



WELCOME

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.

PATIENT INFORMATION

Date _____ SS/HIC/Patient ID # _____ Birthdate _____

Name of Minor/Child _____ Sex M F Age _____

Last Name First Name Middle Initial

Nickname _____ Hobbies _____ Cell Phone (____) _____

Home Address _____

Street City State Zip

Mailing Address _____

Street City State Zip

School Name _____ School Phone (____) _____

Person financially responsible _____ Home Phone (____) _____ Work Phone (____) _____

Whom may we thank for referring you? _____

INSURANCE

<p>Father's/Guardian's Name _____</p> <p>Address (if different from patient's) _____</p> <p>Home Phone (____) _____ Work Phone (____) _____ (if different from above) (if different from above)</p> <p>E-mail _____</p> <p>Employer _____</p> <p>Soc. Sec. # _____ Birthdate _____</p> <p>Do you have dental insurance coverage for minor/child? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Plan Name _____ Phone (____) _____</p> <p>Address _____</p> <p>Group # _____ Policy # _____</p> <p>Is your child eligible for treatment under Medical Assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No Child's Medical Assistance I.D. # _____</p>	<p>Mother's/Guardian's Name _____</p> <p>Address (if different from patient's) _____</p> <p>Home Phone (____) _____ Work Phone (____) _____ (if different from above) (if different from above)</p> <p>E-mail _____</p> <p>Employer _____</p> <p>Soc. Sec. # _____ Birthdate _____</p> <p>Do you have dental insurance coverage for minor/child? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Plan Name _____ Phone (____) _____</p> <p>Address _____</p> <p>Group # _____ Policy # _____</p>
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DENTAL HISTORY

<p>Date of last visit to a dentist _____</p> <p style="text-align: center;">YES NO</p> <p>Has child complained about dental problems? <input type="checkbox"/> <input type="checkbox"/></p> <p>Does child brush teeth daily? <input type="checkbox"/> <input type="checkbox"/></p> <p>Does child use floss every day? <input type="checkbox"/> <input type="checkbox"/></p> <p>Any mouth habits - thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc? <input type="checkbox"/> <input type="checkbox"/></p>	<p>For what service? _____</p> <p style="text-align: center;">YES NO</p> <p>Is fluoride taken in any form? <input type="checkbox"/> <input type="checkbox"/></p> <p>Any injuries to mouth, teeth, head? <input type="checkbox"/> <input type="checkbox"/></p> <p>Any unhappy dental experiences? <input type="checkbox"/> <input type="checkbox"/></p>
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MEDICAL HISTORY

Minor/Child's Physician _____ City/State _____ Phone (____) _____

Date of last physical examination _____ Results _____

Is Minor/Child under care of physician now? YES NO
 Medications _____

Receiving any medication or drugs? _____

Ever been hospitalized? _____

Ever had surgery? Allergies _____

Is there excessive bleeding when cut? _____

Has minor/child had any history of or difficulty with any of the following? If yes, please check (✓).

- | | | | | |
|---|---|---|---|--|
| <input type="checkbox"/> A.I.D.S./H.I.V. | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Drug/Alcohol Abuse | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mumps | <input type="checkbox"/> Other |

In the event of an emergency, whom should we contact?

Name _____ Relationship _____ Phone (____) _____

Name _____ Relationship _____ Phone (____) _____

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 minor child ever has a change in health.

Minor/Child Consent

I am the parent, guardian, or personal representative of _____
Please Print Name of Minor/Child

and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

Insurance Assignment and Release

I certify that my dependent(s) is covered by insurance with _____
Name of Insurance Company(ies)

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my minor/child's health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.



Signature of Parent, Guardian or Personal Representative

Date

Please print name of Parent, Guardian or Personal Representative

Relationship to Patient

TO BE COMPLETED AT LATER VISIT

Has there been any change in patient's health since last dental appointment? Yes No

If yes, please describe _____

Is patient taking any new medications? Yes No If yes, please list _____

Date _____ Parent/Guardian Signature _____

Date _____ Dentist Signature _____

UPDATE

EMERGENCY CONTACT

AUTHORIZATION

Georgetown Family Dentistry

Notice of Privacy Receipt

I, _____, hereby acknowledge that I have received a copy of Georgetown Family Dentistry Notice of Privacy and Office Policies. I have also been given the opportunity to ask questions I may have regarding this notice.

Signature of Patient or Authorized Representative

Date Signed

Relationship or status if signed by parent, legal guardian, personal representative, etc.

Georgetown Family Dentistry

Tel: (912) 924-8484

Fax: (912) 924-8487

Email: ContactUs@georgetownfamilydental.com

GeorgetownFamilyDental.com

Notice of Privacy for Georgetown Family Dentistry

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review carefully.

Introduction

At Georgetown Family Dentistry, we are committed to treating and using protected health information about you responsibly. This notice of Health Information Practices describes information we collect, and how and when we use or disclose the information. It also describes your rights as they relate to your protected health information. This notice is effective March 1, 2011, and applies to all protected health information as defined by federal regulations.

Understanding your health record/ information

Each time you visit Georgetown Family Dentistry, a record of your visit is made. Typically, this record contains your symptoms, examination, test results, diagnoses, treatment, and plan for future care or treatment. This information often referred to as your health or medical record serves as a:

- Basis for planning your care and treatment.
- Means of communication among the many health professionals who contribute to your care.
- Legal document describing the care you received.
- Means by which you or third party payer can verify that services billed were actually provided.
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make informed decisions when authorizing disclosure to others.

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Your health record/ information

Although your health record is the physical property of Georgetown Family Dental, the following information belongs to you:

- Obtain a copy of this notice of information practices upon written request.
- Inspect and copy your health records.
- Amend your health record.
- Obtain and account of disclosures of your dental record.
- Request a restriction on certain uses and disclosures of your information
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities

Georgetown Family Dentistry is required to:

- Maintain the privacy of your health information.
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- Accommodate reasonable requests you may have to communicate dental information
- Abide by the terms of this notice.

We reserve the right to change our practice and to make the new provisions effective for all protected dental information e maintain. Should our practice information change, we will mail a revised notice to the address that we have on record.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue disclosing your dental information after we have received a written revocation of the authorization according to the procedures included in the authorization.

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Examples of Disclosures for Treatment, Payment and Dental Operations

Notifications: We may use or disclose information to notify or assist in notifying a family member, personal relative, or another authorized responsible party, your location, or general condition.

Communication with Family: Health professionals using their best judgment may disclose to a family member, other relative, close personal friend, or any other you identify, health information relevant to that person's involvement in your care or payment related to your care.

Workers Compensation: We may disclose information to the extent authorized by and to the extent necessary to comply with the laws relating to workers compensation or other similar programs established by law.

Insurance Companies: We will release information to insurance companies on your behalf in our quest to expedite any claims on your behalf.

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

Law Enforcement: We may disclose health information to be release to an appropriate health oversight agency, public health authorities or attorneys, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or has otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

Once Georgetown Family Dentistry gives out the information that I authorized release, I accept no fault to practice and members over the information and how it is distributed. Federal or State privacy laws may NO longer protect the information