Dr. John Taylor

Children's Dentistry and Orthodontics for Kids

Health History

The benefits of healthy smiles are immeasurable. Our goal is to help your child have a healthy smile that make their visits with us pleasantand educational as well. Please help us with the following informaiton, which will be used in strict confidence.

Child's Information

Child's Name ___________________________________ Age _____ Date of Birth __________ ☐ Male ☐ Female
Name child goes by ________________________________ Hobbies, Pets ____________________________________

Home Address ____ Home Phone___________________
City ____ Zip ________________
Where does your child attend school? ____ Grade __________
Is your child in day-care? _____ Where? ____

Names and ages of other children in family? ____
Has this office treated any other family members? ______ Name? ____
Whom may we thank for referring you to our office? ____
☐ Friend ☐ Relative ☐ Dentist ☐ Physician

Parental information

Do Parents live together? ☐ Yes ☐ No
If not, with whom does the child live? ___________________________ ☐ Guardians?

Father's Name ____ Occupation _____________________________
Employer ____ Business Phone _________________________
Address ____ *SS# ________________*Cell # ______________

Mother's Name ____ Occupation _____________________________
Employer ____ Business Phone _________________________
Address ____ *SS# _______________ *Cell# _______________

*SS# used for insurance purposes - Cell#s optional

Medical History

Child's Pediatrician or Physician _______________________________________ Date last visited _______________
Address ____ Phone ______________________

☐ Yes ☐ No Has your child ever been hospitalized since birth? Please explain.
____

☐ Yes ☐ No Is your child allergic to any medicines or foods? Please explain.
____

☐ Yes ☐ No Is your child taking any medicines at this time or on a special diet? Please explain.
____

☐ Yes ☐ No Does your child have a Heart Murmur or Heart problem? Please explain.
____

☐ Yes ☐ No Is your child allergic to ☐ Latex ☐ Jewelry ☐ Copper ☐ Nickel

☐ Yes ☐ No Has your child ever received an injury or had a fall to the head, jaws, mouth, or teeth? Please explain.
____

☐ Yes ☐ No Has your child ever had a problem with their ☐ speech ☐ hearing ☐ sight ☐ learning disabilities.
Please explain ____

Medical History

Please indicate below whether your child presently has or previously had any of the following conditions?

☐ Yes ☐ No - Asthma
☐ Yes ☐ No - Seizures
☐ Yes ☐ No - Hyperactivity
☐ Yes ☐ No - Cerebral Palsy
☐ Yes ☐ No - Anemia
☐ Yes ☐ No - Liver disorder
☐ Yes ☐ No - Heart Murmur
☐ Yes ☐ No - Diabetes
☐ Yes ☐ No - Cancer – Tumor
☐ Yes ☐ No - Liver disorder
☐ Yes ☐ No - Blood disorder
☐ Yes ☐ No - Rheumatic fever
☐ Yes ☐ No - Bleeding tendency
☐ Yes ☐ No - Hepatitis
☐ Yes ☐ No - Lung problems / TB
☐ Yes ☐ No - Emotional disorder
☐ Yes ☐ No - Speech problems
☐ Yes ☐ No - Other ___________

Dental History

☐ Yes ☐ No Is this your child's first visit to a dentist? If not, please provide name and date of their last visit?
Dentist Name ____ Date __________________

☐ Yes ☐ No Has your child had a toothache recently? Explain ____

☐ Yes ☐ No Does your child have a dental condition about which you are most concerned? Please explain.
____

☐ Yes ☐ No Has your child had any problems with previous dental treatment? Please explain.
____

☐ Yes ☐ No Does your child have a history of ☐ Thumb sucking ☐ Finger sucking ☐ Pacifier use ☐ Nail biting.

☐ Yes ☐ No Does your child ☐ Snore at night ☐ Grind or grit teeth ☐ Mouth breathe ☐ Other habits _______

☐ Yes ☐ No Does your child have gastric reflux? Or ☐ reflux as an infant?

☐ Yes ☐ No Does your child play sports? Type _____________________________ ☐ Mouth or teeth protection.

☐ Yes ☐ No Does your child play a musical instrument? Type ________________________

☐ Yes ☐ No Has your child had any orthodontic treatment in the past?

How often do you assist brushing your child's teeth ☐ Daily ☐ Often ☐ Seldom.

Consent and financial

I acknowledge that this information is correct and authorize a dental examination of my child. We will tell you if dental X-rays are indicated or if we will be cleaning your child's teeth. **Parents are welcome in the treatment area with their children**.
We see the younger children for morning appointment times only.

Financial Policies

Our office in a Specialty Children's Dental practice geared to providing optimum dental care for children and young adults without the constraints of third party insurance companies, therefore we do not take insurance assignment. Payments are expected as services are rendered and the person bringing the child to our office is the person financially responsible for this account. We will gladly help you by providing the necessary insurance forms you will need to file your dental claims.

Parent or legal guardian ____ Date ___________________________
Signature

Dr. John Taylor

Children's Dentistry and Orthodontics for Kids

Thank you for choosing our office for your children's dentistry

Notice to all our Families

Payment and Insurance Policies

Please be aware that payment is due at the time of services in our office.
You are fully responsible for payment of services rendered.

We accept the following payment methods:
Visa / Mastercard
Personal Checks
Cash

INSURANCE INFORMATION:

- ☐ We do not participate in any federal or state insurance plans.
- ☐ We do not file insurance claims on your behalf.
- ☐ You may or may not be reimbursed by your insurance company for claims you submit.
- ☐ We take no responsibility for any insurance claims denied reimbursement.

We will be glad to provide an insurance form to you for reimbursement of our services. If your insurance company did not provide a dental card with the necessary information, please obtain the following information before your first visit.

- Insurance Company Name and Complete Mailing Address
- Employee/Subscriber ID#
- Employer Name
- Employer Group ID#

We will not need to see your insurance information again unless your information changes. If there is a change at any future appointments, please advise us upon ***arrival***.

We value all of our patients and are proud of the service we provide. We do not look toward any insurance company to make decisions about your child's dental health.

____
Name of Patient(s)

____
Parent's signature - Date

Children's Dentistry Privacy Policy

This notice describes how medical information about your child may be used and disclosed and how you can get access to this information. These are federal regulations under the "HIPAA" Act of 1996.

All healthcare providers must now inform you how medical records and other personal information is used. The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and individually identifiable information used by us in any form are kept properly confidential. This Act gives you rights to understand and control how you and your child's health information is used. HIPPAA provides penalties for covered health professionals that misuse your personal health information.

As required by "HIPAA" law, we have prepared this explanation of how we are required to maintain the privacy of your child's health information and how we may use and disclose this information.

The bottom line is - Children's Dentistry will not share any of your important information except in the following regulated purposes: 1) For Treatment in our office. 2) For Payment purposes. 3) For normal healthcare operations of our office and office staff training.

Treatment means providing, coordinating, or managing normal treatment of your child. An example of this would include communications between dentist and dental hygienist or dental assistant to best treat your child.

Payment means such activities as obtaining reimbursement for services, confirming insurance coverage, billing and collections, and utilization review. An example of this would be sending information to your insurance company.

Healthcare operations include the business aspects of running our practice such as providing appointment reminders, calling you to confirm appointments, referrals to other healthcare providers, training of office staff, improvement of quality assessments activities of the practice.

Any other uses of your or your child's information may only be used with your written consent. You may revoke or modify our use of health information in writing. An example of this would be if you didn't want a reminder card sent to your home.

You also have the following rights by law with respect to your protected health information, which you can exercise by presenting a written request to our office.

- The right to request restrictions on certain uses of your protected health information, including certain disclosure to family members, or any person identified by you. We are not required to agree with all restrictions and must come to a mutual agreement in writing before these restrictions are binding.
- The right to receive a written copy of this notice from us upon request.
- The right to amend your child's health information if there was an error or an omission.
- The right to insect and receive a copy of your child's health information with limited exceptions, with a written request, for a fee.

We are required by law to maintain the privacy of your child health information and provide you with this privacy policy.

This notice is effective as of April 14, 2003 and we are required to abide by these terms of this notice currently in effect or until the privacy notice is changed.

You have the right to file a written complaint with our office, or the Department of Health and Human Services, if you feel your rights were violated.

Office contact Person: Susan Critelli   Phone number: 770-973-7687

Office Address: 1230 Johnson Ferry Rd. Marietta, GA. 30068

From American Dental Association "HIPAA" forms

Notice of Privacy Practices Acknowledgement and Consent

Dr. John Taylor

Children's Dentistry and Orthodontics for Kids

I understand that under the Health Insurance Portability & Accountability Act of 1996 "**HIPAA",** I have certain rights to privacy regarding my child's health information as out-lined in Children's Dentistry Privacy Policy. I understand that Children's Dentistry will not share important information except in the following regulated purposes:

- For Treatment purposes
- For Payment purposes
- For Health care purposes

You have the right to read Children's Dentistry Privacy Policy before signing this form, which has a more complete description of the uses and disclosures on Health Information.

You understand that Children's Dentistry has the right to change its Notice of Privacy Policy from time to time and that you may receive a new notice by contacting Children's Dentistry. You also have the right to revoke this consent at any time by giving us written notice or request a restriction on how your child's information is used to carry out the above operations.

I have had the full opportunity to read and consider the contents of this consent and acknowledgment form and Children's Dentistry Privacy Policy. By signing this form I acknowledge and agree to the protection of my child's health information and the use and disclosure of this information to carry out Treatment, Payment Activities, and Healthcare Operations.

Patient Name: ____

Parent or Personal Representative: __________________________ Date: __________

Relationship to Patient: ____

Office Use Only

We attempted to obtain a Parent's signature in acknowledgement of this notice but were unable to do so as documented below.

Date ____________ Initials _____________ Reason ___________________________

From American Dental Association's "HIPAA" forms.