All for Kids Dental Group, LLC

Dental Practice Policy

Dear Parent/Guardian:

Please read, initial each paragraph, and sign the bottom of page.
Welcome to All for Kids Dental where, "We treat you Great", we appreciate the opportunity to assist with your dental needs and concerns. Our goal is to provide you with the best dental care available in an efficient and professional manner. Together we can accomplish this goal. Like any business we have office policies that we must adhere to so that we can operate in a manner that will benefit our relationship. We will define those policies in the next couple of paragraphs.

_____**We require all Patient/Parents/Guardians to show their insurance or managed care membership card along with their driver's license, so that we may make copies for our permanent record. The office cannot render services on the assumption that our charges will be paid by the insurance company. All services are charged directly to the patient/parent/guardian and he/she remains personally responsible for payment. However, as a courtesy we will file the insurance claim for you.**

_____We must have a 24-hour notice should you be unable to attend your appointment. We have reserved this time for you and must know if you are unable to keep it. If you are unable to give us at least a 24-hour notice, **YOU WILL BE CHARGED A $25 BROKEN APPOINTMENT FEE**.

_____There is a $25 reservation fee for Hospital Patients and a $50 reservation fee for In-Office IV Sedation patients. Before we are able to schedule your child/children for dental restorations to be done at Newton Medical Center or in our office using IV Sedation you must pay your reservation fee.

_____There is a $25 local anesthesia fee for each appointment. This covers the cost of the anesthesia that is given to the patient to complete the work required. This is not a reservation fee and is not covered by your insurance.

_____I understand that dentistry is not an exact science and therefore reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment that I requested and authorized. I understand that each dentist is an individual practitioner and is individually and solely responsible for the dental care rendered to me.

____We require that children 3 years of age and older go back on their own (unless special needs). No Parent/Guardian is allowed back when child is receiving treatment.

____We try very hard to adhere to the schedule. If you are more than 15 minutes late, we may have to reschedule your appointment. Sometimes an emergency can occur that will make us run behind, please be patient with us as it could be you with the emergency. We do respect your time and will make every effort to stay as close to your appointment time as possible. We thank you for choosing All for Kids Dental and look forward to a long relationship with you and your family.

Parent/Guardian Signature_____ **Date**_____

ALL FOR KIDS DENTAL GROUP, LLC
10115 Hwy 142 N
COVINGTON, GA 30014
770-784-7099

Patient Form and Medical History

Patient's Name _____ Sex: M/F Date of Birth_____ Age _____

School_____Grade_____

Home Street Address_____

City _____State_____ Zip Code_____

Mother/Guardian's Full Name_____ Date of Birth _____

Social Security#_____ Driver License#_____ Home

Phone#_____ Cell Phone # _____

Employer _____Work Phone#_____

Father/Guardian's Full Name_____ Date of Birth _____

Social Security#_____ Driver License#_____ Home

Phone#_____ Cell Phone # _____

Employer _____Work Phone#_____

Marital Status of Parents: Married/Separated/Divorced/Other _____

E-Mail Address _____

Name of nearest relative not living with you _____Phone#_____

Whom may we thank for referring you to us _____

Do you have dental insurance: Y/N Medicaid: Y/N Do you have more than one dental insurance: Y/N

Payment of Professional Fees: The policy of payment for dental services in this office will be Cash, Visa or MasterCard. Payment is expected the day that services are rendered. Portions of the bill not covered by insurance or Medicaid is the responsibility of the patient and is due in full at the conclusion of each dental visit. Medicaid recipients must present a current Medicaid card on the day of the visit.

I understand and agree to these terms.

Signature _____ **Date** _____

	Y	N	?	Explain		Y	N	?	Explain
Hearing Problems					**Problems at birth**				
Eye Problems					**Heart Murmur**				
Skin Problems					**Rheumatic Fever**				
Tonsil/Adenoid Problems					**Anemia**				
Emotional/Behavioral Problems					**Sickle Cell Anemia**				
Attention Deficit Disorder					**Bleeding/Hemophilia**				
Hepatitis					**Blood Transfusion**				
AIDS or HIV					**Arthritis**				
Tuberculosis					**Cancer**				
Liver Disease					**Cerebral Palsy**				
Kidney Disease					**Seizures**				
Diabetes					**Autism**				
Asthma					**Cleft Lip**				
Speech Problems					**Down Syndrome**				

List other medical conditions:

_____

If yes to any above, please explain

_____

_____

Is your child taking any medication at this time? _____

Name of Patient's Primary Physician _____ **Telephone #** _____

Last Exam Date _____

Allergies (please list) _____

Dental History

What is your main concern about your child's dental health (problem)?

_____

_____

Has your child been to a dentist before? Y/N If Yes, Date of last visit: _____

Date of last X-Ray: _____ Former Dentist Name: _____

Reason for leaving former dentist: _____

Has your child ever been seen by HELP A CHILD BUS at his/her school Y/N If Yes, Date of last visit: _____

Yes	No	?	
			Has your child experienced an unusual reaction to dental medication or anesthetic?
			Has your child experienced prolonged bleeding following dental treatment?
			Will your child be uncooperative?
			Has your child experienced any complications following dental treatment?
			Has your child inherited any family facial or dental characteristics?
			Has your child had any injury to teeth, jaws, or face?
			Has your child had any clicking or pain in the jaw joints?
			Was your child breastfed? What age stopped?
			Was your child bottle-fed? What age stopped?
			Did your child use a pacifier? When stopped?
			Did your child suck a finger or thumb? When stopped?
			Do your child's gums bleed when brushed?
			Did you or your child ever get instructions in brushing?
			Does your child use fluoride products: rinses, drops, tabs?
			Does your child use dental floss?

Please check if your child has had problems with any of the following:

_____ Cavities _____Color of Teeth _____ Teeth Sensitive to Hot or Cold _____ Bleeding Gums_____ Tooth Aches _____ Gum Infection

____Teeth Sensitive to Sweets ___ Look of Teeth ____Tooth Bumped _____Grinds Teeth ____ Other Dental Problems _____

Explanations and comments: _____

_____

_____

To the best of my knowledge, the answers I have given are accurate. I understand it is important to report changes in my child's medical or dental status to the dentist, and I agree to do so. I give permission to the dentist to obtain additional information from my child's physician regarding medical history needed to provide dental treatment.

PERSON COMPLETING THIS FORM

Signature: _____ Date: _____

Relationship to Patient: _____

Medical and Dental History Reviewed By: _____ Date: _____

ACKNOWLEDEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____have received a copy of this office's Notice of Privacy Practices

_____

Please Print Name

_____

Signature

_____

Date

For Office Use Only

We attempted 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)

_____

_____

_____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTON A: INFORMATION FOR PATIENT:

Name: _____

Address: _____

Telephone: _____Email: _____

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 you protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practice: 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, a healthcare operation, 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 or 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 Privacy Practices, including any revisions of our notice, at any time by contacting:

Office Manager- All for Kids Dental Group

Right to Revoke: You will have the right to revoke this Consent, at any time by giving us written notice of you 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 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 of Patient/Parent: _____ 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.

APPOINTMENT AGREEMENT

We are honored to have the opportunity to treat your child. We appreciate the trust you have placed in us. We strive to give each child the individual attention they deserve. In a sincere effort to acknowledge the importance of each parent's time, and to remain on time ourselves. We ask that you ensure that your child arrives on time for their appointment. This will allow us to see all scheduled patients in a timely and effective. When a patient is late or fails to keep their scheduled appointment, it affects all of the children and their parents that are scheduled that day.

If a patient is more than 15 minutes late, we may need to reschedule their appointment. If we are able to see your child, we cannot guarantee that all treatment will be completed. If a patient misses their appointment, they will be rescheduled once. If a second appointment is missed, the patient may be dismissed from the practice, or required to make a non-refundable deposit before scheduling another appointment.

If necessary, parents may cancel or change their appointment BEFORE 9:30 AM two business days before the appointment.

It is your responsibility to personally confirm you child's appointment. We will make every effort to reach you to confirm. We will call you one business day prior to your child's appointment.

All appointments **may be changed or cancelled by 9:30 AM up to 2 business days BEFORE the appointment date. Additionally, all appointments must be CONFIRMED by 9:30 AM two business days BEFORE the appointment date**. All unconfirmed appointment will be moved off of our schedule to allow another child to be seen by our office.

We make every effort to contact you by phone, text, or email to CONFIRM your appointment.

We ask that you acknowledge our appointment policy by signing below.

_____

Signature Date

In cases where you, the parent are unable to come,

Please **clearly print** the names of other family members who would be authorized to bring your child to an appointment.

Name: _____ Relationship _____

Name: _____ Relationship _____

Name: _____ Relationship _____

Name: _____ Relationship _____