Today's date___________

Welcome to Our Practice!

We strive to make each of your child's visits pleasant and comfortable.
Our goal is to teach your child oral habits which will help keep their smile beautiful for their lifetime.

Your Child

Child's Name ______________________

Nickname ______________________ Sex ________

Birthdate ______________________ Age ________

SS#/SIN ______________________

School ______________________ Grade ______

Child's Home Address ______________________

City ______________________

State/Province __________ Zip/Postal Code __________

Phone ______________________

❑ **Mother** ❑ Stepmother ❑ Guardian

Name ______________________

Home Phone ______________________

Cell Phone ______________________

Work Phone ______________________

SS#/SIN ______________________

Employer ______________________

Occupation ______________________

❑ **Father** ❑ Stepfather ❑ Guardian

Name ______________________

Home Phone ______________________

Cell Phone ______________________

Work Phone ______________________

SS#/SIN ______________________

Employer ______________________

Occupation ______________________

Parent/Guardian's Marital Status

❑ Single ❑ Married

❑ Divorced ❑ Widowed ❑ Separated

Who is responsible for making appointments?

Name ______________________

Relationship ______________________

Primary Dental Insurance

Insured's Name ______________________

Relationship ______________________

Birthdate __________ SS#/SIN __________

Employer __________ Date Employed __________

Occupation ______________________

Insurance Company ______________________

Group No. __________ Emp. No. __________

Ins. Company Address ______________________

Does your child have a secondary dental insurance policy? ❑ Yes ❑ No
If yes, please provide card.

Financial Agreement

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payors and/or appropriate health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group benefits otherwise payable to me. I understand that my dental 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. Payment is due as services are rendered unless prior arrangements have been made. In the event this account is placed with a collection agency, I agree to pay 35% of the principal and interest owing on said account as liquidated damages, and an additional 15% of the principal and interest owing as attorney's fees, for collecting said account.

Signature of parent/guardian ______________________ Date ______________

Over Please

Child's Health History

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

Has your child had any history of, or conditions related to, any of the following:

❑ Anemia	❑ Cancer	❑ Fainting	❑ Immunizations	❑ Mumps	❑ Other ________
❑ Arthritis	❑ Cerebral Palsy	❑ Growth Problems	❑ Kidney	❑ Rheumatic fever	________
❑ Asthma	❑ Chicken Pox	❑ Hearing	❑ Latex allergy	❑ Seizures	________
❑ Asperger's	❑ Chronic Sinusitis	❑ Heart	❑ Liver	❑ Sickle cell	________
❑ Autism	❑ Diabetes	❑ Hepatitis	❑ Measles	❑ Thyroid	________
❑ Bleeding disorders	❑ Earaches	❑ HIV +/AIDS	❑ Mononucleosis	❑ Tuberculosis	________
❑ Bones/Joints	❑ Epilepsy				

Please list the name and phone number of the child's physician:

Name of Physician ______________________________ Phone ______________

Child's History

YES NO

1. Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? .... 1. ❑ ❑
   If yes, please list: ______________________________
2. Is the child allergic to any medications, i.e., penicillin, antibiotics, or other drugs?
   If yes, please explain: ______________________________ 2. ❑ ❑
3. Is the child allergic to anything else, such as a certain food?
   If yes, please explain: ______________________________ 3. ❑ ❑
4. Has the child ever had a serious illness? If yes, when: ______________
   Please describe: ______________________________ 4. ❑ ❑
5. Has the child ever been hospitalized? .... 5. ❑ ❑
6. Does the child have a history of any other illnesses?
   If yes, please list: ______________________________ 6. ❑ ❑
7. Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: ______________ 7. ❑ ❑
8. Has the child had any problem with dental treatment in the past? .... 8. ❑ ❑
9. Has the child ever suffered any injuries to the mouth, head or teeth? .... 9. ❑ ❑
10. Has the child had any orthodontic treatment? .... 10. ❑ ❑
11. What type of water does your child drink? ❑ City water ❑ Well water ❑ Bottled water ❑ Filtered water
12. Does the child take fluoride supplements? .... 12. ❑ ❑
13. Any conditions not mentioned here? .... 13. ❑ ❑
    If yes, please list: ______________________________

Consent to Treat

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. **It is my responsibility to inform this office of any changes in my child's health status.** I authorize the dentist to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my child's dental needs. I also authorize the dentist to perform any and all forms of dental procedures that may be indicated in connection with my child's treatment. I also understand the use of local anesthetic agents have the potential for complications including but not limited to infection, allergic reaction, persistent and/or partial numbness, and hematoma.

Signature of parent/guardian ______________________________ Date ______________

PATIENT CONSENT TO RECEIVE COMMUNICATIONS / MESSAGES

Patient Name: ____

D.O.B.: ____________________

I give authorization to be contacted or leave information pertaining to my care by the following methods, I assume responsibility to update this information whenever it may change.

Check all that apply:

_____ Home Phone and/or Voicemail # ____________________________

_____ Cell Phone and/or Voicemail # ____________________________

_____ Work Phone and/or Voicemail # ____________________________

_____ Email: ____

_____ Other – Please Indicate: ________________________________

List the names of people we can discuss your dental care with:

NAME	RELATIONSHIP	PHONE NUMBER

____
PLEASE PRINT NAME OF PERSON COMPLETING FORM

____
RELATIONSHIP TO PATIENT

____
SIGNATURE DATE

Jeffrey A. Houston, D.M.D.
John P. Robison, D.M.D.
1625 Broadrick Dr.
Dalton, Ga. 30720

Acknowledgment of our Appointment Policy

We want to thank you for choosing us as your dental health care provider. In order to provide you and our other patients with the best care possible, we request that you follow our guidelines regarding broken and/or cancelled appointments.

You are the only one scheduled for your appointment time. Your appointment time is important to you, your dentist and to others who are in need of our services.

If you cannot keep your appointment for any reason, please call us 24 hours prior to your appointment time. If you cancel with less than 24 hours notice, do not show for your appointment, or arrive too late for your procedure to be completed, **a fee could be charged to your account.** You will be personally responsible for this charge. This charge will not be billed to nor paid by your insurance company. Future appointments will not be scheduled until this fee is paid. Please make us aware of any unforeseen circumstances you feel we should know about.

Additionally, we reserve the right to dismiss any patients with multiple broken appointments.

Please help us keep the scheduling of appointments fair for everyone.

Thank you.

________________________ ______________________

Signature Date

____

Printed Name

JEFFREY A. HOUSTON, D.M.D. & JOHN P. ROBISON, D.M.D., P.C.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 1, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

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 intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official 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. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.______ for each page, $______ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, 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.

Restriction: 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).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

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 Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or 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 or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may 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 with us or with the U.S. Department of Health and Human Services.

Contact Officer: LYNN SWEENY

Telephone: 706-226-3334 Fax: 706-277-0689

E-mail: ______

Address: 1625 BROADRICK DR. DALTON, GA. 30720

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

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

____
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)

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