Welcome!

We would like to welcome you and 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

Today's Date: _____

Child's Name: _____
last first MI

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

School: _____ Grade: _____

Child's Home Phone: (_____) _____

Child's SSN: _____

Preferred Name: _____

Child's Home Address:

_____

_____
city state zip

Who is Accompanying the Child Today?

Name: _____Relation_____

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

Person Responsible for Account

Name: _____ Relation:_____

Billing Address: _____

_____
city state zip

Email Address: _____

Drivers License #: _____

Employer: _____

Work Phone: (_____)_____Home Phone (_____)_____

SSN: _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

_____

Previous/Present Dentist: _____

Last Visit Date: _____

Parent's Marital Status: ☐ Single ☐ Widowed ☐ Married ☐ Divorced ☐ Separated

Who is responsible for making appointments?

Name: _____ Home Phone (_____)_____ Work Phone (_____)_____ Cell Phone (_____)_____

Closest relative not living with you?

Name: _____ Home Phone (_____)_____ Work Phone (_____)_____ Cell Phone (_____)_____

Address: _____
city state zip

☐ **Father's Information** ☐ Step Father ☐ Guardian

Name: _____

Birthdate: _____/_____/_____

Work Phone: (_____)_____

Home Phone: (_____)_____

SSN: _____DL# _____

☐ **Mother's Information** ☐ Step Mother ☐ Guardian

Name: _____

Birthdate: _____/_____/_____

Work Phone: (_____)_____

Home Phone: (_____)_____

SSN: _____DL# _____

Dental Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____

Address: _____

Address 2: _____

City,State,Zip: _____

Ins. Company: _____

Address: _____

Address 2: _____

City,State,Zip: _____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of 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.

I understand that the Parent or Guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.

_____

Signature of Parent or Guardian **Date**

James Proctor, D.D.S.,

MEDICAL HISTORY

Name: _____ Date of Birth: _____

Although dental personnel primarily treat the area in and around the mouth, the mouth is a part of the entire body. Health problems that your child may have, or medication that they may be taking, could have an important interrelationship with the dentistry your child will receive. Thank you for answering the following questions.

Is your child under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Has your child ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Has your child ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Is your child taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Has your child ever taken Phen-Fen or Redux? ◯ Yes ◯ No _____
Is your child on a special diet? ◯ Yes ◯ No _____

Child's Physician: _____ Phone: _____ Date of Last Visit : _____

Is your child allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: _____

Does your child have, or have they ever had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
ADD/ADHD ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Autism ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Cerebral Palsy ◯ Yes ◯ No	Handicaps/Disabilities ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Hearing Impairment ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No	Yellow Jaundice ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No	

Has your child ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

Has your child ever had difficulty with dental work? ◯ Yes ◯ No If yes, please explain: _____
Has your child ever had any pain/tenderness in the jaw joint (TMJ)? ◯ Yes ◯ No If yes, please explain: _____

Is the child taking fluoride supplements? ◯ Yes ◯ No
Is the child's water fluoridated? ◯ Yes ◯ No
Does the child brush his/her teeth daily? ◯ Yes ◯ No
Does the child floss daily? ◯ Yes ◯ No

Does/did the child have any of the following habits?
Lip Sucking/Biting ◯ Yes ◯ No
Nail Biting ◯ Yes ◯ No
Nursing Bottle Habits ◯ Yes ◯ No
Thumb/Finger Sucking ◯ Yes ◯ No

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

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PARENT or GUARDIAN _____ DATE _____

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

James Proctor, D.D.S, P.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I _____ (Parent) have reviewed a copy of this office's notice of privacy practices.

Date: _____

- I understand that the child's private health care information may be released to either parent.
- I understand that in the case of single custody the minimal amount of private health information may be released to the non-custodial parent.
- I understand that it is the obligation of the parent bringing the child to the dental appointment to inform the office the status of legal custody or of any changes that may occur regarding that status.
- I give my permission to have records transferred to another dentist at my request.
- I give my permission for messages to be left at home regarding appointment dates and times.

Child's name: _____

Parent Signature: _____

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.

( ) Communication barriers prohibited obtaining the acknowledgement.

( ) An emergency situation prevented us from obtaining acknowledgement.

( ) Other (please specify):

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 14, 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 health care 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 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 to 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, xrays, 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.

APPPOINTMENT 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 can not 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 expenses 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 per page, $ 0 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 a 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 bide 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 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 e-mail, you are entitled to receive this notice in written form.

QUESTIONS AND COMPLAINTS I 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 our 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 in 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 their

address 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 : PATTI MALOOF
TELEPHONE: 770-483-6800
ADDRESS: 2045 HONEYCREEK PARKWAY * CONYERS, GEORGIA * 30013