Patient Information

Patient Information Date_____

Childs's Name_____Nickname_____ M □ F □

Age_____ Date of Birth_____School_____

Whom may we thank for referring you?_____

Family Record

Home Address_____City_____State_____Zip_____

Home Phone_____

Parent's full name_____ M □ F □ Driver's lic #_____Date of Birth_____

Address (if different)_____ Phone #_____

Occupation_____Employer_____SS #_____

Business Address_____Business Phone #_____

Cell Phone #_____

Parent's full name_____ M □ F □ Driver's lic #_____Date of Birth_____

Address (if different)_____Phone #_____

Occupation_____Employer_____SS #_____

Business Address_____Business Phone #_____

Cell Phone #_____

Please list your child's brothers and sisters first names and their ages_____

Has any member of your family been a patient in this office before? Yes □ No □

If yes, please name_____

Dental Insurance

Name of Insured_____Father/Mother/Stepparent/Guardian_____

Birthdate _____Social Security #_____

Insurance Company _____Group #_____Policy #_____

Insurance Co. Address_____City_____State_____Zip_____

Insurance Co. Phone #_____

I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED FOR MY DEPENDENTS.

SIGNATURE OF PARENT/GUARDIAN X_____

FINANCIAL RESPONSIBILITY

(If parents do not live together, the parent that accompanies the child will be responsible for payment at each visit.)

Parent responsible for payment: _____

Dental History

Child's Name_____

Reason for today's visit_____

Former Dentist_____ Date of last visit_____

Has your child had an unfavorable experience in a previous dental office?_____

Have there been any injuries to your child's teeth or jaw – falls, blows, chips, etc.?_____

Does your child receive fluoride vitamins, tablets, water, etc.?_____

Has an orthodontist seen your child? If so, who?_____

Does your child:

Suck his/her thumb/finger	Yes ☐	No ☐	Grind his/her teeth	Yes ☐	No ☐
Suck/bite his/her lips	Yes ☐	No ☐	Bite/chew his/her nails or hard objects	Yes ☐	No ☐
Clench his/her jaw	Yes ☐	No ☐			

Medical History

Physician's Name_____ Date of last visit_____

Phone #_____

Is your child presently under the care of a physician for any medical problem or condition? Yes ☐ No ☐

If so, please describe_____

Is your child currently taking any medications? Yes ☐ No ☐

Please list name and dosage_____

Has your child ever been hospitalized or had surgery? Yes ☐ No ☐

Please describe (for what condition and when)_____

Has your child ever had any of the following:

Asthma	Yes ☐	No ☐	Liver Disorder	Yes ☐	No ☐
Cancer/Tumor	Yes ☐	No ☐	Kidney Disorder	Yes ☐	No ☐
Hepatitis	Yes ☐	No ☐	Gastrointestinal Disorder	Yes ☐	No ☐
Hemophilia/Blood Disorder	Yes ☐	No ☐	Diabetes	Yes ☐	No ☐
Rheumatic Fever	Yes ☐	No ☐	Congenital Heart Defect	Yes ☐	No ☐
Allergies	Yes ☐	No ☐	Heart Murmur	Yes ☐	No ☐
Epilepsy or seizures	Yes ☐	No ☐	Anemia	Yes ☐	No ☐
Tuberculosis	Yes ☐	No ☐	Sickle Cell Anemia	Yes ☐	No ☐

Please describe further any medical problems that your child has:_____

Is your child developmentally delayed, physically handicapped, or have any learning or emotional disabilities?_____

Please describe any other medical history or problem you feel should be brought to the doctor's attention:_____

_____

Please list your child's allergies to any medications, foods, etc._____

I HEREBY AUTHORIZE DR. LISA LEE TO PERFORM A DENTAL EXAMINATION INCLUDING DENTAL XRAYS, IF NECESSARY, FOR MY ABOVE NAMED CHILD. ANY ADDITIONAL PROCEDURES BEYOND A DENTAL CLEANING WILL BE EXPLAINED TO ME PRIOR TO INITIATION OF SUCH PROCEDURES. I ALSO CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE QUESTIONS. I WILL NOT HOLD DR. LISA LEE OR HER STAFF FOR ANY ERRORS OR OMISSIONS I MAY HAVE MADE IN THE COMPLETION OF THIS FORM.

SIGNATURE:_____ RELATIONSHIP TO CHILD:_____DATE:_____

HIPPA Consent Agreement (Privacy Act)

I give consent for the use and disclosure of health information of myself and my dependent for the purpose of treatment, payment, or communication between other healthcare professionals. I understand and have been provided with a copy of this office's Notice of Privacy Practices prior to signing this condensed form.

Signature: _____ Date: _____

_____ _____

Please print name of Parent, Guardian, or Personal Representative Relationship to Patient

Sugarloaf Children's Dentistry NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR CHILD'S HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your child's health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your child's health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 11/2/06 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 your child for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your child's health information to a physician or other healthcare provider providing treatment for your chilld.

Payment: We may use and disclose your child's health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your child's health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your child's health information for treatment, payment or healthcare operations, you may give us written authorization to use your child's 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 child's health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your child's health information to you, as described in the Patient Rights section of this Notice. We may disclose your child's health information to a family member, friend or other person to the extent necessary to help with your child's healthcare or with payment for your child's 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 child's care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your child's 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 child's 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 child's health information for marketing communications without your written authorization.

Required by law: We may use or disclose your child's health information when we are required to do so by law.

Abuse or Neglect: We may disclose your child's health information to appropriate authorities if we reasonably believe that your child is a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your child's health information to the extent necessary to avert a serious threat to your child's 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 official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your child's 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 child's 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. (You must make a request in writing to obtain access to your child's health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we may charge you $5.00 to locate and copy your child's health information, and postage if you want the copies mailed to you. If you request an alternative format. we will charge a cost-based fee for providing your child's health information in that format. If you prefer, we will prepare a summary or an explanation of your child's health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your child's 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 child's 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).

Alternative Communication: You have the right to request that we communicate with you about your child's health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your child's 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 (email), 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 child's health information or in response to a request you made to amend or restrict the use or disclosure of your child's 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 child's health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Kimberly Spikes

Telephone: 770-813-9393 Fax: 770-813-9351

Address: 1299 Old Peachtree Rd.

Suite 102, 103

Suwanee, GA 30024

Please keep for your records.