peachtree hills
PEDIATRIC DENTISTRY

Today's Date: _____/_____/2022

Patient Information

Name: _____ Preferred Name: _____ Sex: ___Male ___ Female

Age: _____ Birth Date: _____/_____/_____

Dental History

Reason for this visit: Checkup/cleaning___ Dental caries___ Mouth Injury___ Toothache___ Crooked Teeth____

Oral Habits___ Other_____

Last Dental Visit/Reason_____ Dentist's Name_____

Any unhappy dental experience? _____

How do you think your child will behave during this visit? _____

Medical History

Patient's Pediatrician_____ Phone_____

Is child under the care of a physician now? Explain _____

Taking any medications or drugs? Explain _____

Ever been hospitalized? Explain _____

History of surgery? Explain _____

Any Drug/Food/Metal/Latex allergies? Explain_____

HAS YOUR CHILD HAD ANY HISTORY OF…

__ADHD	__Cerebral Palsy	__Heart disease	__High/low blood pressure	__Rheumatic fever
__AIDS/HIV	__Convulsions	__Heart murmur	__Prolonged bleeding	__Ear trouble
__Anemia	__Diabetes	__Premature birth	__Problems with anesthesia	__Eye Trouble
__Asthma	__Epilepsy	__Down Syndrome	__Seasonal allergies	__Nose Trouble
__Pregnancy	__Tuberculosis	__Hearing problems	__Hepatitis/Liver Disease	__ Gastric reflux
__Birth defect	__ Kidney disease	__Blood disorder	__Developmental delay	__Lung disease
__ Cancer	__ Thyroid disease			

Comments/Other:_____

_____

_____

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

Name_____ Relationship_____ Phone_____

How were you referred to our office?

___ Our Website ___ Friend/Relative: _____

___ Google Search ___ Sibling: _____

___ Insurance Website ___ Another Doctor: _____

Other: _____

Parent/Guardian Information

Father___ Stepfather___ Guardian___

Name_____ DOB____/____/_____ SSN#_____ Employer_____

Address_____ Unit #: _____City_____ Zip Code_____

Cell: _____ Home: _____ Work: _____

Email_____

Mother___ Stepmother___ Guardian___

Name_____ DOB____/____/_____ SSN#_____ Employer_____

Address_____ Unit #: _____City_____ Zip Code_____

Cell: _____ Home: _____ Work: _____

Email_____

Acknowledgement of Patient Information/Authorization for Initial Evaluation

The information I have given is correct to the best of my knowledge. I understand that all information is confidential, 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 to my child for an initial evaluation. Any other dental services required will be explained and authorized by me after the initial visit.

_____ _____/_____/2022

Signature of Parent/Guardian Today's Date

ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY

Financial Responsibility

All professional services rendered are charged to the patient and **are due at the time of services** unless other arrangements have been made in advance. Necessary forms will be completed to help expedite insurance carrier payments as a courtesy to you. However, you are responsible for all fees, regardless of insurance coverage. **Initial**: _____

Assignment of Benefits (If Insured)

I hereby assign all dental benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s) to issue payment check(s) directly to **Peachtree Hills Pediatric Dentistry** for dental services rendered to myself and/or my dependent(s) regardless of my insurance benefits, if any. Peachtree Hills Pediatric Dentistry will provide an **estimate** of insurance coverage upon request. I understand that Peachtree Hills Pediatric Dentistry is not responsible for inaccurate estimates. Payment(s) of a dental claim is not guaranteed by any insurance and is based on eligibility and policy coverage at the time a claim is submitted**. I understand that I am responsible for any amount not covered by insurance and I agree to pay any balance amount, in a timely manner. Initial**: _____

Authorization to Release Information (If Insured)

I hereby authorize **Peachtree Hills Pediatric Dentistry** to furnish and/or release any information necessary to insurance carriers concerning my/my dependent(s) dental treatment, to process my insurance claim acquired during my/my dependent(s) examination or treatment, to allow a photocopy of my signature to be used to process my insurance claim(s). This order will remain in effect until revoked by me in writing. **Initial**: _____

I, _____, have requested dental services from **Peachtree Hills Pediatric Dentistry** on behalf of myself and/or my dependent(s), and understand that by making this request, I become fully financially responsible for all charges incurred during treatment. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Responsible Party Name/Relationship (Printed): _____

Responsible Party Signature: _____

Today's Date: _____/_____/2022

Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my health information to carry out the following:

- **Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)**
- **Obtaining payment from third party payers (e.g. my insurance company)**
- **The day-to-day healthcare operations at your practice**

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my (and/or my dependent's) protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to there requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected

Print Patient Name: _____

Relationship to patient: _____

Signature: _____