Children's Dentistry of Charleston

NEW PATIENT FORM

ChildrensDentistrySC.com

About Your Child

Child's Name

Name Child Prefers To Be Called

Age Gender Date of Birth

Address Apt

City State Zip

Home Phone Patient's School District (county/city)

Grade Level Patient's Hobbies/Pets

Other Children and Their Ages

Referred To Our Office By (We Wish To Thank Them)

Parent's Marital Status:
❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Single

Dental History

❑ Yes ❑ No Is this your child's first visit to the dentist? If no, when was the last visit and what was done for your child?

❑ Yes ❑ No Do you expect your child to be a cooperative patient? If no, please explain.

❑ Yes ❑ No Do you have well water at home?
❑ Yes ❑ No Does your child take fluoride tablets or vitamins with fluoride?
❑ Yes ❑ No Has your child bumped any teeth? If so, when?

❑ Yes ❑ No Has your child had a history of headaches, pain, popping or clicking of the jaws?
❑ Yes ❑ No Does your child still have a night time bottle?
❑ Yes ❑ No Does your child have a toothache?

Does your child have or has he or she had any of the following problems or habits?

❑ Thumb Sucking How Long?____ Still Active ❑ Yes ❑ No
❑ Finger Habit How Long?____ Still Active ❑ Yes ❑ No
❑ Pacifier How Long?____ Still Active ❑ Yes ❑ No

Medical History

Is your child presently under the care of your family physician for any medical reason? ❑ Yes ❑ No If yes, explain ____

Family Physician's Name:____
Address: ____
Phone Number:____

- Is your child in good health? If no, explain ____ ❑ Yes ❑ No
- Is your child under the care of a physician for other than routine care? If yes, explain ____ ❑ Yes ❑ No
- Does your child have any drug allergies? If yes, explain ____ ❑ Yes ❑ No
- Is your child taking any medications at this time? If yes, list. ____ ❑ Yes ❑ No
- Has your child ever been hospitalized or treated in an emergency room for any particular trauma? When and for what reason? ____ ❑ Yes ❑ No
- Does your child have, or has he or she had, any emotional, mental or nervous disorders? If yes, please explain. ____ ❑ Yes ❑ No
- Have your child's tonsils and/or adenoids been removed? ❑ Yes ❑ No
- Does your child breathe through the mouth? If yes, ❑ Seldom ❑ Often ❑ Yes ❑ No

Please indicate if your child has had any of the following:

❑ Allergy to Penicillin
❑ Anemia
❑ Asthma
❑ Autism/Asperger's Syndrome
❑ Bleeding disorder
❑ Bone disorder
❑ Cleft palate
❑ Diabetes
❑ Endocrine disorder
❑ Epilepsy, seizures
❑ Hyperactivity/ADD/ADHD
❑ Intellectual disability
❑ Latex allergy/sensitivity
❑ Liver problems or hepatitis
❑ Malignancies or leukemia
❑ Other drug allergy
❑ Physical handicap
❑ Positive for H.I.V.
❑ Radiation treatment
❑ Rheumatic fever
❑ Speech problem
❑ Tuberculosis
❑ Heart ailment or murmur. Type, if known____

Is child under the care of a cardiologist or special physician for the problem? If so, whom ____
Phone ____

Please comment on any problems that were checked in the above areas ____

Do you consider your child to be:

- Advanced in the learning process ❑ Yes ❑ No
- Progressing normally ❑ Yes ❑ No
- A slow learner ❑ Yes ❑ No

Dental History

How often does your child brush?_____

Is toothbrushing supervised? ❑ Yes ❑ No

By whom?_____

Is dental floss used? ❑ Yes ❑ No

Does your child receive:

❑ Fluoride tablets/drops

❑ Fluoridated water

❑ Fluoride in vitamins

❑ Bottled water

❑ Well water

Responsible Party

Father's Full Name

Address Apt

City State Zip

SS# Birthdate

Home Phone Cell Phone

Business Phone Employer

Occupation Email Address

Dental Insurance: ❑ Yes ❑ No

Insurance Company Group or Plan Number

Insurance Company Phone

Mother's Full Name

Address Apt

City State Zip

SS# Birthdate

Home Phone Cell Phone

Business Phone Employer

Occupation Email Address

Dental Insurance: ❑ Yes ❑ No

Insurance Company Group or Plan Number

Insurance Company Phone

Nearest Relative/Friend

Name

Address Apt

City State Zip

Phone Relationship

In case you are not at home, what is your neighbor's

Name Phone

Financial Information

Method of Payment:

Please check one:

❑ Check or cash at time of treatment

❑ Visa, Mastercard, American Express or Discover

❑ Insurance form with co-payment at time of treatment

❑ Other: _____

- Payment is expected at time of treatment.
- All emergency patients (being seen for the first time) are required to pay in full at time of treatment.
- Patients with insurance may pay their estimated portion, including deductible, at the time of service. It is the parents responsibility to see that the insurance company makes prompt payment. Any insurance balance over 60 days is due and payable by the parent.

If my account requires servicing by a collection agency or by an attorney, I understand that I will be liable for collection fees, attorney fees, and applicable court costs, in addition to my outstanding balance. I hereby authorize payment directly to Children's Dentistry of Charleston, the group insurance benefits otherwise payable to me and authorize release of information regarding treatment to the insurance company.

SIGNED (Guarantor)

I give my consent to needed dental services, local anesthetic, nitrous oxide analgesia (laughing gas) and use of proper and acceptable methods to complete same. I accept responsibility for payment of services rendered for _____ (child's name). I understand that I will be informed of any treatment (other than routine cleanings, fluoride treatments, x-rays and examinations) before that treatment is performed.

SIGNED (parent or legal guardian) **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 March 1st, 2003, 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

Your child's health information and the rights associated with that health information also rest with the "personal representative" of that individual, generally the parent or legal guardian.
We use and disclose health information 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 your child.
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 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 officials 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. Contact us using the information listed at the end of this Notice for a full explanation of time and fees involved.

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).

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, 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 anyway if you choose to file a complaint.

Contact Officer: Tim Tiffin

Telephone: 678-445-5444 Fax: 678-235-2475

Address: 1350 Spring Street N.W., Suite 600, Atlanta, GA 30309

Authorization for additional disclosure:

I am the "personal representative" of (generally parent or legal guardian) and have legal authority to make health care decisions about the following minor patient:

_____

Patient Name

As the "personal representative" of the above named patient, I authorize the following individuals to accompany my child and have access to health information.

Name: Relationship

1.)_____ _____

2.)_____ _____

3.)_____ _____

4.)_____ _____

5.)_____ _____

6.)_____ _____

_____ _____

"Personal Representative" (Parent or Legal Guardian) Date