Pediatric Dental Specialists of Atlanta, PC

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NEW PATIENT REGISTRATION

Today's Date: _____/_____/_____

Patient:
First Name: _____ MI: _____ Last Name: _____ Date of Birth: _____/_____/_____ Gender

Siblings:
First Name: _____ MI: _____ Last Name: _____ Date of Birth: _____/_____/_____ Gender

First Name: _____ MI: _____ Last Name: _____ Date of Birth: _____/_____/_____ Gender

First Name: _____ MI: _____ Last Name: _____ Date of Birth: _____/_____/_____ Gender

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____)_____-_____

Parent 1: First Name: _____ MI: _____ Last Name: _____

Parent 1 Work #: (_____)_____-_____ Cell Phone: (_____)_____-_____

Parent 1 Occupation/Employer: _____ Date of Birth: _____/_____/_____

Parent 2: First Name: _____ MI: _____ Last Name: _____

Parent 2 Work #: (_____)_____-_____ Cell Phone: (_____)_____-_____

Parent 2 Occupation/Employer: _____ Date of Birth: _____/_____/_____

*E-mail Address (for appointment reminders): _____

Who may we thank for referring you? _____

Insurance Information: ***WE ARE OUT OF NETWORK***

These documents are your consent to informed choice to receive the out-of-network services prior to your child's visit with us. As an out-of-network provider, we are making you aware of our Fee for Service Policy. ***Full payment is expected after your services.*** As a courtesy we will file through insurance for you. Expect a reimbursement in the mail. Please note, some of your services may/may not be fully covered by your insurance carrier.

Name of Insured: _____MI:_____Last Name:_____ **O** father **O** mother **O** other

Birth Date: _____/_____/_____

Social Security #: _____-_____-_____

Employer Name: _____

Employer Phone #: (_____)_____-_____

Insurance Company: _____ Phone: (_____)_____-_____

Group #: _____ Effective Date of Coverage: _____/_____/_____

Member ID #: _____ Electronic Claim Payor ID #: _____

Insurance Claims Filing Address: _____

City: _____ State: _____ Zip: _____

Reason for this visit: _____

Does this patient live with: ____both parents ____mother ____father ____other _____

Previous Dentist: _____ Date of last visit: ____/____/____ X-Rays taken? ___Yes ___No

Any unfavorable reaction to previous medical or dental visits: ____Yes ____No

If yes, please describe: _____

PATIENT MEDICAL HISTORY

Please describe your child's current physical health: Good____ Fair____ Poor____

Please list any medications the patient is currently taking: _____

Please list any medications the patient is allergic to: _____

Please list any other allergies the patient has: _____

Has your child had any of the following medical problems: (Please check, Yes or No)

Yes____ No____ Heart Murmur
Yes____ No____ Rheumatic Fever
Yes____ No____ Congenital Heart Defect
Yes____ No____ Cancer
Yes____ No____ HIV / AIDS
Yes____ No____ Abnormal Bleeding
Yes____ No____ Asthma
Yes____ No____ Handicap / Disability
Yes____ No____ Kidney / Liver problems
Yes____ No____ Hepatitis
Yes____ No____ Diabetes
Yes____ No____ Tuberculosis
Yes____ No____ Hemophilia
Yes____ No____ Epilepsy / Convulsions
Yes____ No____ Hearing Impairment

If yes, describe: _____

Other medical problems: _____

Has your child had any of the following?

Yes____ No____ Trauma of the mouth
Yes____ No____ Speech Difficulties
Yes____ No____ Pain / Clicking in jaw (TMJ)
Yes____ No____ Surgery If yes: _____
Yes____ No____ Ear Infections
Yes____ No____ Tonsils / Adenoids removed
Yes____ No____ Fluoride Supplement

Was your child?

Yes____ No____ Premature
Yes____ No____ Breast Fed
Yes____ No____ Bottle Fed
Yes____ No____ Very ill the first year
Yes____ No____ On the bottle past one year

Does your child have any of the following habits?

Yes____ No____ Thumb / Finger Sucking
Yes____ No____ Mouth Breathing
Yes____ No____ Nail Biting
Yes____ No____ Snoring

Does either parent have history of dental decay? Yes____ No____

Please explain - _____

Is there anything else you feel we should know about your child?

_____

_____

Separated/Divorced Families*: For those families where parents are separated or divorced, the parent who brings the child in to be seen and authorizes treatment is responsible to us for payment. All payments are due when services are rendered. If the divorce decree requires the other parent to pay all or part of the treatment cost, it is the responsibility of the authorizing parent to collect payment from the other parent. PDSofA will not act as a mediator in collecting our payments. If the account is not resolved in a timely manner, the authorizing parent's information will be submitted to our collection agency.* **Please initial**_____

I give permission for PDSofA to communicate with me and/or release dental records regarding my child via email, text or telephone, as needed. Please sign here _____ _____

Signature of Parent or Guardian *Date*

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

Please sign here _____ _____

Signature of Parent or Guardian *Date*

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

HIPAA PRIVACY AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

HIPAA stands for the Health Insurance Portability and Accountability Act. This act, approved by Congress in 1996, provides patients with uniform access to their medical records and more control over how their personal health information is used and disclosed. It also requires healthcare providers to safeguard the security and confidentiality of medical records. Full information about the Act is provided on the US Department of Health & Human Services web site. Pediatric Dental Specialists of Atlanta has taken all required steps to be in compliance with HIPAA regulations. We have adopted a privacy plan and trained our employees on its procedures. We have identified an employee who is responsible for ensuring that the procedures are implemented and up to date with current regulations. We have adopted an Electronic Medical Records (EMR) system that is certified in compliance with the Act. An important aspect of HIPAA is patient notification. When you first visit our offices, you will be asked to read and acknowledge receiving a copy of the following guidelines. Please read them carefully and feel free to ask any questions about how your child's medical records will be maintained.
Notice of Privacy Policies and Practices Pediatric Dental Specialists of Atlanta is committed to protecting our patients' privacy. The confidentiality of our patients is of greatest concern to Dr.Jackson and employees alike. This notice details how our practice collects, handles, and protects personal information about our patients. This policy will be distributed to all patients. We will review this policy on an annual basis and monitor our compliance with this policy.

There are only three (3) reasons why an employee needs to access a patient's chart or computer information: to treat or care for the patient, to process billing for services, or to respond to a medical records request.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

Patients' rights
Our patients have the following rights to privacy and respect regarding their personal information:

- The right to access and copy health records with reasonable notice.
- The right to request restriction on how health information is disclosed or used.
- The right to file a complaint if they believe that our safeguards and procedures have not been followed.

Complaints
If you think that we have not properly respected the privacy of your health information, you are free to complain to us, the U.S Department of Health and Human Services or Office for Civil Rights. If you want to make a complaint to us, send a written complaint to happyteeth755@gmail.com or 755 Mt. Vernon Hwy NE, 100 Atlanta, Ga 30328.

OUR NOTICE OF PRIVACY PRACTICES
By law, we must abide by the terms of the Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices we will post the new information in our office and have copies available.

APPOINTMENT REMINDERS
We may call, email, text, or write to remind you of scheduled appointments, past due reminders, or treatment and services available. Unless you tell us otherwise, we will mail or email you an appointment reminder on a post card or leave a message on your voicemail.

Acknowledgment of Receipt
I acknowledge that I received a copy of the Notice of Privacy Practices

Patient Name/s:_____

Guardian Signature:_____