Tell Us About Your Child

Child's Name

Preferred Name

Age Date of birth

☐ M ☐ F

Address APT

City State Zip

Home Phone Patient's School

Grade Level Patient's Hobbies/Pets

Other Children And Their Ages

Whom can we thank for the referral

MEDICAL HISTORY

- Is your child presently under the care of your family physician for any medical reason? ☐ yes ☐ no

  If yes, what? _____

- Family Physician's / Pediatrician's Name _____

  Address _____ Phone number _____

- Is your child in good health? If no, what? _____ ☐ yes ☐ no
- Is your child under the care of a physician for other than routine care? If yes, explain? _____ ☐ yes ☐ no
- Is your child taking any medication at this time? ☐ yes ☐ no

  If yes, list _____
- Has your child ever been hospitalized or treated in an emergency room for any particular trauma? When and for what reason? _____ ☐ yes ☐ no
- Does your child have, or has he or she has, any emotional, mental, or nervous disorders? If yes, please explain _____ ☐ yes ☐ no
- Have your child's tonsils/or adenoids been removed? ☐ yes ☐ no
- Does your child breathe through the mouth? If yes, ☐ yes ☐ no

  ☐ Seldom ☐ Often

PLEASE INDICATE IF YOUR CHILD HAS HAD ANY OF THE FOLLOWING:

- ☐ Allergy to Penicillin
- ☐ Other drug allergy
- ☐ Anemia
- ☐ Rheumatic fever
- ☐ Bone disorder
- ☐ Mental handicap
- ☐ Positive for H.I.V
- ☐ Diabetes
- ☐ Epilepsy, seizures
- ☐ Bleeding disorder
- ☐ Tuberculosis
- ☐ Endocrine disorder
- ☐ Cleft palate
- ☐ Asthma
- ☐ Liver problems
- ☐ Malignancies or leukemia
- ☐ Speech problem
- ☐ Hyperactivity
- ☐ Attention Deficit Disorder
- ☐ Heart murmer. Type, _____ Is child under the care of a cardiologist or special physician for the problem?

  If so, whom _____

  Phone _____

  Other _____

DENTAL HISTORY

Yes No

- ☐ ☐ Is this your child's first visit to the dentist? If no when was the last visit and what was done for your child? _____
- ☐ ☐ Do you expect your child to be a cooperative patient? If no, please explain. _____
- ☐ ☐ Does your child have a toothache?
- ☐ ☐ Does your child take fluoride tablets or vitamins with flouride?
- ☐ ☐ Has your child bumped any teeth? If so, when? _____
- ☐ ☐ Has your child had a history of headaches, pain, popping or clicking of the jaws? _____
- ☐ ☐ Does your child still have a night time bottle?
- ☐ ☐ Does your child have or has he or she had any of the following problems or habits?

☐ Thumbsucking	How long? _____	Still Active?	☐ yes	☐ no
☐ Finger Habit	How long? _____	Still Active?	☐ yes	☐ no
☐ Pacifier	How long? _____	Still Active?	☐ yes	☐ no

How often does your child brush _____

Is toothbrushing supervised? ☐ yes ☐ no

Dental floss? ☐ yes ☐ no

RESPONSIBLE PARTY: FATHER/MOTHER

Father's Full Name | Address | City | State | Zip

SS # | Birth Date

Email Address | Home Phone #

Business Phone # | Employer | Occupation

Dental Insurance ☐ yes ☐ no

Insurance Company | Insurance Company Phone # | Group or Plan #

Mother's Full Name | Address | City | State | Zip

SS# | Birth Date | Home Phone # | Business Phone #

Employer | Occupation | Email Address

Dental Insurance ☐ yes ☐ no

Insurance Company | Group Plan Number | Insurance Company Phone

Parent's marital status:
Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Single ☐

FINANCIAL INFORMATION AND CONSENT

Method of Payment: Please Check One

- ☐ Cash at time of treatment
- ☐ Visa, Mastercard, American Express
- ☐ Insurance from with co-payment at time of treatment

- Payment is expected at time of treatment.
- All emergency patients (being seen for the first time are required to pay in full at time of treatment.
- Patients with insurance may pay their estimated portion, including deductible, at the time of service. It is the parents responsibility to see that the insurance company makes prompt payment. Any insurance balance over 60 days is due and payable by parent.

If my account requires servicing by a collection agency or by an attorney I understand that I will be liable for collection feed, attorney fees, and applicable courts costs in addition to my outstanding balance. I hereby authorize payment directly to Smile Magic Dentistry, LLC the group insurance benefits otherwise payable to me and authorize release of information regarding treatment to the insurance company.

_____

SIGNED (INSURED PERSON)

I give my consent to needed dental services, local anesthetic, nitrous oxide analgesia (laughing gas) and use of proper and acceptable methods to complete same.
I accept responsibility for payment of service rendered for _____

(Child's Name.)

I understand that I will be informed of any treatment (other than routine cleanings, fluoride treatments, x-rays and examinations) before treatment is performed.

_____

SIGNED (parent or legal guardian) DATE

NEW PATIENT AGREEMENT

We are happy to have the pleasure of meeting your child's dental needs here at Smile Magic Dentistry! Please read carefully and sign the following agreement of terms in order to be accepted into our practice.

- ✓ I understand that I must have a current insurance card preset in order for my child to be seen.
- ✓ I understand that if I do not give a 24 hour notice to cancel or change an appointment, I may be limited in my options to reschedule.
- ✓ I understand that parent or guardian must accompany my child at any and all appointments.
- ✓ I understand that my presence in the office is required while my child is being treated at Smile Magic Dentistry.
- ✓ I understand that I am responsible for notifying Smile Magic Dentistry of any, and all insurance coverage for my child.
- ✓ I understand that I am responsible for any charges not covered by my child's insurance.

Payment is expected in full at each visit for any procedure not covered by your child's insurance. These items will be explained to you before they are done for your child.
By signing, I agree and fully understand the terms stated in this agreement.
Smile Magic Dentistry will file my primary insurance for me and any filing of secondary insurance will be my responsibility.

_____ _____

Parent or Guardian Signature Date

2880 Old Alabama Rd. Suite 400, Alpharetta GA 30022
P: 678-240-2777 F: 678-240-2782
www.smilemagicga.com

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligences, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. Contact us using the information listed at the end of this Notice for a full explanation of time and fees involved.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for payments, other than treatment, payment, and healthcare operations and certain other activities, for the last

6 years, but not before April 14, 2003. If you request this accounting more than once in a 12- month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTION AND COMPLAINTS

If you want more information about our privacy practices of have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information, you may complain to us using the contact information at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint.

Authorization for additional disclosure:
I am the "personal representative" of (generally parent or legal guardian) and have legal authority to make health care decisions about the following minor patient:

Patient Name

As the "personal representative" of the above named patient, I authorize individuals to accompany my child and have access to health information.

Name	Relationship
1._____	_____
2. _____	_____
3. _____	_____
4. _____	_____

_____ _____

"Personal Representative" (Parent of Legal Guardian) Date