pediatric dentistry
of central georgia

Dr. Margaret Moore, DMD
900 Professional Drive
Warner Robins, Georgia 31088
(478) 333-3636
Fax (478) 333-6399

We are so 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 any questions, we will be glad to assist you. We look forward to working with you in maintaining your child's dental health!

PATIENT INFORMATION

Child's Name:____
LAST FIRST MIDDLE NICKNAME

❑ Male ❑ Female Date of Birth: ___/_______/_______ Hobbies:______________________

Address: ____
STREET APT# CITY STATE ZIP

Home Phone#:________________ Mom's Cell#:______________Dad's Cell #:________________

E-mail Address:____

How would you prefer us to contact you regarding notice of upcoming appointments?
❑ Email ❑ Text ❑ Cell ❑ Home Phone

Whom may we thank for referring you to our practice?______________________________

PARENT'S INFORMATION

❑ Mother ❑ Stepmother ❑ Guardian Name:______________________________

Address (if different from above): ______________________________

Home # (if different from above):____________Work#:____________ ext____ Employer:______________

Social Security#______________________ DOB ________________

❑ Father ❑ Stepfather ❑ Guardian Name: ______________________________

Address (if different from above):______________________________

Home # (if different from above):____________Work#:____________ ext____ Employer: ______________

Social Security#______________________ DOB ________________

PRIMARY INSURANCE INFORMATION

Policy Holder:_______________ Relationship to patient:_______________

Policy Holder's Social Security#: _______________ Date of Birth:_____/_____/____

Insurance Company:_______________ Employer: _______________

Policy #_______________ Group#_______________ Telephone # of Ins Company_______________

SECONDARY INSURANCE INFORMATION

Policy Holder:_______________ Relationship to patient:_______________

Policy Holder's Social Security#: _______________ Date of Birth:_____/_____/____

Insurance Company:_______________ Employer: _______________

Policy #_______________ Group#_______________ Telephone # of Ins Company_______________

DENTAL HISTORY

Last dental visit: ______/______/______ *Last Cleaning:*______/______/______ *Last* X-rays:______/______/______

Previous Dentist:_______________ Do you have a copy of previous X-rays? ❑ Yes ❑ No

My child brushes his/her teeth ____times a day.

Do you ever help your child brush his/her teeth? ❑ Always ❑ Sometimes ❑ Never

Does your child floss every day? ❑ Yes ❑ No

Is there a history of bad dental experiences? ❑ Yes ❑ No

Please explain_______________

Do you expect your child to be cooperative? ❑ Yes ❑ No

Is your child in pain today? ❑ Yes ❑ No

Please explain_______________

Is fluoride taken in any form? ❑ Yes ❑ No

Any injuries to mouth/teeth? ❑ Yes ❑ No

Are you on well water? ❑ Yes ❑ No

Does your child do well at hair appts.? ❑ Yes ❑ No

Does your child have any mouth habits? (Please circle all that apply)

Thumb/Finger Sucking   Grinding during sleep   Pacifier   Sleeping with bottle   Other_______________

Does your child have a dental condition about which you are especially concerned? _______________

____

MEDICAL HISTORY

Child's Name: ______________________________

Child's Pediatrician: ____________________ City/State: ____________________ Phone: ________________

Date of last physical exam: _____/_____/_____ Patient's weight ______________________________

Has he/she ever been hospitalized or had surgery? ❑ Yes ❑ No If so, why?: ______________________

Any handicaps/disabilities? ❑ Yes ❑ No Please List: ______________________

Place a mark on "yes" or "no" if your child has had any of the following:

Condition	Yes/No	Condition	Yes/No	Condition	Yes/No
ADD/ADHD	❑ Yes ❑ No	Drug/Alcohol Abuse	❑ Yes ❑ No	Reflux	❑ Yes ❑ No
AIDS/HIV	❑ Yes ❑ No	Epilepsy	❑ Yes ❑ No	Rheumatic Fever	❑ Yes ❑ No
Anemia	❑ Yes ❑ No	Fainting	❑ Yes ❑ No	Sensory Processing Disorder	❑ Yes ❑ No
Aspergers	❑ Yes ❑ No	Headaches	❑ Yes ❑ No	Scarlet Fever	❑ Yes ❑ No
Asthma	❑ Yes ❑ No	Heart Murmur	❑ Yes ❑ No	Sickle Cell	❑ Yes ❑ No
Autism	❑ Yes ❑ No	Heart Valve Replacement	❑ Yes ❑ No	Sinus Problems	❑ Yes ❑ No
Bladder Issues	❑ Yes ❑ No	Hepatitis	❑ Yes ❑ No	Skin Disorder	❑ Yes ❑ No
Bleeding Issues	❑ Yes ❑ No	Hemophilia	❑ Yes ❑ No	Speech Problem	❑ Yes ❑ No
Cancer/Tumors	❑ Yes ❑ No	Kidney/Stomach Disease	❑ Yes ❑ No	Thyroid Disease	❑ Yes ❑ No
Cerebral Palsy	❑ Yes ❑ No	Learning Disabilities	❑ Yes ❑ No	Tuberculosis	❑ Yes ❑ No
Cleft Palate	❑ Yes ❑ No	Lung Disease	❑ Yes ❑ No	Other: ________________	
Hearing Loss	❑ Yes ❑ No	Measles	❑ Yes ❑ No	________________	
Chicken Pox	❑ Yes ❑ No	Mumps	❑ Yes ❑ No	________________	
Diabetes	❑ Yes ❑ No	Radiation/Chemotherapy	❑ Yes ❑ No		

Girls: Are you pregnant? ❑ Yes ❑ No Are you on well water? ❑ Yes ❑ No

If you said yes for the following:

Asthma when was your child's last attack?______ Has he/she ever been hospitalized for asthma?_______ If so when?_______

Epilepsy when was your child's last seizure?______ Has he/she ever been hospitalized for epilepsy?______ If so when?______

Any additional health concerns?____

____

MEDICATIONS

Please list any medications that your child is currently taking and the correlating diagnosis: ____________________

____

ALLERGIES

❑ None ❑ Penicillin/Amoxicillin ❑ Latex ❑ Aspirin ❑ Sulfa ❑ Local Anesthetic

❑ Metal ❑ Other (Please list):______________________________

Update:______________________________ ____________ ____________
signature date current weight

Update:______________________________ ____________ ____________
signature date current weight

Update:______________________________ ____________ ____________
signature date current weight

Update:______________________________ ____________ ____________
signature date current weight

Update:______________________________ ____________ ____________
signature date current weight

CONSENT FOR TREATMENT

I am the parent or legal guardian of the minor child ____________________________________ and there are no court orders now in effect that prevent me from signing this consent. The information I have given is correct to the best of my knowledge. I fully understand that Dr. Moore and the staff at Pediatric Dentral Center of Georgia, LLC are relying on the information I have provided in agreeing to treat my child. It will be held in the strictest confidence and it is my responsibility to inform Pediatric Dentistry of Central Georgia PC, of any changes in my child's medical status. I authorize Dr. Moore and/or associates to perform the following necessary dental procedures including, but not limited to, the use of Nitrous Oxide (laughing gas), local anesthetic (like Lidocaine), dental cleanings, fluoride applications, and any necessary x-rays needed on my child.

ALL PROCEDURES WILL BE DISCUSSED WITH YOU PRIOR TO ANY DENTAL TREATMENT AND A TREATMENT PLAN SIGNED.

Parent/Guardian:____ Date:____

FINANCIAL INFORMATION

Our policy requires payment in full at the time of service.

For those families utilizing insurance benefits, we are happy to file your insurance claim as a courtesy. However, there is no direct relationship between our office and your insurance company. The type of plan chosen by you, and/or your employer, determines your insurance benefits. As such, we have no say in the selection of your insurance company, no control over the terms of your contract, the methods of reimbursement or the determination of your insurance benefits. Reimbursement for covered services is subject to maximum allowable fees, deductibles, and co-payments. Your responsibility is ***estimated*** and ***due at the time of treatment***. It is also your responsibility as parent/guardian to pay any remaining balance on your account after any and all insurance benefits have been collected.

If your insurance company denies your claim, you are immediately liable for the full balance. It is your responsibility to work with your insurance company if you feel they are wrongfully denying your claim. We reserve the right to collect this balance in full, send the account to collects and/or file suit on the balance if it is not paid in a timely manner.

If your account is not paid within 75 days, you will be liable for all collection fees, interest charges, and any other expenses incurred while collecting your account. There is a fee of $50 for returned checks.

I hereby authorize all insurance benefits, if any, to be assigned directly to Pediatric Dentistry of Central Georiga, otherwise payable to me for services rendered. I authorize the release of any information to process insurance claims, including the use of my signature on all insurance submissions.

Parent/Guardian:____ Date:____

CONFIRMATION & MISSED APPOINTMENT POLICY

We are dedicated to provide the best dental care possible for your child. We want to give your child the time and ***INDIVIDUAL*** attention they deserve. In a sincere effort to acknowledge the importance of each parent's time, and to remain on time during our busy schedule, we must ask that parents arrive on time for their children's appointments. This allows us to be able to see all the children that are scheduled in a timely and efficient way. When a parent is *late* or *fails* to make a scheduled appointment, this may jeopardize all the children's treatment. It also affects other parent's schedules that have children scheduled after your child that day.

- Parents may change or cancel their child's appointment with at least 48 hours notice (2 business days)
- If a patient is more than 15 minutes late, we may need to reschedule the appointment. If we are able to see the child, we cannot guarantee that all treatment will be completed.
- There may be a $25 fee charged to your account for all appointments that are cancelled and/or broken within less than 24 hours. If your child is being sedated and you do not give 48hrs notice (2 business days) you will forfeit your deposit.
- After having 2 missed or broken appointments, we will no longer be able to provide your child dental care. If this happens, you will be notified by mail of your child's dismissal for the practice. We will continue to provide emergency dental care for your child for up to 30 days following the dismissal.

Appointments must be confirmed *48 hours in advance.* If you do not confirm the appointment then it will be moved off the schedule. Pediatric Dentistry of Central Georgia, PC will place a courtesy call prior to your appointment to answer any questions you may have. Please call 478-333-3636 any time you have concerns about your child's dental health. Feel free to leave a message on the machine.

Parent/Guardian: ____ Date:____

pediatric dentistry
of central georgia

PEDIATRIC DENTISTRY OF CENTRAL GEORGIA, PC

HIPAA STATEMENT

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.

Purpose and Applicability of this Notice

The Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") and the regulations implementing HIPAA require health plans to notify participants and beneficiaries about how their protected health information ("PHI") may be used by the Plan and disclosed to other parties. "PHI" means your individually identifiable health information, including demographic and genetic information, that relates to your past, present, or future physical or mental health or condition, related health care services, and payment for health care services.

Responsibilities of the Plan

The Plan is required by law to make sure that your PHI is kept private, to give you this Notice of the Plan's legal duties and privacy practices related to the use and disclosure of your PHI, to notify affected individuals after a breach of unsecured PHI, to follow the terms of the Notice currently in effect, and to communicate to you any future changes to this Notice.

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give this Notice about our privacy practice, our legal duties, and your right concerning your health information. We must follow the privacy practices that are described in the Notice while it is in effect. This Notice takes effect September 23, 2013 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 term 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 PHI without your Authorization

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 operation, 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 you 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 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.

National Security: We may disclose to the 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 security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, text messages, e-mail messages, postcards, or letters).

Patient's Rights

Access: You have the right to look at or get copies of your health information, with limited exceptions. Contact us using the information listed at the end of this Notice for a full explanation of time and fee involved.

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

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your 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).

Amendment: You have the right to request that we amend your 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 website or by electronic mail (e-mail), 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 concern, 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 health information or in response to a request you made to amend or restrict the use or disclosure of your 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 health information.

Contact Officer: **Jaime Anderson__** **Email:** **jaime@growbigsmiles.com**

Telephone: **478-333-3636____** **Fax:** **478-333-6399___________**

Address: **900 Professional Dr. Warner Robins, GA 31088________**

Authorization for additional disclosure:
I am the "personal representative" of (generally parent or legal guardian) and have legal authority to make health care decisions about the following minor patient(s):

____

Patient(s) Name(s)

As the "personal representative" of the above named, I authorize the following to accompany my child and have access to PHI.

Name:	Relationship:
1.)____	____
2.)____	____
3.)____	____
4.)____	____

____ ____
"Personal Representative" (Parent or Legal Guardian) **Date**

In General, the HIPAA privacy rule gives individuals the right to request a restriction of their health information. The individual is also provided the right to request confidential communications or that a communication of PHI (Protected Health Information) be made by alternative means, such as, sending information to the individual's office instead of their home.

I wish to be contacted in the following manner (Check all that apply)

Home Telephone
- ☐ OK to leave message with details
- ☐ Leave message with only call back #
- ☐ OK to speak to spouse

Written communication
- ☐ OK to mail to my home
- ☐ OK to mail to my work
- ☐ OK to fax to designated #

Cell Phone
- ☐ OK to leave message with details
- ☐ OK to leave message via text
- ☐ Leave message with call back # only

E-mail
- ☐ OK to write E-mail with details
- ☐ Write E-mail with only call back # only

Work Telephone
- ☐ OK to leave message with details
- ☐ Leave message with only call back #

I give Pediatric Dentistry of Central Georgia, PC permission to use and disclose PHI necessary to carry out TPO (Treatment Payment or Operations) this also indicated a “Good Faith Effort” was made on behalf of Drs. Margaret Moore and Megan Flournoy. By signing this form, I understand that the privacy practices of the office have been disclosed to me. This information will stay on record for six years.

Signature____ Date ____________________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ____, have received a Copy of this office’s Notice of Privacy Practices.

____
Please print child’s (or children’s names, if more than 1 child) name

____
Parent’s Signature

____
Date

FOR OFFICE USE ONLY

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

________ Individual refused to sign

________ Communication barriers prohibited obtaining the acknowledgement

________ An emergency situation prevented us from obtaining acknowledgement

________ Other (Please explain)

____
____
____
____