CHILDREN'S DENTISTRY OF ATLANTA
Janice Lee, DMD * Amanda Sengel, DDS
1100 Lake Hearn Dr., Suite 210 • Atlanta, GA 30342
404.255.5686 • www.childrensdentistryatlanta.com

Child's Name:_____ Date of Birth_____

PARENT INFORMATION

Parent Name:_____ Parent Name:_____

Social Security Number:_____ Social Security Number:_____

Date of Birth:_____ Date of Birth:_____

Home Address:_____ Address (if different):_____

City:_____ City:_____

Zip Code:_____ Zip Code:_____

E-mail address:_____ E-mail address:_____

Employer:_____ Employer:_____

Occupation:_____ Occupation:_____

******Please list at least 2 telephone numbers we may use to contact your family******

Home/Work Phone:_____ Cell Phone:_____

Which phone number is the best to contact you at?_____

FINANCIAL POLICY:
Payment is expected at the time that services are rendered. We accept American Express, Mastercard, Visa, Check and Cash. Upon payment, you will receive an itemized statement detailing services rendered. Should you have dental insurance, we will file your dental claims electronically. Your dental insurance company will then reimburse you directly according to your policy benefits.

CONSENT FOR DENTAL TREATMENT:
I have read and agreed to the above financial policy and hereby authorize Dr. Janice R. Lee and any additional personnel as she may designate to examine my child and provide necessary and appropriate dental services.

Signed:_____Date:_____
Parent/Guardian Signature

24 HOUR CANCELLATION NOTICE OF AN APPOINTMENT IS REQUIRED TO AVOID A BROKEN APPOINTMENT CHARGE.

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Medical History Questionnaire

Child's name_____ What does your child like to be called? _____

Date of Birth: _____Male or Female Child's hobbies/interests: _____

Siblings and their ages: _____

Grade Level: _____ School: _____

Name of Physician: _____ Date of Last physical exam:_____

Whom may we thank for referring you to our office? _____

Is your child under the care of a physician for anything other than routine care? If yes, please explain: _____

_____

Has your child been hospitalized for any reason? _____

Does your child take any current medications, prescription or over the counter? If yes, please list _____

_____

Does your child have **ANY** allergies to drugs or foods? Yes / NO. If yes, please be specific: _____

_____

Please **CIRCLE** any of the following that your child has or has had:

Heart Murmur	Congenital Heart Lesions	Damaged/Artificial Heart Valves	Asthma
Respiratory problems	Other Heart Conditions	Kidney Disease or Dialysis	Diabetes
Genetic Disorder	Sensory Integration Disorder	Neurological Disorder	ADHD
Liver Disease	Seizure Disorder	Arthritis/Painful Swollen joints	Anemia
Psychiatric Disorder	Muscle Disorder	Bleeding Problems	HIV
Mononucleosis	Thyroid Condition	Congenital Disorder	Autism
Immune Disorder	Mental/Physical Delays	Cancer or Tumor	Bruise Easily
Recurrent headaches	Stomach/Intestinal Problems	skin disorder	Hepatitis
Ear/Eye disorder	Speech Problem	Other: _____	

(Please be sure to complete back side of form)

Please **CIRCLE** yes or no, whichever applies to the following questions:

1. Has your child ever seen a pediatric dentist before? If yes, name and date: _____ Yes No

2. Has your child been seen by a general dentist before? If yes, name and date: _____Yes No

3. Does your child take a bottle or sippy cup to go to sleep? _____Yes No

4. Does your child eat or drink anything at night AFTER brushing their teeth? _____ Yes No

5. Does your child take Fluoride tablets, drops, or vitamins that contain fluoride? _____Yes No

6. Has your child ever bumped any teeth? If yes, please explain: _____Yes No

7. Has your child ever sucked his/her finger, thumb, pacifier, blanket or something else? _____ Yes No
   If yes to the above question, has your child stopped? If so, at what age did it cease?
_____

8. Does your child have difficulty breathing through the nose with his/her mouth closed? _____Yes No

9. Is there anything else that you would like us to know or that we need to know about your child?_____ Yes No

_____

I certify that I have read and understand the above Medical History Questionnaire. To the best of my knowledge all of the preceding health history answers I have given are true and correct. I also understand that it is my responsibility to notify Children's Dentistry of Atlanta of any changes to the above information.

_____

Signature of Patient/Guardian Date

PLEASE USE THE SPACE BELOW TO NOTE ANY CHANGES

Medical History Update

Date _____ Updates _____

Grade _____ School _____ Signature _____

Date _____ Updates _____

Grade _____ School _____ Signature _____

Date _____ Updates _____

Grade _____ School _____ Signature _____

Date _____ Updates _____

Grade _____ School _____ Signature _____

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DENTAL INSURANCE INFORMATION

Dear Patient,

As a courtesy to you, we are now offering ELECTRONIC INSURANCE FILING. We hope this service will benefit your family in many ways including faster reimbursement times, less paperwork and saving time and money on your part.

We will still collect payment in full, up front. However, should you have dental insurance we will submit your claim at time of service. Most insurance companies will send reimbursement within a couple of weeks.

For MetLife, Delta Dental and Guardian Insurance companies your Social Security number is your Member I.D. Should you wish not to disclose your Social Security number, we would then let you file your insurance on your own.

In order to provide this service to you, we need the below information completed and returned to us.

Name of Patient(s): _____

Insured's Information *(Policy Holder)*:

POLICY HOLDER NAME_____

POLICY HOLDER Home Address_____

_____

POLICY HOLDER Date of Birth _____

POLICY HOLDER Social Security Number _____

POLICY HOLDER Member ID Number _____

POLICY HOLDER Employer Name _____

Dental Insurance Company _____

Group Number_____Payer ID*(if available)*_____

Dental Insurance Company Address_____

_____

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Office Policies

We are thrilled to have the opportunity to care for your child's dental needs. Please rest assured that our goals are the same as yours…we want your child to have a healthy smile and the most pleasant dental experience possible. To best accomplish our goal, our office must operate upon certain guidelines. We ask that you read over these guidelines so that you will be informed of them. Your cooperation is appreciated.

Initial appointments
Your child's first visit to our office will be as a new patient exam and cleaning. This allows us to clean the teeth thoroughly so that a complete examination can be performed. It also affords your child the opportunity to become familiar with our office, our staff, and the instruments that will be a part of each dental visit.

Following examination, any treatment requirements observed will be discussed, your questions addressed, a treatment plan will be provided to you and emergency situations will be addressed (i.e. patient discomfort, infections will not go unattended). This allows us to be extremely efficient when you return for treatment. Until we examine your child, we do not know the extent of the work that will be required. We do not know the behavior of your child, any special needs he/she may have or the necessary time that will need to be allocated to appropriately treat your child.

Consultation appointments
If a patient is a referred by another dentist's office, a consultation appointment may be the first visit. At this appointment, we will examine your child, address emergency concerns and schedule treatment based upon findings. We do not routinely begin treatment at this appointment for the reasons stated above.

We do believe that children need familiarity and continuity for long term success. If your child is referred to our practice, we welcome them as a patient. Once treatment has been completed, we will recommend that they are seen by our office for routine cleaning appointments. We do not continue to schedule "consultation" appointments and "treatment" appointments only, as we do not feel that this allows us to provide the quality of care that we desire for your child. Your child's "dentist" should be the one to restore the decay noted. We would love to fill that role for you until your child's age and behavior allow them to accompany you to your adult dentist for comprehensive care.

Parents in the treatment area
One of the most important tools that we have to assure that your child has a pleasant dental visit is the ability to communicate with him/her the activities that he/she will experience. This is done in manner that is meant to be fun and intriguing. When possible, we prefer to have children enter the treatment area with our trained staff members. This allows your child the opportunity to establish a relationship with our staff. It also allows us to focus the allocated appointment time on your child completely.

A staff member will always speak to you prior to your child entering the treatment and cleaning area. They will explain the upcoming appointment and make note of any specific concerns that you may have. Once examining your child, Dr. Lee and staff will be able to discuss your concerns with the necessary information.

We never want your child to be worried or anxious. Sometimes children may arrive at our office a little anxious based on previous experiences, misconceptions, or just due to immaturity in age. It can be difficult to alleviate their concerns, but please allow us the opportunity to try our approach. It is very difficult to have several people trying to explain something to an already anxious child. If our approach is unsuccessful, your child will not be forced. You will be informed and may be invited into the treatment area to assist us in accomplishing the necessary exam or treatment.

Parents who enter the treatment area will be placed in private rooms or areas, as to protect medical privacy of other patients who may be in the open hygiene bay. Parents who have more than one child with them (i.e. younger siblings) are encouraged to bring assistance if they must come back with the patient. Small children are not allowed to wander unattended in the treatment areas. This is for their own safety as well as to ensure cleanliness of the office for other patients.

_____ Initials

Financial policy

Our office does operate on a "fee for service" basis. Payment is expected at the time services are rendered. We accept cash, MasterCard, Visa, American Express and checks as acceptable forms of payment. For our patients who have insurance, a claim will be filed electronically on your behalf. The claim will be submitted to your dental insurance carrier for direct reimbursement to you based upon your policy benefits.

Parents of patients requiring return visits will be provided a written treatment plan with ADA codes, office fees, and estimated number of visits required to accomplish treatment. If there are any concerns or questions regarding this information, please address it prior to the day of treatment so that your child may receive the benefit of the full time allocated for his/her appointment.

Broken Appointments and cancellations

We will do everything within our power to ensure that your child has an incredible start with his/her dental experience in life. You will find our staff to be friendly, welcoming and accommodating. We do not operate a dental clinic, but rather an appointment based office that allows you to receive necessary dental treatment in a predictable and efficient manner. When an appointment is scheduled, staff members will be here to treat you and meet your needs.

We do understand that needs change and unexpected occurrences arise from time to time. If you have scheduled an appointment and this is the case, we do ask that you contact our office as soon as possible. You will find our staff happy to accommodate you and reschedule your appointment as conveniently for you as our schedule allows. We do require a minimum of a 24 hour notice (business hours) to cancel or reschedule an appointment. Monday appointments should be rescheduled by noon the Friday prior to the appointment to avoid classification as a broken appointment.

Appointments that are cancelled or rescheduled within 24 hours of the appointment time are considered to be broken appointments. Broken appointments are subject to a broken appointment fee. Specific time has been set aside for each child and staff is available to address each concern on the day's schedule. Broken appointments will be billed so that increases in the cost of business overhead will not be unfairly passed along to other patients. We ask your cooperation in avoiding the need to bill for unused office hours.

I have been informed of office policies for Children's Dentistry of Atlanta.

_____ _____

Signature of parent or legal guardian Date

_____

Printed name of parent or legal guardian

Patient Name:_____

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School Forms (Form #3300)

If your child will be requiring a #3300 form for the upcoming school year, please advise us at the time of your child's visit and we will be happy to complete it for you at your child's check up appointment. **There is no charge for this service at your regularly scheduled checkup appointment.**

Forms completed outside of normal visits or replacement forms which may be requested will require advance notification of 3 business days prior to completion. Such forms are also subject to a processing fee of $20. Once completed, they will then be faxed or available for pick up during normal office hours. Unfortunately, we can no longer have them requested at random as this is becoming a distraction from our regularly scheduled patient appointments.

We will make every attempt to accommodate you as quickly as possible. However, we reserve the right to address these matters outside of regularly scheduled patient appointments, thus mandating advance notice of such requests and the ability to provide additional personnel time to complete them. We thank you in advance for your cooperation in this matter.

I have read the above and been informed of the policy regarding school forms.

_____ _____

Parent Signature Date

_____

Printed Name

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Dear Patient,

It is our desire to communicate to you that we are taking the new Federal HIPPA (Health Insurance Portability and Accountability Act) laws written to protect the confidentiality of your child's health information seriously. We want you to know the policies and procedures that we have developed to make sure that your child's health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your child's health information. In keeping with these laws, we want you to understand our procedures and your rights. We will use and communicate your child's health information only for the purposes of providing treatment, obtaining payment and conducting health care operations. Your child's health information will not be used for other purposes unless we have asked for and been voluntarily given your written permission.

HOW YOUR CHILD'S HEALTH INFORMATION MAY BE USED

To Provide Treatment
We will use your health information within our office to provide you with the best dental care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between hygienist, dental assistant, dentists, clinical and dental laboratories, pharmacies or other health care personnel providing treatment to your child.

To Obtain Payment
Although our practice operates on a "fee for service" basis, circumstances may necessitate our including your child's health information with an invoice used to collect payment for services that you have received in our office. We may be called to provide your insurance company with information regarding your services to insure your prompt reimbursement.

To Conduct Health Care Operations
Your child's health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. Your child's health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

In Patient Reminders
Because we believe regular care is very important to your child's oral and general health, we will remind you of a scheduled appointment. We may also remind you that it is time for you to contact us and schedule an appointment. Additionally, we may contact you to follow up on care that your child has received or to inform you of treatment that may be recommended for your child.

Family, Friends and Caregivers
We may share your child's health information with those you tell us will be helping with your child's home hygiene, treatment, medications, transportation or payment. We will be sure to use our very best judgment when sharing this information with only those who will be participating in your child's care.

Law Enforcement
If required by State or Federal law, we may disclose your child's health information to designated personnel.

Authorization to Use or Disclose Health Information
Other than is stated above or where Federal, State or Local law requires us, we will not disclose your child's health information other than with your written authorization. You may revoke that authorization at any time.

PATIENT RIGHTS

This new law is careful to describe that you have the following rights related to your child's health information.

Restrictions
You have the right to request restrictions on certain uses and disclosures of your child's health information. Our office will make every effort to honor reasonable restriction preferences from our patient's parents and/or guardian.

Communications Confidential
You have the right to request that we communicate with you in a certain way. We will make every effort to honor your reasonable requests for confidential communications. We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, send you an email and/or text, leave you a reminder message on your cell phone, home answering machine or with someone that answers your phone if you are not home.

Inspect and Copy Your Health Information
You have the right to read, review, and copy your child's health information, including his/her complete chart, radiographs and billing records. If you would like a copy of your child's health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Child's Health Information
You have the right to ask us to update or modify your child's records if you believe these records are incomplete or incorrect. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change.

Documentation of Health Information
You have the right to ask us for a description of how and where your child's health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. A reasonable fee may be charged for such requests.

Request a Paper Copy of this Notice
You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or fax a copy to you. We are required by law to maintain the privacy of your child's health information. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure that all of our patients receive a copy of the revised Notice.

You have the right to express complaints to us if you believe your child's privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your child's information. Please let us know of your complaints in writing.

PATIENT ACKNOWLEDGEMENT

Thank you very much for taking the time to review how we are carefully using your child's health information. If you have any questions we want to hear from you. If not, we would appreciate your acknowledging your receipt of our policy by signing below.

_____ _____

Signature of Legal Guardian Date

_____

Printed Name of Patient