

CHILD REGISTRATION

Today's Date: _____	Date of Birth: _____
Child's Full Name: _____	Child's Soc. Sec. #: _____
Mailing Address: _____	City: _____ State _____ Zip Code _____
Street Address: _____	Home Phone: _____
School Name: _____	Grade: _____
Child's Dental Insurance Name: _____	Number: _____
Child's Medical Insurance Name: _____	Number: _____
Child's Physician's Name: _____	Phone #: _____
Is your child now under care of physician? _____	Last Visit: _____ Reason: _____
Is this your child's first dental visit? _____	Has child ever had an unhappy dental experience? (Yes/ No)
If so, please explain? _____	Whom may we thank for referring you? _____

Father's Full Name: _____	Date of Birth: _____
G/mail address: _____	Soc. Sec #: _____
His Address: _____	Home Phone: _____
Employer: _____ How Long? _____	Business Phone: _____
Father's Medical Insurance Co.: _____	Policy # _____ Group # _____
Father's Dental Insurance Co.: _____	Policy # _____ Group # _____

Mother's Full Name: _____	Date of Birth: _____
E-mail address: _____	Soc. Sec #: _____
Her Address: _____	Home Phone: _____
Employer: _____ How Long? _____	Business Phone: _____
Mother's Medical Insurance Co.: _____	Policy # _____ Group # _____
Mother's Dental Insurance Co.: _____	Policy # _____ Group # _____

With whom does the patient live? _____

Person financially responsible: _____

Address: _____ Phone #: _____

Please list other family members who are patients in this office: _____

I accept financial responsibility for all services rendered to my child. The parent or guardian bringing the child to our office is responsible for payment of the account. I authorize the release of any medical information to process my insurance claims or payment assigned to Young Smiles Dentistry for Kids or Dr. Kevin R. Jackson. This office will assist in the prompt filing of all insurance forms; however, I understand my insurance policy is a contract between me and my insurance company and I am responsible for any services not covered in my policy. In the event of default on my account, I agree to pay collection costs including attorney's fees and court costs, which may represent one-third of the balance due.

Signed: _____ Date: _____

Name _____ Age _____ Date _____

CHILD'S MEDICAL AND DENTAL HISTORY

GENERAL HEALTH REVIEW Please review your child's past and present health history. *Mark the box ONLY if your child has the condition now or has been treated for the condition in the past.*

THE EYES, EARS, NOSE AND THROAT

- Allergies
- Chronic Earaches
- Deafness/Hearing Loss
- Speech Problems
- Chronic Sore Throat/Tonsillitis
- Tonsils/Adenoids Removed
- Blindness/Low Vision
- Other _____

THE LUNGS

- Asthma Date of last attack _____
- Uses inhaler as needed
- Uses daily oral medicines or inhaler
- Uses steroids or has used steroids
- Bronchitis
- Pneumonia
- Tuberculosis
- Other _____

THE CIRCULATORY SYSTEM

- Heart Murmur
- Antibiotics for previous dental work
- Circulation Problems
- Congenital Heart Problems
- Heart Surgery
- Artificial Heart Valve
- Rheumatic or Scarlet Fever
- Excessive Bleeding/Hemophilia
- Hepatitis
- Sickle Cell Anemia
- HIV/AIDS
- Leukemia
- History of Blood Transfusion Date _____
- Other _____

THE NERVOUS SYSTEM, MUSCLES AND BONES

- Epilepsy or Seizure
- Fainting
- Cerebral Palsy
- Nervous Problems
- Mental retardation
- Down Syndrome
- Autism
- Attention Deficient Disorder
- Head Trauma/Brain Injury
- Spina Bifida
- Muscular Dystrophy
- Orthopedic Problems
- Artificial Joints
- Other _____

THE STOMACH, LIVER, KIDNEYS, BLADDER

- Stomach Problems
- Diabetes
- Kidney Problems
- Hepatitis
- Bladder Problems
- Other _____

ALLERGIES

- Allergy to food, food additives
- Allergy to household items, dust, pets
- Allergy to plants, pollen, grass
- Allergy to latex rubber
- Allergy to Drugs. Specify _____
- Other _____

INFECTIONS AND SERIOUS ILLNESSES

- Immunizations are up-to-date
- Chicken Pox
- Chemotherapy Date(s) _____
- Hospitalization. Date(s) _____
- Cancer or other malignancies
Type _____

GROWTH AND DEVELOPMENT

- Prematurely or complicated pregnancy
- Birth defects
- Concerns with growth
- Learning, behavioral, or communication problems
- Psychological problems, testing or counseling
- Alcohol, tobacco, or drug use

LIST ANY MEDICATIONS YOUR CHILD IS PRESENTLY TAKING

CHILD'S PHYSICIAN _____ "Phogp%"

IS THERE ANYTHING ELSE WE NEED TO KNOW ABOUT YOUR CHILD'S HEALTH HISTORY?

REVIEWED BY DR. Jackson ON _____ / _____ / _____

(OVER)

DENTAL HEALTH REVIEW Please review your child's past and present dental health for us. **Mark the box ONLY if your child has had the condition now or has been treated for the condition in the past.**

FIRST VISIT INFORMATION (only new patients and their parents need to complete this section)

- THIS IS MY CHILD'S FIRST DENTAL VISIT.
- MY CHILD IS WORRIED ABOUT TODAY'S VISIT
- MY CHILD'S PREVIOUS VISITS WERE UNSATISFACTORY.
- MY CHILD HAD AN ACCIDENT, HURTING THE HEAD, MOUTH, OR TEETH
- MY CHILD HAS HAD A TOOTHACHE RECENTLY
When eating only OR Keeps him/her up at night (Please circle)

DENTAL HEALTH AND HABITS. Please mark only the boxes that apply to your child.

- MY CHILD HAS HAD REGULAR DENTAL EXAMS AND CLEANINGS
 - LAST EXAM, CLEANING AND FLUORIDE TREATMENTS (DATE _____) +
 - MY CHILD PRESENTLY TAKES A FLUORIDE SUPPLEMENT
 - DENTAL X-RAYS WERE TAKEN AT EARLIER VISITS WITH DR. _____
 - MY CHILD WAS BREAST OR BOTTLE FED FOR MORE THAN 1 YEAR
 - MY CHILD SLEPT WITH A BABY BOTTLE. (What was in the bottle? _____)
 - MY CHILD SUCKS A THUMB OR FINGERS.
 - MY CHILD USES A PACIFIER
 - MY CHILD IS A MOUTH BREATHER
 - MY CHILD GRINDS or CLINCHES TEETH.
 - INJURY TO MOUTH AND/OR TEETH.
 - BLEEDING GUMS
 - ARE THERE ANY OTHER DENTAL CONCERNS TO YOU AS A PARENT?
- _____
- _____
- _____

WHAT IS THE FAMILY'S WATER SUPPLY

- Well
- Public system
- Bottled/distilled

HOW OFTEN ARE YOUR CHILD'S TEETH BRUSHED PER DAY?

- ONCE
- TWICE
- AFTER EACH MEAL
- NONE

WHAT TYPE OF TOOTHPASTE DOES YOUR CHILD USE? _____

DO YOU HELP YOUR CHILD FLOSS DAILY? Yes or No

Thank you for your help. If there is any information you think might be of value to us in treating your child, please feel free to comment. I certify that I have read and understand the above questions. I will not hold Dr. Jackson, his associates and other healthcare professionals on his staff responsible for any errors or omissions I may have made in the completion of this form.

Signature of Parent or Legal Guardian

Relationship to patient

Witness

Date

Young Smiles Dentistry for Kids
4150 Macland Road Suite 205
Powder Springs, GA 30127
Phone: 770-222-1344 Fax: 770-222-1345

PATIENT AUTHORIZATION

I, _____, hereby authorize Young Smiles Dentistry for Kids (including all providers under the umbrella of practice) to receive and release protected information (paper, verbal, or electronic) concerning my dental treatment to other health care professionals involved in my care and treatment.

I authorize Young Smiles Dentistry for Kids to release information to my insurance company as needed to file charges for services. I authorize the payment of insurance benefits to be made directly to Young Smiles Dentistry for Kids and I understand that I am responsible for any amount not covered by the insurance company.

I authorize and give consent for observation of treatments by other health care professionals.

I understand I have the right to revoke this authorization, in writing by sending a written notice to the office of Young smiles Dentistry for Kids.

A copy of this authorization shall be as the original. This authorization shall be in force indefinitely, unless rescinded in writing.

Patient Name

Signature of Patient Representative

Date

Printed Name of Patient Representative

Relationship of Representative

Young Smiles Dentistry for Kids
4150 Macland Road Suite 205
Powder Springs, GA 30127
Phone: 770-222-1344 Fax: 770-222-1345

STATEMENT of Financial Policies for Our Patients

First, please allow us to welcome you to our office. We hope to make your visit as pleasant as possible. Unfortunately aside from the emotional and physical impact of any dental treatment, there is all too often a degree of financial impact as well. We would like to ease your potential financial burden as much as possible. Your review of our financial policies at this time will help greatly to avoid future misunderstandings and make everyone's job that much easier.

1. Our relationship and our contract with you is that of Dentist-Patient. We do not provide dental services to insurance companies and have no responsibility to assure that the insurance company is pleased with your dental care. Insurance companies are happy if you pay your premiums and make limited claims for benefits. We will not shortchange your dental care to satisfy an insurance company.
2. Any contract that exists between you and your insurance company for dental care reimbursement does not obligate us to comply with the provisions of your policy. We will assist you in filing of your claims. The ultimate responsibility for the correct filing and processing of this paperwork, etc. however remains with you and your insurance company. If you are unsure of any of the specific requirements of your insurance company please ask them. **Do not depend upon us to be familiar with all the different types of insurance plans.**
3. In most cases we have no contract with insurance companies. In those circumstances where we do have such a contract, certain responsibilities remain with the patient and are well documented in your insurance benefits guide provided by your insurance company.
4. We do not file under any circumstances for medical coverage with your insurance company.
5. **Payment is expected at time of services for all procedures not covered by your insurance.** When payment from the insurance company has not been received within 30 days of treatment, it will be your responsibility to contact the insurance company and to send our office payment in full at that time. We accept cash, check, debit card, or credit cards (Visa, MasterCard, Discover, and American Express). It is also our policy not to file secondary insurance.
6. Often insurance companies will use the term "usual and customary" or similar such language when denying charges for dental care. The implication is that the doctor charges too much for given procedure of visit. Universal "usual and customary: fee schedule **DO NOT EXIST.** The amount an insurance company reimburses for a procedure will vary with the company, the type and quality of the policy and sometimes variation in charges is when there exists a contract between an insurance company and us to provide care at a discount in exchange for qualifying as "participating dentist".
7. In the event of default patient/guarantor will be responsible for all collection costs, which include attorney and court fees.

We are all too aware of the current nationwide crisis in health care financing. Quality personalized dental care is sometimes quite expensive. Despite the pressure to pass along increased costs to the patient, we work hard to contain fees and other charges. We are here to serve you for dental care needs. If we have done well, please tell your family and your friends. If not please tell us!

I have read and understand the above. I have given every opportunity to receive a copy of this document upon request.

Signed: _____ Date: _____

Confirmation Policy

Due to our high volume of patients and previous appointment conflicts, we have implemented a confirmation policy. To ensure your child is seen in a timely manner, we require you to confirm all appointments 24 hours in advance. This ensures your child's appointment. We will attempt to reach you at all phone numbers you have provided. If our attempt is unsuccessful, it is your responsibility to confirm your child's appointment.

We understand that unforeseen situations can occur. To assist in communication during these times, there are two different ways for you to confirm your appointment:

1. Call our office during office hours and speak to a staff member 770-222-1344.
2. Call our office after hours to leave a message on our 24-hours answering service.

If you are unable to confirm your appointment, but you do arrive on time for the scheduled appointment, we will make every attempt to see your child. Please understand this is a courtesy; your child's appointment may have been moved so that another child may be seen. As we will still try to accommodate you, there are times we may have to reschedule. Again, confirmation ensures your child's appointment and ensures that all patients will be seen in a timely manner.

Signature of Parent or Guardian

Date

I also understand that it is my responsibility to inform the front office of any change in my phone numbers or my mailing address.

Thanks you for your cooperation!

YOUNG Smiles

DENTISTRY for kids

NOTICE OF PRIVACY PRACTICES

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.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/14/03 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 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 operations, 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 your 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 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 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 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 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 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 health information. You may obtain a form to request access by using the contact

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

Please Print Name

Signature

Date

For Office Use Only

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

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

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