WELCOME KIDS

We would like to welcome your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime!

1 Tell Us About Your Child

Today's Date: _____

Child's Name: _____
Last First M

Child's Birthdate: ____/____/____ Child's Age: _____

Nickname: _____ ☐ Male ☐ Female

School: _____ Grade: _____

Hobbies: _____

Child's Home #: (_____)_____ SS #: _____

Child's Home Address: _____
Apt / Condo #

_____
City State Zip

2 General Information

Who is accompanying the child today?

Name: _____ Relation: _____

Do you have legal custody of this child? ☐ Yes ☐ No

Whom may we Thank for referring you? _____

Other siblings: _____

Previous / Present Dentist: _____ Last Visit Date _____

Dentist's Phone #: (_____) _____

Relative or Friend not living with you:

Name: _____ Phone: (_____) _____

Address: _____
City State Zip

3 Parent's Information

Person Responsible for Account: _____ Parent's Marital Status ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorce ☐ Separated

☐ Father ☐ Step Father ☐ Guardian

Name: _____ Birthdate: ____/____/____

Address: (If different than Child's) Hm #: (_____) _____

_____

_____

SS #: _____ DL #: _____

Wk #: (_____)_____ Ext: _____ Cell/Other #: (_____) _____

Email: _____

Employer: _____

Employer's Address: _____

_____
City State Zip

If you have Dental Insurance Coverage for the Child, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____

_____
City State Zip

Insurance Phone: (_____)_____

Group # (Plan, Local, or Policy #): _____

☐ Mother ☐ Step Mother ☐ Guardian

Name: _____ Birthdate: ____/____/____

Address: (If different than Child's) Hm #: (_____) _____

_____

_____

SS #: _____ DL #: _____

Wk #: (_____)_____ Ext: _____ Cell/Other #: (_____) _____

Email: _____

Employer: _____

Employer's Address: _____

_____
City State Zip

If you have Dental Insurance Coverage for the Child, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____

_____
City State Zip

Insurance Phone: (_____) _____

Group # (Plan, Local, or Policy #): _____

4 Release

I certify that my child is covered by _____ Insurance Co. and I assign all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____
Signature of Parent or Guardian Date

USA

Continued on Back

5 Dental History

Why did you bring the child to the dentist today? _____

_____

_____

Has the child ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

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

Is the child currently in pain? ☐ Yes ☐ No

Does the child require antibiotics before dental treatment? ☐ Yes ☐ No

Has the child ever had a serious/difficult problem associated with previous dental work? ☐ Yes ☐ No

Is the child's water fluoridated? ☐ Yes ☐ No

Is the child taking fluoridated supplements? ☐ Yes ☐ No

Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Does the child brush his/her teeth daily? ☐ Yes ☐ No

Floss his/her teeth daily? ☐ Yes ☐ No

Child's Physician: _____

Phone #: _____ Date of Last Visit: _____

Is the child currently under the care of a physician? ☐ Yes ☐ No

Please describe the child's current physical health:

☐ Good ☐ Fair ☐ Poor

Please list all drugs that the child is currently taking:

_____

_____

Aside from the items below, please list all drugs/things that the child is allergic to:

_____

_____

Yes No Latex Yes No Metals/Nickel Yes No Plastic

6 Medical History

Has the child experienced the following medical problems?

Y	N	Abnormal Bleeding / Hemophilia	Y	N	Heart Murmur
Y	N	ADD/ADHD	Y	N	Hepatitis
Y	N	AIDS/HIV+	Y	N	High Blood Pressure
Y	N	Anemia	Y	N	Hives/Skin Rash
Y	N	Any Hospital Stays/Operations?	Y	N	Kidney Problems
Y	N	Artificial Bones/Joints/Valves	Y	N	Liver Problems
Y	N	Asthma	Y	N	Low Blood Pressure
Y	N	Cancer	Y	N	Lupus
Y	N	Chicken Pox	Y	N	Measles
Y	N	Congenital Heart Defect	Y	N	Mitral Valve Prolapse
Y	N	Convulsions	Y	N	Mononucleosis
Y	N	Diabetes	Y	N	Prosthetics
Y	N	Epilepsy	Y	N	Rheumatic Fever
Y	N	Exposed to HIV, but Neg.	Y	N	Scarlet Fever
Y	N	Handicaps/Disabilities	Y	N	Sickle Cell Disease
Y	N	Hearing Impairment	Y	N	Tuberculosis (TB)

Are the child's immunizations current? ☐ Yes ☐ No

Anything you would like to discuss with the Doctor in private? ☐ Yes ☐ No

Please discuss any serious medical problems the child experienced:

_____

_____

Does/did the child experience any of the following?

Y	N	Breast Fed	Y	N	Nursing Bottle Habits
Y	N	Chewing on Objects	Y	N	Speech Problems
Y	N	Clenching/Grinding Teeth	Y	N	Thumb/Finger Sucking
Y	N	Lip Sucking/Biting	Y	N	Tongue/Cheek Biting
Y	N	Mouth Breather	Y	N	Tongue Thrust
Y	N	Nail Biting	Y	N	Used Pacifier

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

_____

Signature of Parent or Guardian Date

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I have verbally reviewed the medical/dental information above with the parent/guardian & patient named herein. _____

Signature of Dentist Date

Dentist's Comments: _____

_____

Medical History Update

Has there been any change in your child's health status since their last visit? ☐ Y ☐ N

If Yes, please explain. _____

_____

Has there been any change in your child's health status since their last visit? ☐ Y ☐ N

If Yes, please explain. _____

_____

_____

Parent/Guardian Signature Date

_____

Dentist Signature Date

_____

Parent/Guardian Signature Date

_____

Dentist Signature Date

ROBINSON
FAMILY DENTISTRY
Building Smiles Daily

2015 HIPPA Agreement

CONSENT FOR USE AND DISCLOSE OF HEALTH INFORMATION

Please read the following statements carefully and sign at the bottom of the page

PURPOSE OF THE CONSENT: We have a duty to protect the confidentiality of medical information about you. We are required to provide you with a Notice of Privacy Practices explaining ways we may use and disclose your medical information. The notice also describes your legal rights and our obligations regarding the use and disclosure of your medical information. By signing this form, you will consent to our use and disclosure of your picture and protected health information to carry out treatment, payment activities, healthcare options and electronic filing of your insurance claims.

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, health information, and of our other important matters about your protected health information. A copy of our notice accompanies this consent upon request. 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.

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. Please understand that revocation of the 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.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: We will gladly furnish you with a set of our Privacy Practices Notice upon request at any time, if any time you have questions or concerns regarding this law, please feel free to ask us.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU: We may use or disclose identifiable health information about you for many reasons, including treatment, payment, healthcare operation, public health purposes, auditing, national security and protective services, worker's compensation, lawsuits and disputes, activities of managed care networks in which we participate, activities of our affiliates, appointment reminders, law enforcement purposes, to avert a serious threat to health or safety, military command authorities, and required by law.

COMPLAINTS: If you believe your rights have been violated, you may file a written complaint with this office at ***Kit Robinson, D.M.D., Attn: Privacy Officer, P.O. Box 603 Hahira, Georgia 31632*** or with the Secretary of the U.S. Department of Health and Human Services.

PRINT NAME: _____ DATE: _____

SIGNATURE: _____

FAMILY MEMBERS I GIVE PERMISSION TO RELEASE INFORMATION TO:

1) _____ _____
NAME RELATIONSHIP

2) _____ _____
NAME RELATIONSHIP

950 Georgia Hwy 122 W • P.O. Box 603 • Hahira, GA 31632
Phone: 229.794.3003 • Fax: 229.794.3804 • www.KitRobinsonDMD.com

ROBINSON
FAMILY DENTISTRY
Building Smiles Daily

Financial Agreement

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the highest quality dental care using only the best material and technology available. We are also committed to providing you with up to date information and educational tools so that you may fully participate in maintaining optimum oral health. This financial agreement is intended to provide you with excellent service while minimizing our administrative costs.

Your **estimated** co-payment for treatment, which is the amount not covered by your insurance, is due at the time services are provided. Your co-payment may be adjusted after the time of service depending upon the final reconciliation of insurance payments. Our office accepts cash, personal checks and all major credit cards. Outside financing through Care Credit is available upon request and approval.

All charges are your responsibility. We must emphasize that as your dental care provider, our relationship is with you, our patient, not your insurance company. As a courtesy to you we will help you by processing all of your insurance claims. In order for our office to file your insurance claim, you must provide us with up to date information. It is your responsibility to notify our office of any insurance changes so that claims may be submitted properly at all times.

- Return checks are subject to $30.00 fee.
- **Appointments that are canceled without the proper 24 hour notice will be assessed a $30.00 reinstatement fee.**
- Any accounts that are 60 days past due will be referred to the County Magistrate Court in your county to be processed for wage garnishment.

Please refer any questions you may have to any member of our team. Robinson Family Dentistry is committed to providing you with a comfortable and positive experience.

_____	_____
Name (Please Print)	Signature
_____	_____
Date	Witness

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