Pediatric DENTISTRY OF SAVANNAH

Registration

Child/Children's Names: _____

_____

_____

Parents/Legal Guardians' Name: Mr./Mrs./ Ms./Dr._____

Who Has Legal Custody? O Mom O Dad O Both O Other_____

Address: _____ City:_____ State_____ Zip_____

Preferred communication methods: O Home Phone O Cell Phone Call O Text Message O Email

Phone Numbers: Home:(____) _____-_____ Cell #:(____) _____-_____ Work:(____) _____-_____

Email address:_____ Referred by: _____

Is your child covered under any dental insurance: O Yes O No

If Yes:

What dental insurance company?_____ ID #:_____

Name of policy holder:_____ Employer:_____

Policy holder SS#:_____-_____-_____ Policy holder birthday:___ /___ /_____ Relation:_____

If there are other persons you would like to give permission to bring your child/children to Pediatric Dentistry of Savannah, and to make dental treatment decisions on your child's behalf, please list:

_____ _____

Name of Person Relationship to Child

_____ _____

Name of Person Relationship to Child

Please sign below if you agree to the following statements:

1. *I attest that the above information is true to the best of my knowledge. I hereby authorize the dentist or dental auxiliaries under her supervision, to perform any necessary dental treatment upon my child/children listed above, including but not limited to the use of local anesthetic, x-rays, and/or Nitrous Oxide. I will allow photographs to be taken of my child/ children or child's teeth for diagnostic, education, or marketing purposes.*
2. *I have received, read, and fully understand Pediatric Dentistry of Savannah's Financial Policy and Appointment/ Cancellation policy and I accept all provisions.*
3. *I have received, read, and fully understand Pediatric Dentistry of Savannah's Assignment of Benefits Agreement and authorize my insurance company (if any) to pay my dental benefits directly to Pediatric Dentistry of Savannah.*
4. *I have received, read, and fully understand Pediatric Dentistry of Savannah's Notice of Privacy Practices. I understand that I may refuse to sign this acknowledgement if I do not agree.*

Parent's/Guardian's Signature _____ Date:_____

Doctor's Review: _____

Alert Adds : _____

Pediatric DENTISTRY OF SAVANNAH

Medical History

Child's Name: _____ Preferred Name:_____

Birthday:_____ O Male O Female Today's Date:_____

Is your child in good health? Date of last physical exam:_____ O Yes O No

Name of child's pediatrician/group practice:_____

Has your child ever been hospitalized? _____ O Yes O No

Is your child allergic to anything?_____ O Yes O No

Is your child currently taking any medications? O Yes O No

Please give medication, dose and reason: _____

Please check if your child has been treated for any of the following:

O ADHD	O Congenital birth defects	O Mental / Physical delays
O Adverse drug reactions	O Diabetes	O Psychological disorders
O AIDS/HIV	O Ear and/or tonsil surgery	O Rheumatic fever
O Anemia	O Endocrine/growth	O Seizures/Epilepsy/Fainting
O Artificial Valve/Joint	O Eyesight	O Sickle Cell Anemia
O Asthma/breathing	O Heart condition/murmur	O Speech/hearing
O Autism	O Hepatitis	O Spina Bifida
O Blood disorders	O High/Low blood pressure	O Tuberculosis
O Cancer/tumors	O Kidney disease	
O Cerebral palsy	O Liver/GI disease	O Significant injuries
O Cleft lip/palate	O Measles/Mumps	O Other problems

Please explain any items checked:_____

_____

Dental History

Is today your child's first visit to the dentist? O Yes O No

Previous dentist:_____

Date of last visit/cleaning: _____

Date of last x-rays:_____

Has your child had any unfavorable dental experiences? Explain: _____

Is there any information you feel might help us better treat your child?_____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature _____ Date:_____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Pediatric Dentistry of Savannah to use and disclose protected health information (PHI) about me and/or my child/children to carry out treatment and financial transactions regarding my account. Pediatric Dentistry of Savannah's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Pediatric Dentistry of Savannah reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Pediatric Dentistry of Savannah's Privacy Officer at: 310 Eisenhower Drive #6, Savannah, GA 31406

By signing this form, I am consenting to Pediatric Dentistry of Savannah's use and disclosure of my child's/children's PHI to carry out appointment reminders, insurance items, account transactions/information and any calls/emails/faxes pertaining to my child's/children's dental care. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent or later revoke it, Pediatric Dentistry of Savannah may decline to provide treatment to you/your child.

Name of your child/children:_____

Printed name of parent/guardian signing form:_____

Your signature: _____ **Today's date:** _____

For Office Use Only

We have attempted to obtain written acknowledgement 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 specify):

FINANCIAL AGRREEMENT

Thank you for choosing us for your dental needs. We are committed to providing your child with excellent dental care. Our convenient financial arrangements are based on an open and honest discussion of recommended treatment options, respective fee and patients' financial capabilities.

PAYMENT

Payment in full is due at the time of service unless prior financial arrangements are made. We offer several payment options:

Cash, Checks, Visa, Master Card, and Care Credit

INSURANCE

Our office is committed to helping patients maximize their benefits. Because insurance policies vary greatly, we can estimate your coverage in good faith, but cannot guarantee it. As a service to our patients, we will be happy to manage all claim submissions and follow up on your behalf.

MISSED APPOINTMENTS

Once an appointment has been made, that time is reserved specifically for your child. We reserve the right to charge a $37 fee for a no show appointment or for a last minute cancellation. We do ask that you try to give us at least 24 hours notice of cancellation.

FINANCE CHARGE

The policy of this office is to charge 1% interest monthly or a billing charge to all account over 90 days past due. There is also a $40.00 fee for returned checks.

I understand and agree to this Financial Policy

Parent:_____ Date:_____