Welcome

Patient ID # _____ Today's Date _____

to our practice! We strive to make each of your child's visits pleasant and comfortable. Please fill out this form completely in ink.

Your Child

Child's Name _____

Nickname _____ Sex _____

Birthdate _____ Age _____

SS#/SIN _____

School _____ Grade _____

Child's Home Address _____

City _____ State/ Prov. _____ Zip/ P.C. _____

Phone _____

Responsible Party

Name _____

Relationship _____

Address _____

City _____ State/ Prov. _____ Zip/ P.C. _____

Email _____

SS#/SIN _____

DL # _____

Who is responsible for making appointments?

Name _____

Home Phone _____ Cell Phone _____

Work Phone _____ Ext. _____

Best time to call _____

Time _____ Days _____

_____

Mother ☐ Stepmother ☐ Guardian

Name _____

Home Phone _____ Cell Phone _____

Work Phone _____ Ext. _____

Email _____

Employer _____

Occupation _____

SS#/SIN _____

DL # _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Father ☐ Stepfather ☐ Guardian

Name _____

Home Phone _____ Cell Phone _____

Work Phone _____ Ext. _____

Email _____

Employer _____

Occupation _____

SS#/SIN _____

DL # _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Primary Insurance

Insured's Name _____

Relationship _____

Birthdate _____ SS#/SIN _____

Employer _____ Date Employed _____

Occupation _____

Insurance Company _____

Group # _____ Employee # _____

Ins. Co. address _____

City _____ State/ Prov. _____ Zip/ P.C. _____

Deductible _____ Copay _____

Amount already used _____

Max. annual benefit _____

Additional Insurance

Insured's Name _____

Relationship _____

Birthdate _____ SS#/SIN _____

Employer _____ Date Employed _____

Occupation _____

Insurance Company _____

Group # _____ Employee # _____

Ins. Co. address _____

City _____ State/ Prov. _____ Zip/ P.C. _____

Deductible _____ Copay _____

Amount already used _____

Max. annual benefit _____

Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer.

Payment in full at each appointment. ☐ Cash ☐ Personal Check

Credit Card ☐ Visa ☐ MC ☐ I wish to discuss the office's payment policy.

Dental & Health History *CONFIDENTIAL* Patient ID # _____

Your child's overall health as well as any medications which your child takes could have an important inter-relationship with the dental care your child receives. Please answer each of the following questions completely.

How often does your child brush? _____ How often does your child floss? _____

Is your child's water fluoridated? ☐Yes ☐No Does your child take fluoride supplements? ☐Yes ☐No

Does your child:

Suck thumb/finger ☐Yes ☐No Chew hard objects (pencils, etc.) ☐Yes ☐No

Suck/Bite lip ☐Yes ☐No Grind teeth ☐Yes ☐No

Bite/Chew nails? ☐Yes ☐No Clench jaws ☐Yes ☐No

Previous dentist _____ Address _____

Date of last dental visit? _____ _____

Has your child had difficulty with previous dental visits? ☐Yes ☐No

Child's physician _____ Address _____

Phone # _____ _____

Previous Hospitalizations/Surgeries/Serious Illnesses? When?

_____ _____

_____ _____

_____ _____

Is your child currently taking medications? ☐Yes ☐No (if yes, please list)

_____

Has your child ever taken Fen-Phen/Redux? ☐Yes ☐No

_____

Does your child have a history of allergies/sensitivities/adverse reactions to any drugs or medications (penicillin, Novocain, etc.)? ☐Yes ☐No (if yes, please describe) _____

Does your child have a history of allergies to any other substances (latex, environmental, etc.)?

_____

Has your child ever had any of the following:

Asthma ☐Yes ☐No Stomach, liver or kidney problems ☐Yes ☐No

Cancer ☐Yes ☐No Handicaps/Disabilities ☐Yes ☐No

Hepatitis ☐Yes ☐No Tuberculosis ☐Yes ☐No

HIV/AIDS ☐Yes ☐No Diabetes ☐Yes ☐No

Hemophilia ☐Yes ☐No Rheumatic Fever ☐Yes ☐No

A persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks) ☐Yes ☐No

Congenital Heart Defect ☐Yes ☐No

Heart Murmur ☐Yes ☐No

Convulsions/Epilepsy ☐Yes ☐No

Abnormal Bleeding ☐Yes ☐No

Please explain any medical problems that your child has: _____

_____

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 authorize 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 and request my insurance company to pay directly to the Dentist or Dentist's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____

Signature of patient (or parent/guardian if minor) Date

Dentist Review:

_____ _____

Signature of Dentist Date

Dentistry for Children and Teenagers
H. Todd Chambliss, DMD
7058 Professional Place
Daphne, AL 36526
Telephone (251) 447-0627
Fax (251) 447-0639

In order to protect the quality of time reserved for your child with Dr. Chambliss, we attempt to confirm your child's appointment via phone call, email reminders and text messaging. Dental cleaning appointments receive a postcard approximately two weeks prior to the appointment. All appointments receive phone call reminders starting two days prior to appointment time. We ask that you inform our office as soon as possible if you will need to reschedule your appointment, we will be glad to accommodate you, we do request a 48 hour notice if at all possible. You may elect text message reminders sent to your phone. You will be responsible for any fees from your phone service provider.

If a patient is more than 15 minutes late to their appointment, the patient's appointment may need to be rescheduled for a future appointment time. We will do our best to accommodate you the same day as your original appointment.

Please sign below and provide your mobile number if you would like text message appointment reminders and your email.

Signature of Patient or Guardian: _____

Email: _____

Mobile Number: _____

Date: _____

PAYMENT OF SERVICES AND INSURANCE

Payment is due when services are rendered. A billing fee will be assigned if a statement has to be sent. If any unpaid balance requires the assistance of a credit agency, the patient or responsible party will be responsible for all collection agency fees, attorney fees and court costs. If you have BC/BS of AL or All Kids we require you pay the **estimated** portion that the insurance will not cover. All co-pays, deductibles, and percentages are due at the time of service. As a courtesy to you, we will submit claims to your **primary** insurance carrier, giving them all necessary information to maximize your benefits. We no longer file secondary insurances however we will give you all the required forms and instructions to file the claim yourself. If for some reason, BC/BS of AL or All Kids does not pay, you are responsible for **all charges. A $15.00 billing fee will automatically be added to any balance that is 30 days past due and requires an additional statement to be sent.**

There are certain services that you select that are not covered by BC/BS of AL. **For these services, you will be responsible for the fee schedule difference.** For example, your contract will pay for amalgam (silver) fillings on posterior teeth, when a composite (tooth colored) filling is **only** used in our practice. You will be expected to pay the **difference,** up to the fee schedule amount for the composite fillings.

In addition, **procedures that are considered cosmetic are not covered by your contract and you will be responsible for payment in full.** Our goal as a staff is to provide the entire family with a safe, healthy, and happy environment.

I hereby understand the policies of Daphne Pediatric Dentistry.

Signature_____Date_____

Daphne Pediatric Dentistry

{NAME OF PRACTICE}

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

patient

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient #: _____ Social Security #: _____

SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: _____

Telephone: 447-0627 Fax: 447-0639

E-mail: _____

Address: 7058 Professional Place Daphne, AL 36526

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

patient

SIGNATURE

X _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

parent

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.

Daphne Pediatric Dentistry

{NAME OF PRACTICE}

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

patient

X I, _____, have received a copy of this office's Notice of Privacy Practices.

parent

Please 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)

_____

_____

_____