



HEALTH HISTORY FORM

Today's Date _____

1 Tell Us About Your Child

Patient's Full Name _____
Preferred Name _____ Male Female
Siblings We Treat _____
Patient's Birth Date ____/____/____ Age _____
School _____ Grade _____
Social Security Number _____
Home Address _____
City _____ State _____ Zip _____
Home Phone (____) _____
Email _____

2 Mother's Information

Name _____
 Mother Stepmother Guardian
Birth Date ____/____/____
Employer _____
Work Phone (____) _____ Ext. _____
Home Phone (____) _____
Cell Phone (____) _____
SSN _____ DL# _____
Email _____

3 Father's Information

Name _____
 Father Stepfather Guardian
Birth Date ____/____/____
Employer _____
Work Phone (____) _____ Ext. _____
Home Phone (____) _____
Cell Phone (____) _____
SSN _____ DL# _____
Email _____

4 How Did You Hear About Us?

5 Who is Accompanying the Child Today?

Name _____
Relationship _____
Do you have legal custody of this child? Yes No

6 Person Responsible for Account

Name _____
Relationship _____
Billing Address _____
City _____ State _____ Zip _____
Home Phone (____) _____
Cell Phone (____) _____
Work Phone (____) _____ Ext. _____
Email _____

7 Primary Dental Insurance

Insurance Co. Name _____
Insurance Co. Address _____
Insurance Phone (____) _____
Group # (Plan, Local, or Policy #) _____
Policy Owner's Name _____
Relationship to Patient _____
Policy Owner's Birth Date ____/____/____
Policy Owner's SSN _____
Policy Owner's Employer _____

8 Secondary Dental Insurance

Insurance Co. Name _____
Insurance Co. Address _____
Insurance Phone (____) _____
Group # (Plan, Local, or Policy #) _____
Policy Owner's Name _____
Relationship to Patient _____
Policy Owner's Birth Date ____/____/____
Policy Owner's SSN _____
Policy Owner's Employer _____

9 *Dental History*

Is this your child's first visit to the dentist? Yes No
 If not, how long has it been since the last visit to the dentist?

Previous Dentist's Name _____

Were any x-rays taken at previous dental visits? Yes No

Have there been any injuries to the teeth, face, or mouth?

Yes No

If yes, please explain _____

Why did you bring your child to the dentist today? _____

Does the child have any of the following habits?

- | | |
|---|--|
| <input type="radio"/> Y <input type="radio"/> N Lip Sucking/Biting | <input type="radio"/> Y <input type="radio"/> N Nail Biting |
| <input type="radio"/> Y <input type="radio"/> N Thumb/Finger Sucking | <input type="radio"/> Y <input type="radio"/> N Pacifier |
| <input type="radio"/> Y <input type="radio"/> N Mouth Breathing | <input type="radio"/> Y <input type="radio"/> N Snoring |
| <input type="radio"/> Y <input type="radio"/> N Nursing/Bottle Habits | <input type="radio"/> Y <input type="radio"/> N Teeth Grinding |

Has your child ever had a serious or difficult problem associated with previous dental work? Yes No

If yes, please explain _____

Is your child's water fluoridated? Yes No

Is your child taking fluoride supplements? Yes No

Has your child ever had any pain or tenderness in his/her jaw joint (TMJ/TMD)? Yes No

Does your child brush his/her teeth daily? Yes No

Does your child floss his/her teeth daily? Yes No

I understand that the information I have given is correct to the best of my knowledge, that it will be held in strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. **I authorize the dental staff to perform the necessary dental services my child may need.**

Parent/Guardian Name (Print) _____

Parent/Guardian Signature _____

10 *Health History*

Has your child had any of the following conditions?

- | | |
|--|--|
| <input type="radio"/> Y <input type="radio"/> N ADD/ADHD | <input type="radio"/> Y <input type="radio"/> N Diabetes |
| <input type="radio"/> Y <input type="radio"/> N AIDS/HIV+ | <input type="radio"/> Y <input type="radio"/> N Disabilities/Special Needs |
| <input type="radio"/> Y <input type="radio"/> N Allergies | <input type="radio"/> Y <input type="radio"/> N Eating Disorder |
| <input type="radio"/> Y <input type="radio"/> N Asthma | <input type="radio"/> Y <input type="radio"/> N Hearing/Visual Impairment |
| <input type="radio"/> Y <input type="radio"/> N Autism | <input type="radio"/> Y <input type="radio"/> N Heart Disease/Murmur |
| <input type="radio"/> Y <input type="radio"/> N Blood Disorders | <input type="radio"/> Y <input type="radio"/> N Hepatitis |
| <input type="radio"/> Y <input type="radio"/> N Bone/Muscular Disorder | <input type="radio"/> Y <input type="radio"/> N Hospital Stays |
| <input type="radio"/> Y <input type="radio"/> N Cancer | <input type="radio"/> Y <input type="radio"/> N Immune Disorders |
| <input type="radio"/> Y <input type="radio"/> N Congenital Birth Defects | <input type="radio"/> Y <input type="radio"/> N Kidney/Liver Conditions |
| <input type="radio"/> Y <input type="radio"/> N Convulsions/Epilepsy | <input type="radio"/> Y <input type="radio"/> N Rheumatic/Scarlet Fever |
| <input type="radio"/> Y <input type="radio"/> N Depression/Anxiety | <input type="radio"/> Y <input type="radio"/> N Tuberculosis |

Please discuss any serious medical conditions your child has had _____

Please list all drugs your child is currently taking

Please list all allergies (drugs, latex, etc.) _____

Is your child currently under the care of a physician?

Yes No

Physician Name _____

Physician Phone (_____) _____

Please describe your child's current physical health:

Excellent Good Fair Poor

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

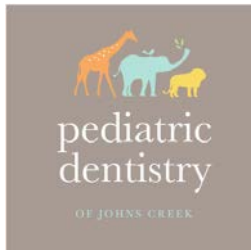


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I verbally reviewed the medical/dental information above with the parent/guardian and patient named herein. Initials _____ Date _____

Doctor's Comments _____



James Hicks, DMD, MS
Pediatric Dentist

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Johns creek, Georgia 30097
(678) 822-9818 o (678) 822-9820 f
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APPOINTMENT POLICY

The scheduled appointment is reserved specifically for your child. Any change in this appointment affects many patients.

- ✔ *We prefer to schedule all restorative procedures (fillings, extractions, etc.) in the morning for children 6 years and younger.* Children, as well as adults, are more prepared and do better in the morning for these types of procedures.
- ✔ **We strive to see all patients on time for their scheduled appointment.** There are times when our schedule is delayed in order to accommodate an injured child or an emergency. Please accept our apology in advance should this occur during your appointment. We promise to give the exact same courtesy if your child is in need of emergency treatment.
- ✔ *If you arrive 10-15 minutes late for your appointment, you may be asked to reschedule for the next available appointment time.*
- ✔ **Please call at least 48 hours in advance if a cancellation is unavoidable** so that we can give the appointment time to another patient.
- ✔ *Broken or missed appointments affect many people.* If two (2) broken/missed appointments occur OR two (2) cancellations without 48 hour notice, our office reserves the right to NOT schedule any subsequent appointments and/or charge a \$50.00 broken appointment fee.
- ✔ **A parent or legal guardian (with official documentation) must be present** during all restorative appointments. The “Authorization To Bring Child Form” must be filled out for someone other than a parent or legal guardian for routine dental visits.

If at any time you have questions, please feel free to ask our staff or call our office. We are here to help in any way we can. We appreciate you entrusting your child’s dental health to us. Thank you!

Patient Name

Parent/Guardian Signature

Date



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FINANCIAL POLICY

Thank you for choosing our office for your child's dental treatment. We are committed to their successful treatment! Please understand that *payment of your bill is considered a part of your child's treatment.*

- ✔ Please be aware that the parent bringing the child to Pediatric Dentistry of Johns Creek is *legally responsible for payment of all charges.* We cannot send statements to other persons.
- ✔ Payment is expected in full for each appointment as services are rendered.

TYPES OF PAYMENT - We accept cash, personal checks and all major credit cards (Visa, MasterCard, Discover and American Express). Personal checks cannot be post-dated and there is a \$50.00 fee for all returned checks.

DENTAL INSURANCE - If we have received all of your insurance information on the day of the appointment, we will be happy to file the claim for you. You must be familiar with your insurance benefits, as we will collect from you the estimated amount insurance is not expected to pay.

- ✔ By law your insurance company is required to pay each claim within 30 days of receipt. We file all insurance electronically, so your insurance company will receive each claim within days of the treatment.
- ✔ *You are responsible for any balance on your account after 30 days, whether insurance has paid or not.* If you have not paid your balance within 60 days a re-billing fee of 1.5% will be added to your account each month until paid. We will be glad to send a refund to you if your insurance pays us.

PLEASE UNDERSTAND that *we file insurance as a courtesy to our patients.* We do not have a contract with your insurance company, only you do. We are not responsible for how your insurance company handles its claims or for what benefits they pay on a claim. We can only assist you in estimating your portion of the cost of the treatment, however, we have no influence over your coverage.

We recognize that under unusual circumstances an account balance may be incurred. Pediatric Dentistry of Johns Creek requires that all outstanding balances be *paid in full within thirty (30) days* unless other arrangements have been made. Also note if we have not received payment, or you have not contacted us within thirty (30) days, further action may be taken. Thank you in advance for your understanding of our financial policy!

Patient Name

Parent/Guardian Signature

Date



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NOTICE OF HIPAA 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 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.

PATIENT RIGHTS

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.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign

I, _____, have received a copy of this office's Notice of Privacy Practices.

Patient Name (Print)

Parent/Guardian Signature

Date



FOR OFFICE USE ONLY



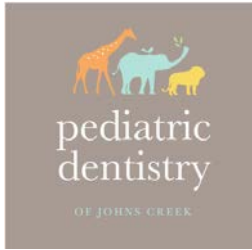
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained due to:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgment

_____ Other (please explain)



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AUTHORIZATION TO BRING CHILD

I hereby authorize Dr. James Hicks and his staff members, in my absence, to allow the individual(s) named below to bring my child to Pediatric Dentistry of Johns Creek to provide dental services.

I understand that my child will not be allowed to have any dental treatment performed without a legal guardian present at the appointment. This form is for routine dental services only.

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Please note that the person authorized to accompany your child MUST present identification at the time of the appointment.

Patient Name (Print)

Parent/Guardian Name (Print)

Parent/Guardian Signature

Date



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SOCIAL MEDIA

So that our friends can like and share in your child's experience at Pediatric Dentistry of Johns Creek, do we have your permission to use your child's/children's picture on our Facebook page?

_____ Yes

_____ No

Patient Name (Print)

Parent/Guardian Name (Print)

Parent/Guardian Signature

Date