CHRIS CHILDS, DMD

COMPREHENSIVE DENTAL CARE

Please Complete and Return to the Business Office

Personal Information

Name: Last First Middle

Address: Street or P.O. Box # City State Zip Code

Phone Number:
Home:
Work:

Cell Phone:

Email Address:

Age: Yrs.

Birth Date: Mo. Day Year

Birthplace:

( )Married
( )Unmarried
( )Separated

Social Security No: (If child, parents)

Driver's License No:

Occupation:

Employer:

Preferred Pharmacy

Person Responsible for Bill:

Address:

Relationship:

Social Security No.:

Driver's License No.:

Employer:

Insurance Information

Insured Person's Full Name

Date of Birth

Social Security Number

Relationship to Patient

Work Phone

Insurance Company Name

Group or Union Name

Group or Local Numbers

Employer's Name

Full Address of Employer

Getting to Know You

1. Why did you select our practice?
2. Whom may we thank for referring you?
3. Is another member of your family or relative a patient in our practice?
4. Person to contact for emergency:
   Phone:
5. When was your last dental visit?
6. When was the last time you had complete dental radiographs taken?
   Name and address of last dentist:
7. Have you ever had any teeth removed?
   How long have these teeth been missing?
   Have these teeth been replaced?
   How? ☐ Bridge ☐ Partial ☐ Denture ☐ Implants

Payment Alternatives

Please check appropriate box:

☐ 1. As a special service to you, we offer a cash courtesy if you pay for your entire treatment plan in full, in advance.

☐ 2. Cash and personal checks are accepted as your treatments are provided.

☐ 3. If you have dental insurance, we want you to receive the full benefit of it. Our office team can assist you in completing your insurance forms and verifying the coverage that your particular program provides. We accept assignment of your insurance payment, another service to you. This means that you are responsable for your deductible and the portion the insurance does not cover. Remember, however that you are responsible for the account if the insurance company, for any reason, does not honor their commitment to you and to us.

☐ 4. MasterCard, Visa and Discover

☐ 5. For long term or extended payments, we offer a healthcare financing program, which once you are extended a line of credit will allow small monthly payments for the treatment received.

FOR ALL PATIENTS

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistance as he or she deems fit. I also understand that previous tod- treatment, full explantation of the procedure(s) involved will be given by the doctor and/or team. I agree to pay for all services rendered by this office.

Medical History

1. How do you feel about getting and maintaining a healthy mouth?_____

_____

2. How do you feel about the appearance of your teeth?_____

_____

3. If you could change anything about your smile, what would you change?_____

_____

4. Are you having dental problems at this time? ☐ Yes ☐ No
5. Do your gums bleed at any time? ☐ Yes ☐ No
6. Do you feel very nervous about having dental treatment? ☐ Yes ☐ No
7. Have you ever had a bad experience in the dental office? ☐ Yes ☐ No
8. Have you been under the care of a medical doctor during the past two years? ☐ Yes ☐ No
   If yes: for what reason? _____
   Please provide the name, address, and telephone number of your physician.

_____

9. Have you been a patient in the hospital during the past two years? ☐ Yes ☐ No
   If yes: for what reason? _____
10. Have you taken any medicine or drugs during the past two years? ☐ Yes ☐ No
    If yes, please list:_____
11. Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, latex, aspirin, codeine, or any other drugs or medicines? ☐ Yes ☐ No
    If yes, please list:_____
12. Have you ever had excessive bleeding requiring special treatment? ☐ Yes ☐ No
13. Do you use any tobacco products? ☐ Yes ☐ No
14. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? ☐ Yes ☐ No
15. Do your ankles swell during the day? ☐ Yes ☐ No
16. Have you lost or gained more than 10 pounds in the last year? ☐ Yes ☐ No
17. Do you use more than 2 pillows to sleep? ☐ Yes ☐ No
18. Do you ever wake up from sleep, short of breath? ☐ Yes ☐ No
19. Are you on a special diet? ☐ Yes ☐ No
20. Check any of the following which apply in either the past or present:

☐ Heart Valve Prolapse	☐ High Blood Pressure	☐ Cortisone Medication
☐ Heart Failure	☐ Anemia	☐ Arthritis
☐ Heart Disease or Attack	☐ Asthma	☐ Pain in Jaw Joints
☐ Family History of Cardiovascular Disease	☐ Emphysema	☐ X-Ray or Cobalt Treatment
☐ Angina Pectoris (Chest Pain)	☐ Shortness of Breath	☐ Cancer or Tumors
☐ Rheumatic Fever	☐ Hay Fever	☐ Chemotherapy (Cancer, Leukemia)
☐ Congenital Heart Lesions	☐ Allergies or Hives	☐ Thyroid Disease
☐ Scarlet Fever	☐ Fainting or Dizzy Spells	☐ Glaucoma
☐ Artificial Heart Valve	☐ Epilepsy or Seizures	☐ HIV Positive (AIDS)
☐ Heart Pacemaker	☐ Nervousness	☐ Venereal Disease
☐ Heart Surgery	☐ Psychiatric Treatment	☐ Cold Sores or Fever Blisters
☐ Artificial Joint of Any Type	☐ Any Form of Eating Disorder	☐ Genital Herpes
☐ Diet Medication: Name_____	☐ Recreational Drug Use	☐ Kidney Trouble
☐ Heart Murmer	☐ Drug Addiction/Alcoholism	☐ Diabetes
☐ Bruise Easily	☐ Tuberculosis (TB)	☐ Ulcers
☐ Blood Transfusion	☐ Any Form of Hepatitis	☐ Stroke
☐ Hemophilia	☐ Liver Disease	☐ Birth Control Medication
☐ Sickle Cell Disease	☐ Rheumatism	☐ Pregnant - Due Date _____

21. Do you have any disease, condition or problem(s) not listed? If so, please list..... ☐ Yes ☐ No

_____

CHRIS CHILDS, DMD

COMPREHENSIVE DENTAL CARE

1283 Sims Street
Gainesville, GA 30501
(770) 536-0581
www.chrischildsdental.com

Consent for Use and Disclosure of Health Information

Section A: Patient Giving Consent

Name: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Patient #: _____ Social Security #: _____

Section B: To the Patient – Please Read the Following Statements Carefully

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

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, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. 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.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: DR. CHRIS CHILDS
Telephone: 1283 SIMS STREET GAINESVILLE, GA 30501 Fax: _____
Email: 7705360581

Address: _____

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 listed above. Please understand that revocation of this 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.

Signature

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

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Acknowledgement of Receipt of Notice of Privacy Practices

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

_____
Name (Please Print)

_____
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
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

_____

CHRIS CHILDS, DMD

COMPREHENSIVE DENTAL CARE

(770) 536-0581

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 03 / 14 / 03, 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: Amanda Robinson, EFDA, Office Manager

Telephone: 770-536-0581 Fax: 770-534-1288

E-mail: _____

Address: 1283 SIMS STREET
GAINESVILLE, GA. 30501