WELCOWEWLDS

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!

Tell Us About Your Child			General Information			
To	oday's Date:		Who is accomp	anying the child	today?	
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		165	Do you have legal cu			
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ckname:			Other siblings:			
hool:			Previous / Present D			
bbles:			Dentist's Phone #: (
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lld's Home Address:		Apt / Condo #	Name:			
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		Parent's	Information			
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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 denties 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 Quardian

Date

Yes No Namenta Name	Abnormal Bleeding / Hemophilis Y N Heart Murmur N ADD/ADHD Y N ADD/ADHD Y N Hepatitis High Blood Pressure Y N ADS/HIV+ Y N High Blood Pressure Y N Anemia Y N Any Hospital Stayal Operations Y N Kidney Problems treatment? Yes No Y N Any Hospital Stayal Operations Y N Kidney Problems Y N Additional Bones/Joints/Valves Y N Liver Problems Treatment? Yes No Y N Asthma Y N Low Blood Pressure W N Concer Y N Lupus Yes No Y N Concer Y N Lupus Yes No Y N Concer Y N Metales Yes No Y N Concer Y N Metales Yes No Y N Concer Y N Metales Yes No Y N Convolsions Y N Mononucleosis Y N Broblems He child experiences/ed; Y N Breast Fed Y N Nursing Bottle Habits Y N Broblems Y N Brob
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Has your child event taken Phon-Pers?	Yes No
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Is see critic currently in pain? Year No No Year Additional boroex/Jointa/Nales Year No Low Blood Prev	trestment? Yee No
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Is the child water fluoridates? See No	Yes No
Is the child taking fluoridated supplemental? Yes No	s/her
Has the child ever had any pain/fendemens in his/her yes No	Sher
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Chies of ryspears. Date of Last Visit:	Are the child's immunizations current? Are the child's immunizations current? Anything you would like to discuss with the Doctor in private? Anything you would like to discuss with the Doctor in private? Please discuss any serious medical problems the child experiences/ed: 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 lickel Yee No Plastic Y N Nail Biting Y N Used Pacifier Inmitted to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA. Prect to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this thus. I authorize the dental staff to perform the necessary dental services my child may need. Signature of Parent or Guardian Date
Phone a:	Anything you would like to discuss with the Doctor in private? Yes No Please discuss any serious medical problems the child experiences/ed; Anything you would like to discuss with the Doctor in private? Yes No Please discuss any serious medical problems the child experiences/ed; Does/did the child experience any of the following? Yes No Please Fed Yes No Please Fed Yes No Please Yes Yes No Please Yes Yes No Please Yes Yes No Please Yes No Nail Biting Yes No Yes Please Yes No Nail Biting Yes No Yes Please Yes No Please Yes No Nail Biting Yes No Yes Please Yes Yes No Nail Biting Yes No Yes Yes No Please Yes Yes No Nail Biting Yes No Yes Yes No Yes No Nail Biting Yes No Yes Yes Yes No Yes Yes Yes No Yes Yes No Yes Yes No Yes Yes Yes No Yes Yes No Yes Yes No Yes Yes Yes Yes No Yes Yes Yes No Yes Yes Yes Yes No Yes Yes Yes Yes No Yes
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Has there been any change in your child's health status since their last visit?	n status since their last visit?
If Yes, please explain. Parent/Guardian Signature Date	
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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.

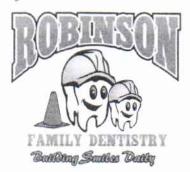
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: We will gladly furnish you with a set of our Privacy Practices Notice upon request at any time, if any time you have questions or concerns regarding this law, please feel free to ask us.

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.

INT NAME:	DATE:
SNATURE:	
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MILLY MEMBERS I GIVE PERMIT	SSION TO RELEASE INFORMATION TO:
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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	

