you to cancel an appointment or leave a message after our regular office hours. Please feel free to call our office anytime, 24 hours a day! Please note that we reserve the right to dismiss your child from our practice for continued failure to keep scheduled appointments.

MEDICAID/PEACHCARE RECIPIENTS

- We require all patients and their families covered under Medicaid/Peachcare benefits to bring a current Medicaid/Peachcare card to each appointment. We will not verify Medicaid/Peachcare coverage for you. Your child's appointment will be rescheduled if you do not bring your child's current Medicaid/Peachcare card. Continued failure to bring your child's Medicaid/Peachcare card will be considered failure, to keep your scheduled appointment and will result in dismissal from our practice.

PERMISSION FOR TREATMENT

- A consent form will be required prior to any treatment. **In addition, we require that anyone, other than a parent or legal guardian, bring a permission slip signed by the parent or legal guardian allowing that person to make decisions regarding dental treatment for that child.**

PAYMENT TERMS

- Payment is due at the time of treatment. We gladly accept cash, check and most credit cards.
- You are entitled to a clear understanding of your financial obligations before treatment is rendered. A wide variety of services are available in this office; therefore, we have no uniform policy, which covers all treatments and procedures.
- Insurance — As a courtesy, we will be happy to file your insurance claims with benefits assigned to First Class Pediatric Dentistry. Any amount that is estimated to not be covered by your policy is due at the time of service. The estimate of benefits is based on information that our office has received from the insurance company. It should be understood that your insurance company may periodically change the level of your benefits without our knowledge. Therefore, it is important to understand that you will be responsible for any difference in payment that may be discovered between the estimated and the actual coverage amount. If you know of any changes in your coverage, please notify our office immediately. A copy of your current insurance card will be required for our file.
- The patient's parent/guardian understands and agrees that he or she is responsible for all amounts due, and further agrees to pay any fees (including attorney's fees and the other costs) associated with collections as well as interest in the amount of 18.00% annual percentage yield on past due accounts.
- There is a $25 return check fee for all returned checks.

Patient Name _____

I acknowledge that I have read and accept the above office policies of the First Class Pediatric Dentistry

Parent/Legal Guardian Signature _____ Date_____

Rev.O1-05 Form 9