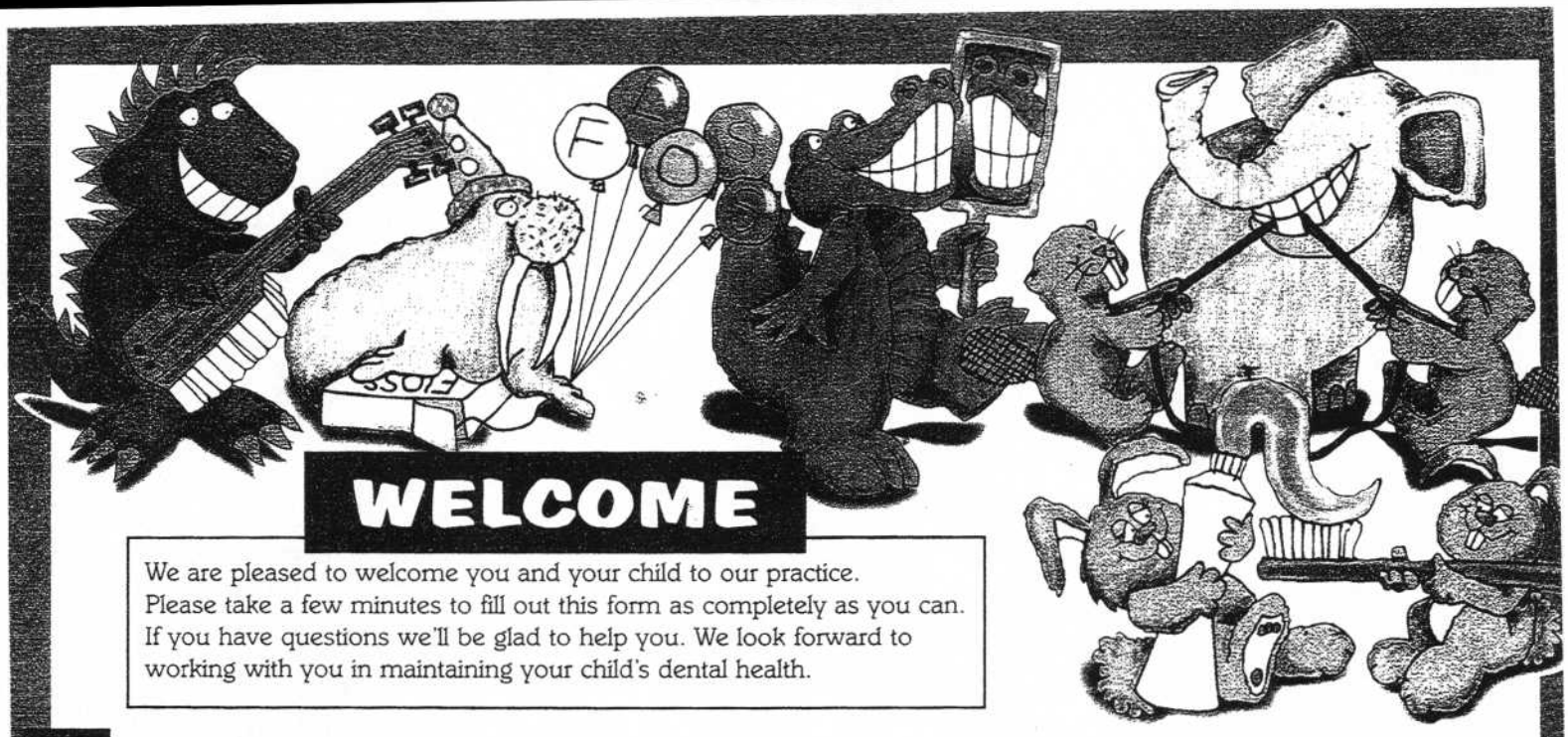

WELCOME

We are 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 questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.

PATIENT INFORMATION

Date _____ SS/HIC/Patient ID # _____ Birthdate _____

Name of Minor/Child _____ Sex ☐ M ☐ F Age _____
Last Name First Name Middle Initial

Nickname _____ Hobbies _____ Cell Phone (____) _____

Home Address _____
Street City State Zip

Mailing Address _____
Street City State Zip

School Name _____ School Phone (____) _____

Person financially responsible _____ Home Phone (____)_____ Work Phone (____) _____

Whom may we thank for referring you? _____

INSURANCE

Father's/Guardian's Name _____

Address (if different from patient's) _____

Home Phone (____)_____ Work Phone (____) _____
(if different from above) (if different from above)

E-mail _____

Employer _____

Soc. Sec. # _____ Birthdate _____

Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name _____ Phone (____) _____

Address _____

Group # _____ Policy # _____

Mother's/Guardian's Name _____

Address (if different from patient's) _____

Home Phone (____)_____ Work Phone (____) _____
(if different from above) (if different from above)

E-mail _____

Employer _____

Soc. Sec. # _____ Birthdate _____

Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name _____ Phone (____) _____

Address _____

Group # _____ Policy # _____

Is your child eligible for treatment under Medical Assistance? ☐ Yes ☐ No Child's Medical Assistance I.D. # _____

DENTAL HISTORY

Date of last visit to a dentist _____ For what service? _____

	YES	NO
Has child complained about dental problems?	☐	☐
Does child brush teeth daily?	☐	☐
Does child use floss every day?	☐	☐

	YES	NO
Is fluoride taken in any form?	☐	☐
Any injuries to mouth, teeth, head?	☐	☐
Any unhappy dental experiences?	☐	☐

Any mouth habits - thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc? ☐ ☐

Please Complete Both Sides

MEDICAL HISTORY

Minor/Child's Physician _____ City/State _____ Phone (____) _____

Date of last physical examination _____ Results _____

	YES	NO
Is Minor/Child under care of physician now?	☐	☐
Receiving any medication or drugs?	☐	☐
Ever been hospitalized?	☐	☐
Ever had surgery?	☐	☐
Is there excessive bleeding when cut?	☐	☐

Medications _____

Allergies _____

Has minor/child had any history of or difficulty with any of the following? If yes, please check (✔).

☐ A.I.D.S./H.I.V.	☐ Cerebral Palsy	☐ Epilepsy	☐ Kidney Disease	☐ Rheumatic Fever
☐ Anemia	☐ Chicken Pox	☐ Fainting	☐ Liver Disease	☐ Sinus Problems
☐ Asthma	☐ Convulsions	☐ Hearing Problems	☐ Measles	☐ Thyroid Disease
☐ Bladder Problems	☐ Diabetes	☐ Heart Problems	☐ Mononucleosis	☐ Tuberculosis
☐ Cancer	☐ Drug/Alcohol Abuse	☐ Hepatitis	☐ Mumps	☐ Other

EMERGENCY CONTACT

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

Name _____ Relationship _____ Phone (____) _____

Name _____ Relationship _____ Phone (____) _____

AUTHORIZATION

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

Minor/Child Consent

I am the parent, guardian, or personal representative of _____
Please Print Name of Minor/Child

and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

Insurance Assignment and Release

I certify that my dependent(s) is covered by insurance with _____
Name of Insurance Company(ies)

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my minor/child's health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Parent, Guardian or Personal Representative — Date

_____ _____
Please print name of Parent, Guardian or Personal Representative — Relationship to Patient

UPDATE

TO BE COMPLETED AT LATER VISIT

Has there been any change in patient's health since last dental appointment? ☐ Yes ☐ No

If yes, please describe _____

Is patient taking any new medications? ☐ Yes ☐ No If yes, please list _____

Date _____ Parent/Guardian Signature _____

Date _____ Dentist Signature _____

GeorgeTown
Family Dentistry

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Savannah, Ga. 31419

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Email: Georgetownfamily@aol.com

GeorgeTownFamilyDental.com

Notice of Privacy Receipt

I, _____, herby acknowledge that I have received a copy of Georgetown Family dentistry Notice of Privacy and office policies. I have also been given the opportunity to ask questions I may have regarding this notice.

Signature of patient or authorized representative date signed

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Relationship or status if signed by parent, legal guardian, personal representative, etc.

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Notice of Privacy for Georgetown Family Dentistry

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review carefully.

Introduction

At Georgetown Family Dentistry, we are committed to treating and using protected health information about you responsibly. This notice of Health Information Practices describes information we collect, and how and when we use or disclose the information. It also describes your rights as they relate to your protected health information. This notice is effective March 1, 2011, and applies to all protected health information as defined by federal regulations.

Understanding your health record/ information

Each time you visit Georgetown Family Dentistry, a record of your visit is made. Typically, this record contains your symptoms, examination, test results, diagnoses, treatment, and plan for future care or treatment. This information often referred to as your health or medical record serves as a:

- Basis for planning your care and treatment.
- Means of communication among the many health professionals who contribute to your care.
- Legal document describing the care you received.
- Means by which you or third party payer can verify that services billed were actually provided.
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make informed decisions when authorizing disclosure to others.

Your health record/ information

Although your health record is the physical property of Georgetown Family Dental, the following information belongs to you:

- Obtain a copy of this notice of information practices upon written request.
- Inspect and copy your health records.

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- Amend your health record.
- Obtain and account of disclosures of your dental record.
- Request a restriction on certain uses and disclosures of your information
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities

Georgetown Family Dentistry is required to:

- Maintain the privacy of your health information.
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- Accommodate reasonable requests you may have to communicate dental information
- Abide by the terms of this notice.

We reserve the right to change our practice and to make the new provisions effective for all protected dental information e maintain. Should our practice information change, we will mail a revised notice to the address that we have on record.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue disclosing your dental information after we have received a written revocation of the authorization according to the procedures included in the authorization.

Examples of Disclosures for Treatment, Payment and Dental Operations

Notifications: We may use or disclose information to notify or assist in notifying a family member, personal relative, or another authorized responsible party, your location, or general condition.

Communication with Family: Health professionals using their best judgment may disclose to a family member, other relative, close personal friend, or any other you identify, health information relevant to that person's involvement in your care or payment related to your care.

Workers Compensation: We may disclose information to the extent authorized by and to the extent necessary to comply with the laws relating to workers compensation or other similar programs established by law.

Insurance Companies: We will release information to insurance companies on your behalf in our quest to expedite any claims on your behalf.

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Public Health: As required by law we may disclose your health information to the public or legal authorities charged with preventing or controlling disease, injury, or disability.

Law Enforcement: We may disclose health information to be release to an appropriate health oversight agency, public health authorities or attorneys, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or has otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

Once Georgetown Family Dentistry gives out the information that I authorized release, I accept no fault to practice and members over the information and how it is distributed. Federal or State privacy laws may NO longer protect the information.