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Welcome to our practice! In order to know you and your child better, please complete the information requested as completely as you are able. If you have any questions, please ask for assistance. Thank You!

Patient Information

Child's Name: _____
Last First MI Nickname

Male Female Date of Birth: _____ Child's Social Security #: _____

Hobbies/Pets: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Home Phone: _____

Names and ages of any other children in the family: _____

Do parents live together? Yes No If not, with whom does the child live? _____

Parent/Guardian Information

Mother Stepmother Guardian: Name _____

Address (if different from above): _____

City: _____ State: _____ Zip Code: _____

Home # (if different from above): _____ Work: _____ Cell: _____

Date of Birth: _____ Social Security #: _____

Employer: _____ Occupation: _____

Marital Status: _____ E-mail Address: _____

Does this person have the legal right to make health care decisions for the patient listed above? Yes No

Parent/Guardian Information

Father Stepfather Guardian: Name _____

Address (if different from above): _____

City: _____ State: _____ Zip Code: _____

Home # (if different from above): _____ Work: _____ Cell: _____

Date of Birth: _____ Social Security #: _____

Employer: _____ Occupation: _____

Marital Status: _____ E-mail Address: _____

Does this person have the legal right to make health care decisions for the patient listed above? Yes No

List any person(s) you do not want patient/family information released to: _____

List any person(s) allowed to bring patient to an appointment and make dental/financial decisions for the above patient: _____

How were you referred to our practice? _____

Who is your family dentist? _____

Method of Payment

Payment in full at time of treatment (Cash, Electronic Check, Master Card, Visa, AMEX, Care Credit)

Insurance- All co-payments are due at time of treatment and are estimated. Any amount not covered by insurance is the responsibility of the parent accompanying the patient.

Georgia Medicaid, Wellcare-**Please advise us of any additional dental insurance plans for your child.**

Primary Dental Insurance

Policy Holder: _____ Relationship to patient: _____
Policy Holders Social Security #: _____ Date of Birth: _____
Insurance Company: _____ Employer: _____
Policy #: _____ Group #: _____ Member ID # _____
Insurance Company Phone #: _____

Is child covered by any other dental insurance plans (including Medicaid)? Yes NO

Secondary Dental Insurance

Policy Holder: _____ Relationship to patient: _____
Policy Holders Social Security #: _____ Date of Birth: _____
Insurance Company: _____ Employer: _____
Policy #: _____ Group #: _____ Member ID # _____

Dental History

Is this your child's first visit to the dentist? Yes No If no, please give date of last dental care: _____
Previous Dentist: _____

Do you have a copy of your child's dental records? Yes No

Is your child on a bottle? Yes No If no, at what age was it discontinued? _____

Is your child a thumb/finger sucker or ever used a pacifier? Yes No Age discontinued _____

Is your primary source of water from a well? Yes No

Does your child take fluoride in any form? Toothpaste Rinse Tablet City Water/Nursery Water

Has your child had any traumatic injury to his/her teeth? Yes No If yes, please explain: _____

Has your child had any problems with previous dental treatment? Yes No If yes, please explain: _____

Does your child have any dental conditions you are concerned about today? Yes No If Yes, please explain: _____

Medical History

Child's pediatrician: _____ Phone Number: _____

Date of last visit: _____

Has your child been hospitalized or had surgery since birth? Yes No If Yes, please explain: _____

Does your child have any special needs? Yes No Please list: _____

Has your child ever had any of the following? (Please select yes or no for each condition)

- | | | | |
|------------------------|--|---------------------------|--|
| Abnormal Bleeding | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemophilia | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| ADD/ADHD | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| AIDS/HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Learning Disabilities | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asperger's | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Lung Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Autism | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mental/Emotional Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer/Tumors | <input type="checkbox"/> Yes <input type="checkbox"/> No | Muscular Dystrophy | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cerebral Palsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nose/Throat Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cleft Lip/Palate | <input type="checkbox"/> Yes <input type="checkbox"/> No | Premed Needed | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | History of RSV | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Downs Syndrome | <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Epilepsy/Convulsions | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sickle Cell Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hearing Impaired | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sickle Cell Trait | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Condition/Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Cont'd- Patient Name: _____

Speech Problems Yes No
Stomach Disorder Yes No
Thyroid Disease Yes No

Tuberculosis Yes No
Vision Problems Yes No

If you answered yes to any questions above please explain or give additional details: _____

Any other medical condition or concern? _____

For patients 14 and over: Any recreational use of tobacco, alcohol or history of substance abuse? Yes No

If yes, please provide additional details: _____

Please list all current medications-prescription, non-prescription and supplements. _____

Allergies

None Penicillin/Amoxicillin Codeine Latex Ibuprofen Anesthetic

Other (Please list): _____

Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I am the parent, guardian or personal representative of this patient and have the legal right to authorize medical and dental care for this child. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical or dental status. I authorize the dentist and staff of Center For Pediatric Dentistry to perform the necessary dental services my child may need. I also authorize the dentist and staff of Center For Pediatric Dentistry to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or health practitioners. I authorize the use of radiographs and photographs for the purpose of teaching and scientific publications. I request that my insurance company pay directly to the dentist. I agree to remain on the premises while my child is being treated. I understand that my insurance carrier may pay less than the actual bill for services; therefore, I agree to be responsible for payment of all services rendered on my child's behalf. I also agree that any fees incurred on this account for finance charges, collection actions or delayed payment by myself or the insurance company will be my responsibility.

Signature of Parent/Guardian: _____ **Date:** _____

Printed Name of person signing: _____ **Relationship to patient:** _____

Does the person signing have the legal right to make health care decisions for the patient? Yes No

Reviewed and signed by Dr: _____ **Date:** _____

Center for Pediatric Dentistry HIPPA Acknowledgment

You May Refuse to Sign This Acknowledgment

I have read and been offered a copy of this office's Notice of Privacy Practices.

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)

Important Information for Our Patients

Dental Insurance:

We are glad to assist you in obtaining the maximum benefit from your dental insurance plan. Please realize that insurance coverage is a relationship between you, the insured and your insurance company. In most instances, once your plan coverage has been verified, we will accept assignment of payment from your insurance company. Most plans only cover a portion of the dental fee, which means you will be responsible for your deductible and any co-payment. Your co-payment is expected at the time you are in our office for dental care. As a courtesy to our patients and families we estimate co-payments for visits. This estimate does not guarantee that insurance will pay the remaining balance and any amount not paid by your insurance will be your responsibility. For your convenience, our office will file insurance claims on your behalf. However, any claims that remain outstanding after 60 days will become your responsibility and a finance charge will be applied to any balance due. Payment will be expected on any such claims and no further attempt will be made by our office to collect from the insurance company in this event. Please speak with us if you have questions regarding this policy.

Payment Policies:

Please be aware that the parent/guardian who brings the patient to their appointment is responsible for payment of all charges and co-payments at the time of service. For your convenience, we accept Visa, MasterCard, and American Express. We are also a participating Care Credit provider. Personal checks will be taken electronically. There will be a \$35.00 service charge for all returned checks. Center for Pediatric Dentistry requires that all outstanding balances be paid in full within 30 days unless other arrangements have been made. Balances remaining after 30 days will be assessed a finance charge. Non-payment of your account could result in further collection actions including but not limited to transferring your account to an outside collection agency. You will be responsible for any fees incurred in collecting your account. Only emergency care will be available if your account balance is not paid within 30 days.

Appointments and Appointment Confirmations:

Our appointments are scheduled to respect your time. We reserve a specific time for your child's care and we make every effort to see you at that appointed time. We appreciate your promptness and consideration in not changing your scheduled time. However, if you need to change an appointment, a 48 hour notice is requested. Late arrivals affect our ability to see patients in a timely and efficient manner. Patients arriving 15 minutes, or more, late for an appointment may need to be rescheduled. If we are able to see the patient, we cannot guarantee all treatment will be completed. If two (2) appointments are missed without 24 hours' notice, we may no longer be able to provide dental care for your child.

Appointments and Appointment Confirmations (continued):

Appointments will be confirmed at least 48 hours in advance. We respectfully request that appointments be confirmed by the parent or guardian. If we are unable to reach you regarding your child's scheduled appointment, it may be moved off the schedule. You can confirm your appointments by phone at 706-855-8989, by e-mail: appointments@drleebaker.com or through our automated system of e-mail and text messages. For after hours, you may leave us a message to confirm your appointment. Please contact us during business hours to reschedule or cancel appointments.

Electronic Communications:

For your convenience, Center for Pediatric Dentistry uses e-mails, text messaging and an automated calling system to contact our patients.

I understand the confidentiality of electronic communications (e-mail, text messages, etc.) cannot be guaranteed and Center for Pediatric Dentistry is not responsible for the confidentiality or security of any message sent to or by me. If any of my contact information changes or at any time I wish to revoke my consent, I agree to notify Center for Pediatric Dentistry in writing or in person.

***Please check "Yes" below if you will allow our office to send E-mail correspondence prior to sending automated calls and/or text messages.**

- Yes No Text messages for appointment confirmations and notifications.
- Yes No E-mail for appointment notifications and confirmations.*
- Yes No E-mail for general account, insurance and/or billing questions.*

Our relationship with our patients is of utmost importance to us. We are happy to answer any questions you may have about our office. We look forward to providing an excellent experience for you and your child. Thank you for your cooperation!

Parent's signature: _____ **Date:** _____

Permission Form

Date: _____

Patient(s) Name(s): _____

I, _____, give the individuals listed below permission to bring my child(ren) to their dental visits and authorize Center for Pediatric Dentistry to give them any information regarding dental care for my child(ren). They have full authority to make any dental and financial decisions for my child(ren), including, but not limited to: sedation, nitrous oxide, radiographs, and fluoride treatments. I understand that payment for services rendered is due at the time of treatment and agree to make payment arrangements with Center for Pediatric Dentistry if the individual accompanying my children is not prepared to make payment in full. Center for Pediatric Dentistry will make every effort to keep the accompanying adult informed before treatment is changed, however I realize that this may not always be possible and the adult will be informed of any changes at the completion of the appointment. I understand that if I need to make any changes to this agreement I must do so in writing.

<u>Name</u>	<u>Phone Number(s)</u>	<u>Relationship to Patient</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____

Parent/Legal Guardian Signature: _____