PLEASE FILL OUT ONE FORM (FRONT AND BACK) PER FAMILY

Child(ren) ____

____

Address ____

City ______________ State ______________ Zip Code ______________

Mom Cell ______________ Dad Cell ______________ Home Phone ______________

Email ____

Whom may we thank for referring you to our practice? ______________________

PARENT/GUARDIAN INFORMATION

Biological/Adoptive Mother/Guardian ______________________ Date of Birth __________

Address ______________________ SSN __________

Biological/Adoptive Father/Guardian ______________________ Date of Birth __________

Address ______________________ SSN __________

Step Mother ______________________ Date of Birth __________

Step Father ______________________ Date of Birth __________

Who does the child live with? ______________________

Is either parent active military? ☐ Yes ☐ No

Are the child’s biological or adoptive parents married? ☐ Yes ☐ No

Are the child’s biological or adoptive parents divorced? ☐ Yes ☐ No

Is there a divorce decree or custody order that states who must carry health insurance for the child(ren)? ☐ Yes ☐ No

*If there is a decree or order, we will need a copy of the relevant portion (not the entire order) stating who must hold insurance.

MEDICAL INSURANCE INFORMATION

Insurance Company ______________________ Policy # __________

PRIMARY DENTAL INSURANCE INFORMATION

Policy Holder ______________________ Policy Holder SS# __________

Insurance Company ______________________ Ins. Co. Phone # __________

Policy # ______________________ Group # __________

Employer ____

SECONDARY DENTAL INSURANCE INFORMATION

Policy Holder ______________________ Policy Holder SS# __________

Insurance Company ______________________ Ins. Co. Phone # __________

Policy # ______________________ Group # __________

Employer ____

CONSENT FOR TREATMENT

I am the parent or legal guardian of the minor child or children listed with this packet and there are no court orders now in effect that prevent me from signing this consent. The information I have given is correct to the best of my knowledge. I fully understand that Pediatric Dentistry of Central Georgia, PC is relying on the information I have provided in agreeing to treat my child. It will be held in the strictest confidence and it is my responsibility to inform Pediatric Dentistry of Central Georgia PC, of any changes in my child's medical status. I authorize Dr. Moore, Dr. Flournoy and/or associates to perform any necessary dental procedures. **ALL PROCEDURES WILL BE DISCUSSED WITH YOU PRIOR TO ANY DENTAL TREATMENT AND A TREATMENT PLAN SIGNED**.

Parent/Guardian: ____ **Date**: ________________________

Print Name: ____

FINANCIAL INFORMATION

Our policy requires payment in full at the time of service. For those families utilizing insurance benefits, we are happy to file your insurance claim as a courtesy. However, there is no direct relationship between our office and your insurance company. The type of plan chosen by you, and/or your employer, determines your insurance benefits. As such, we have no say in the selection of your insurance company, no control over the terms of your contract, the methods of reimbursement or the determination of your insurance benefits. Reimbursement for covered services is subject to maximum allowable fees, deductibles, and co-payments. Your responsibility is ***estimated*** and ***due at the time of treatment***. It is also your responsibility as parent/guardian to pay any remaining balance on your account after any and all insurance benefits have been collected. I hereby authorize all insurance benefits, if any, to be assigned directly to Pediatric Dentistry of Central Georgia, otherwise payable to me for services rendered. I authorize the release of any information to process insurance claims, including the use of my signature on all insurance submissions. If your account is not paid within 75 days, you will be liable for all collection fees, interest charges, and any other expenses incurred while collecting your account. There is a fee of $50 for returned checks.

Parent/Guardian: ____ **Date**: ________________________

Print Name: ____

CONFIRMATION & MISSED APPOINTMENT POLICY

We are dedicated to provide the best dental care possible for your child. We want to give your child the time and ***INDIVIDUAL*** attention they deserve. In a sincere effort to acknowledge the importance of each parent's time, and to remain on time during our busy schedule, we must ask that parents arrive on time for their children's appointments. This allows us to be able to see all the children that are scheduled in a timely and efficient way. When a parent is *late* or *fails* to make a scheduled appointment, this may jeopardize all the children's treatment. It also affects other parent's schedules that have children scheduled after your child that day.

- Parents may change or cancel their child's appointment with at least a 48-hour notice (2 business days).
- Appointments must be confirmed *48 hours in advance.* If you do not confirm the appointment then it will be moved off the schedule. Pediatric Dentistry of Central Georgia, PC will place a courtesy call prior to your appointment to answer any questions you may have.
- If a patient is more than 15 minutes late, we may need to reschedule the appointment. If we are able to see the child, we cannot guarantee that all treatment will be completed.
- There may be a $25 fee charged to your account for all appointments that are cancelled and/or broken within less than 48 hours. If your child is being sedated and you do not give 48 hours notice (2 business days) you will forfeit your deposit.
- After having 2 missed or broken appointments, we will no longer be able to provide your child dental care. If this happens, you will be notified by mail of your child's dismissal for the practice. We will continue to provide emergency dental care for your child for up to 30 days following the dismissal.

Parent/Guardian: ____ **Date**: ________________________

PLEASE FILL OUT ONE FORM (FRONT AND BACK) FOR EACH CHILD.

Name ____

Date of Birth ____________ ☐ Male ☐ Female Hobbies ________________________________

DENTAL HISTORY

Last Dental Visit: ____________ Last Cleaning: ____________ Last X-Rays: ____________

Previous Dentist ____________________ Do you have a copy of x-rays? ____________

My child brushes his/her teeth _______ times per day.

Do you help your child brush his/her teeth? ☐ Always ☐ Sometimes ☐ Never

Does your child have any mouth habits? (Please circle all that apply)

Thumb/Finger Sucking   Grinding during sleep   Sleeping with bottle   Pacifier

Other: ____

Does your child floss every day? ☐ Yes ☐ No
Is fluoride taken in any form? ☐ Yes ☐ No
Do you expect your child to be cooperative? ☐ Yes ☐ No
Does your child do well at hair appointments? ☐ Yes ☐ No

Any injuries to the mouth/teeth? ☐ Yes ☐ No Please explain: ____________________

____

Is there a history of bad dental experience? ☐ Yes ☐ No Please explain: ____________________

____

Is your child in pain today? ☐ Yes ☐ No Please explain: ____________________

____

Does your child have a dental condition about which you are especially concerned? ____________________

____

Has he/she ever been hospitalized or had surgery? ☐ Yes ☐ No Why? ____________________

Any handicaps/disabilities? ☐ Yes ☐ No List: ____________________

MEDICAL HISTORY Child's Name ______________________ Weight ______________

CURRENT ADDRESS/PHONE ____

Place a mark on yes or no for each of the following.

Condition		Condition		Condition	
ADD/ADHD	☐ Yes ☐ No	Drug/Alcohol Abuse	☐ Yes ☐ No	Reflux	☐ Yes ☐ No
AIDS/HIV	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fainting	☐ Yes ☐ No	Sensory Process Disorder	☐ Yes ☐ No
Asperger's	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Sickle Cell	☐ Yes ☐ No
Autism	☐ Yes ☐ No	Heart Valve Replacement	☐ Yes ☐ No	Sinus Problems	☐ Yes ☐ No
Bladder Issues	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Skin Disorder	☐ Yes ☐ No
Bleeding Issues	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No	Speech Problem	☐ Yes ☐ No
Cancer/Tumors	☐ Yes ☐ No	Kidney/Stomach Disease	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Cerebral Palsy	☐ Yes ☐ No	Learning Disabilities	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Cleft Palate	☐ Yes ☐ No	Lung Disease	☐ Yes ☐ No	Other:	
Hearing Loss	☐ Yes ☐ No	Measles	☐ Yes ☐ No	______________	
Chicken Pox	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Are you on well water?	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Radiation/Chemotherapy	☐ Yes ☐ No	**Girls:** Are you pregnant?	☐ Yes ☐ No

If you said yes for the following, please provide additional information:

Asthma When was your child's last attack? ______________ Ever hospitalized? When? ______________

Epilepsy When was your child's last seizure? ______________ Ever hospitalized? When? ______________

Child's Pediatrician ______________________ City/State ______________

Pediatrician Phone # ______________________ Date of last exam: ______________

Any health concerns? ____

MEDICATIONS List any medications that your child is currently taking and the correlating diagnosis: ______________

____

ALLERGIES ☐ NONE ☐ Penicillin/Amoxicillin ☐ Latex ☐ Aspirin ☐ Sulfa ☐ Metal ☐ Local Anesthetic

☐ Other - List ____

SIGNATURE: ______________________ (signature) ______________ (date)

SIGNATURE: ______________________ (signature) ______________ (date) ______________ (UPDATED weight)

SIGNATURE: ______________________ (signature) ______________ (date) ______________ (UPDATED weight)

SIGNATURE: ______________________ (signature) ______________ (date) ______________ (UPDATED weight)

SIGNATURE: ______________________ (signature) ______________ (date) ______________ (UPDATED weight)

Pediatric Dentistry of Central Georgia, PC HIPAA STATEMENT

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.

I. PURPOSE AND APPLICABILITY OF THIS NOTICE

The Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") and the regulations implementing HIPAA require health plans to notify participants and beneficiaries about how their protected health information ("PHI") may be used by the Plan and disclosed to other parties. "PHI" means your individually identifiable health information, including demographic and genetic information, that relates to your past, present, or future physical or mental health or condition: related health care services and payment for health care services.

II. RESPONSIBILITIES AND RIGHTS UNDER THE PLAN

Our Responsibilities

- The Plan is required by law to make sure that your PHI is kept private, to give you this Notice of the Plan's legal duties and privacy practices related to the use and disclosure of your PHI, to notify affected individuals after a breach of unsecured PHI, to follow the terms of the Notice currently in effect, and to communicate to you any future changes to this Notice.
- We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give this Notice about our privacy practice, our legal duties, and your right concerning your health information. We must follow the privacy practices that are described in the Notice while it is in effect. This Notice takes effect January 1, 2020 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 term 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.

Your 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 fee 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-base fee for responding to these 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).
- **Amendments:** 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 website or be electronic mail (e-mail), you are entitled to receive this Notice in written form.

III. USES AND DISCLOSURES OF PHI WITH AND WITHOUT YOUR AUTHORIZATION

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. If we refer you to another provider, we will forward your records to that office.
- **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.
- **Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

- **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 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.
- **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.
- **With 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 disclosure 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 extend necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so on the following page.
- **As Required by Law:** We may use or disclose your health information when we are required to do so by law.
- **National Security**: We may disclose to the military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to federal officials health information required for lawful intelligence, counterintelligence, and other 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.

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

IV. Questions and Complaints

If you want more information about our privacy practices or have questions or concern, 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.

Contact Officer: Sarah Graham
Telephone: 478-333-3636
Fax: 478-333-6399
E-mail: frontdesk@growbigsmiles.com
Address: 900 Professional Drive Warner Robins, GA 31088

Authorization for Additional Disclosure

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

Child/Children's name(s) ____

____

Parents and legal guardians are automatically authorized. If you would like to authorize additional individuals (ie: grandparents, babysitters), please list them below. I authorize the following individuals to (please check all that apply):

Name	Relationship	Accompany Child	Access PHI	Consent to Tx
____________________	__________	☐	☐	☐
____________________	__________	☐	☐	☐
____________________	__________	☐	☐	☐
____________________	__________	☐	☐	☐

Authorization for Methods of Contact

In general, the HIPAA privacy rule gives individuals the right to request a restriction of their health information. The individual is also provided the right to request confidential communications or that a communication of PHI (Protected Health Information) be made by alternative means, such as, sending information to the individual's office instead of their home. If you contact us in a method listed below, we will assume that it is okay to respond in the same manner or contact. I acknowledge that I will be contacted in all of the manners listed below.

Please check any manner that you do NOT want us to use:

Written Communication	☐ Mail to my home	☐ Mail to my work	☐ Fax to designated number
Email	☐ Write message with details	☐ Write message to call back	☐ Speak with spouse
Cell Phone	☐ Leave message with details	☐ Leave message to call back	☐ Speak with spouse
Home Telephone	☐ Leave message with details	☐ Leave message to call back	☐ Speak with spouse
Work Telephone	☐ Leave message with details	☐ Leave message to call back	

Authorization for to use/disclose PHI according to this Notice.

I give Pediatric Dentistry of Central Georgia, PC permission to use and disclose PHI necessary to carry out TPO (Treatment Payments or Operations). This also indicates that a "Good Faith Effort" was made on behalf of Dr. Margaret Moore. By signing this form, I understand that the privacy practices of the office have been disclosed to me. This information will stay on record for six years.

Acknowledgment of receipt of Notice.

I have received a copy of this offices notice of Privacy Practices.

______________________________________ ____________________

Parent or Legal Guardian 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:

☐ An emergency situation prevented us from obtaining acknowledgment

☐ Individual refused to sign

☐ Communication Barriers prohibited obtaining the acknowledgement

☐ Other

Patient Advisory and Acknowledgment

Receiving Dental Treatment During the COVID-19 Pandemic

Dear Patient:

You have come to our office today for a routine dental evaluation and/or treatment that will be done during the COVID-19 pandemic. Please be advised of the following:

> While our office complies with State Health Department and the Centers for Disease Control and Prevention infection control guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees.
>
> Our staff are symptom-free and, to the best of their knowledge, have not been exposed to the virus. However, since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge.

In order to reduce the risk of spreading COVID-19, we have asked you a number of "screening" questions below. For the safety of our staff, other patients, and yourself, please be truthful and candid in your answers.

______________________________ ______________

PATIENT/RESPONSIBLE PARTY **DATE**

PLEASE ANSWER "YES" OR "NO" WITH YOUR INITIALS, TO THE FOLLOWING QUESTIONS:

ARE YOU CURRENTLY AWAITING THE RESULTS OF A COVID-19 TEST? ______ YES ______ NO

DO YOU HAVE A FEVER? ______ YES ______ NO

DO YOU HAVE ANY SHORTNESS OF BREATH? ______ YES ______ NO

DO YOU HAVE A DRY COUGH? ______ YES ______ NO

DO YOU HAVE A RUNNY NOSE? ______ YES ______ NO

DO YOU HAVE A SORE THROAT? ______ YES ______ NO

DO YOU HAVE SNEEZING, WATERY EYES, AND/OR SINUS PAIN/PRESSURE THAT IS UNUSUAL AND NOT RELATED TO SEASONAL ALLERGIES? ______ YES ______ NO

HAVE YOU EXPERIENCED HEADACHES, FATIGUE, OR WEAKNESS? ______ YES ______ NO

HAVE YOU LOST YOUR SENSE OF TASTE AND/OR SMELL? ______ YES ______ NO

WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELLED TO ANY FOREIGN COUNTRY? ______ YES ______ NO

WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELLED WITHIN THE UNITED STATES? ______ YES ______ NO

IF SO, WHERE? ____

A Trip to the Dentist - Download our App!

Pediatric Dentistry
OF CENTRAL GEORGIA

We have a new App that walks your child through a trip to the dentist! The flipbook style App comes complete with pictures, narration and the funny sounds they will hear on their next cleaning visit.

To download, search: "A Trip to the Dentist" in the App Store

Or, scan the QR code below.

FOR IPHONE/IPAD

FOR ANDROID