

**PEDIATRIC DENTAL SPECIALISTS, P.C.**

**David H. Brantley, DDS**

**John W. Spratling, DMD**

**Kelly W. Hughes, DMD**

Child's full name \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex F M

Name child goes by \_\_\_\_\_

Child's Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone# \_\_\_\_\_

Child's Social Security # \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

Name & age of siblings \_\_\_\_\_

Home E-mail Address \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Phone Number \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

Who is your family dentist? \_\_\_\_\_

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

**PARENT OR GUARDIAN INFORMATION** \_\_\_\_\_ **MOTHER** \_\_\_\_\_ **STEPMOTHER** \_\_\_\_\_ **GUARDIAN**

Name \_\_\_\_\_ DOB \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

S.S. # \_\_\_\_\_ Work E-mail \_\_\_\_\_ Work # \_\_\_\_\_

**PARENT OR GUARDIAN INFORMATION** \_\_\_\_\_ **FATHER** \_\_\_\_\_ **STEPFATHER** \_\_\_\_\_ **GUARDIAN**

Name \_\_\_\_\_ DOB \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

S.S. # \_\_\_\_\_ Work E-mail \_\_\_\_\_ Work # \_\_\_\_\_

Our office communicates with our patients electronically, via e-mail and text messaging. Please inform us of your preference of communication:

\_\_\_\_\_ E-mail E-mail address \_\_\_\_\_

\_\_\_\_\_ TextCell # \_\_\_\_\_

\_\_\_\_\_ Please do not contact me by e-mail nor text

**METHOD OF PAYMENT** \* Fees for dental services are due at time of treatment\*

\_\_\_\_\_ Check, cash, or credit/debit card

\_\_\_\_\_ Dental Insurance - Plus co-payment (At the present time we are only participating providers with **United Concordia** and premier providers with **Delta Dental**). As a courtesy, our office will file for insurance benefits for treatment rendered. Any

deductibles, co-payments, or balances not covered by your insurance must be paid in full at treatment visit.

\_\_\_\_\_ GA. Medicaid # \_\_\_\_\_ GA. Peachcare # \_\_\_\_\_ Wellcare# \_\_\_\_\_

All account balances which have not been paid within 30 days becomes the responsibility of the parent/guardian.

Returned Check Fee Charge- \$35.00

## CHILD'S MEDICAL HISTORY

Child's full name \_\_\_\_\_ Birthdate \_\_\_\_\_

Name of child's pediatrician or physician \_\_\_\_\_

Has your child been hospitalized since birth?  Yes  No If yes, explain \_\_\_\_\_

Is your child allergic to any medications or foods?  Yes  No If yes, explain \_\_\_\_\_

Is your child presently taking any medication?  Yes  No If yes, explain \_\_\_\_\_

Please check any of the following medical conditions your child has experienced:

<input type="checkbox"/> Asthma	<input type="checkbox"/> Inhaler	<input type="checkbox"/> Special Needs	<input type="checkbox"/> Convulsions/Epilepsy
<input type="checkbox"/> Anemia		<input type="checkbox"/> Heart Condition	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Hepatitis		<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Ear Problems
<input type="checkbox"/> Abnormal Bleeding		<input type="checkbox"/> Nose/Throat Disorder	<input type="checkbox"/> Tubes in Ears
<input type="checkbox"/> Blood Disease		<input type="checkbox"/> Tonsils/Adenoids Removed	<input type="checkbox"/> Speech/Vision Problems
<input type="checkbox"/> Diabetes		<input type="checkbox"/> Cancer/Tumors	<input type="checkbox"/> ADD/ADHD
<input type="checkbox"/> Tuberculosis		<input type="checkbox"/> Stomach/Kidney Problems	<input type="checkbox"/> Emotional Disorder
<input type="checkbox"/> Skin Disorder		<input type="checkbox"/> Liver Problems	<input type="checkbox"/> Latex Allergy
<input type="checkbox"/> Autism / Asperger's Syndrome		<input type="checkbox"/> Seasonal Allergies	<input type="checkbox"/> Other _____

Please explain any medical condition(s) or concerns that your child has \_\_\_\_\_

## CHILD'S DENTAL HISTORY

1. Is your child on a bottle?  Yes  No If no, at what age was it discontinued? \_\_\_\_\_

2. Is your child a thumb/finger sucker or ever used a pacifier?  Yes  No Age discontinued? \_\_\_\_\_

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

4. Has your child ever been seen by a dentist?  Yes  No

5. If so, please give the date of last dental care: \_\_\_\_\_ Previous Dentist Name: \_\_\_\_\_

6. Has your child had problems with previous dental treatment?  Yes  No

7. If yes, please explain: \_\_\_\_\_

8. Has your child had any type of injury to his/her teeth?  Yes  No

9. If yes, please explain: \_\_\_\_\_

10. Is your child in pain today?  Yes  No If yes, please explain: \_\_\_\_\_

12. Does your child have a dental condition about which you are especially concerned?  Yes  No

13. If yes, please explain: \_\_\_\_\_

## AUTHORIZATION & RELEASE

To the best of my knowledge, the questions on this form have been accurately answered. 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 status. I also authorize the dental staff to perform the necessary dental services my child may need. I also authorized the dentist 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 other 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 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.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

# Pediatric Dental Specialists, P.C.

## Appointment Policy

Pediatric Dental Specialists reserves appointments for your child according to their needs and cooperation. Patients may not be seen in the order they arrive due to their treatment needs and the doctor providing their treatment.

As a courtesy, our office will attempt to contact you 1-2 days before your appointment for confirmation. However, we do ask that patients assume responsibility for their appt. time.

We hope to be able to serve you better by establishing the following guidelines:

- ❖ Broken appointments or short term cancellations (within 24 hours) without proper notification can be costly and unfair to patients who need appointments. Please note: ***Repeated broken appointments and short term cancellations may be subject to dismissal from the practice.***
- ❖ Late arrivals cause schedule delays for those patients who arrive promptly at their appointment time. Late arrivals will be worked into the schedule if time allows or re-appointed to another day.
- ❖ During the school months, late afternoon appointments are in high demand. We try to honor after school requests and ask that you help us by understanding when we need to appoint during school hours. We will gladly provide you with a school excuse for your child.

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Signature

Date

## Privacy Notice To Patients

This notice describes how medical/dental information about you may be used and disclosed by Pediatric Dental Specialists, P.C. and how you can get access to this information. Please read it carefully. ***For all purposes, the term "you" or "your" in our Privacy Notice refers to you and any minor under your care/guardianship.***

Effective Date: April 14, 2003

Under the HIPAA Privacy regulations, Pediatric Dental Specialists and all similar health care providers are required by federal law to maintain the privacy of your protected health information (PHI) and will abide by the terms in this Privacy Notice.

Please be advised that Pediatric Dental Specialists may use your PHI in rendering treatment to you. For example, we are permitted to use your PHI in providing you with care/treatment when you visit our office or when we treat you in a hospital facility. Under federal law, we may disclose our PHI to you or we can disclose your PHI to third parties for treatment. For example, if we refer you to a specialist we will forward your medical information to such specialist. We can disclose your PHI for payment purposes. For example, we will disclose you PHI to your insurance provider, employer, Medicare, Medicaid or other party responsible for providing you with health/dental insurance coverage. We will also use or disclose your PHI for health care operations. For example, we may use your PHI when we engage in quality assurance and medical chart reviews, which are part of our health care operations. We may also disclose your PHI, when required by the Secretary of The US Department of Health & Human Services.

Unless disclosure is required under federal, state law, or certain other exceptions, including law enforcement, we are prohibited from disclosing your PHI without your authorization. Our practice may use or disclose your PHI in accordance with the specific requirement of the HIPAA rules without Pediatric Dental Specialists needing to obtain your authorization if the information is:

1. Required by law
2. Required for public health purposes
3. Required disclosures about victims of abuse, neglect or domestic violence
4. Required by a health oversight agency for oversight activities authorized by law
5. Required in the course of any judicial or administrative proceeding
6. Required for a law enforcement purpose to a law enforcement official
7. Required by a coroner or medical examiner
8. Required by an organ procurement organization for research
9. If disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public

Additionally, if you are a member of the armed forces, we are permitted to disclose your PHI without your consent if deemed necessary by appropriate military command authorities to assure an appropriate mission.

We may also contact you via mail or phone to remind you of appointments with our office or to discuss treatment alternatives.

In the event our practice wishes to disclose your PHI to another entity for reasons other than treatment, payment, practice operations, or those referenced above, we are required to obtain your authorization. For example, if we desired to participate in an outside research study, we would need your written authorization prior to releasing your PHI. If you provide us with an authorization, you have the ability to revoke such authorization at any time by sending Pediatric Dental Specialists a written revocation. However, if we have already released such information pursuant to your prior authorization, the revocation will be effective for all future disclosures.

Please be further advised that you have the ability to access, copy, inspect, and amend your medical information that we maintain. You may be subjected to a fee for copy costs for staff involvement. Additionally, if you desire, we can provide you with an accounting of all disclosures for treatment, payment, or healthcare operations and pursuant to authorization.

If you have a dispute with our practice regarding our use of your PHI or a disclosure by Pediatric Dental Specialists and believe that your primary rights have been violated, please contact our office to file a dispute. You may alternatively contact the Secretary of Health and Human Services.

Lastly, please be advised that you have the right to request restrictions on certain use and disclosures of you PHI to carry out treatment, payment or healthcare operations or disclosures by Pediatric Dental Specialists of your PHI to a family member, relative, or a close personal friend. However, we are not required by federal law to agree to your requested restriction. If you request a copy of your PHI, you also have the ability to request that we send it to an alternative location (different address). Pediatric Dental Specialists reserves the right to amend this notice as revised. Notices will be posted and be provided to you upon your visit. If you have any questions, please call our office at (706) 863-7351.

Please sign below acknowledging receipt of Pediatric Dental Specialists Privacy Notice.

Thank You.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Child's name

Names of other children in family:  
  
\_\_\_\_\_  
  
\_\_\_\_\_