brookhaven
CHILDREN`S DENTISTRY

Child's First (Mi) Last Name _____ Preferred Name? _____

Date of birth _____ Age _____ Male Female Grade Level _____ School _____

Child's Physician _____ Approximate Date of Last Physical Exam _____

Patient's Hobbies, Interests, Pets, etc. _____

Other children & their ages: _____

Reason for visiting our office today: Checkup Habit Decay Orthodontics Emergency Other

YES NO Is your child under the care of a physician for any reason, other than routine care?
If yes, please explain: _____

YES NO Does your child have a heart murmur, artificial heart valve, prosthetic joint, or any other foreign materials/objects?
If yes, which one? _____ Who diagnosed it? _____

YES NO Does your child have any drug allergies or has your child ever had a reaction to a drug?
If yes, please list the drug(s) and the reaction(s): _____

YES NO Does your child take any medications on a regular basis? If yes, please list: _____
_____

YES NO Is your child taking any medication at this time that he/she does not normally take on a regular basis?
If yes, please explain: _____

YES NO Has your child EVER been a patient in a hospital?
If yes, please explain: _____

YES NO Has your child EVER been seen in an emergency room for ANY reason?
If yes, please explain: _____

YES NO Does your child have or does anyone in your family have a condition called methylenetetrahydrofolate reductase deficiency (MTHFR) or hyperhomocysteninemia?

Please mark next to the condition your child currently has or has ever had:

Adrenal Disorder ☐	Brain Disorder ☐	HIV Positive ☐	Autism ☐	Stomach Problem ☐
Hearing Problem ☐	Ear/Eye Disorder ☐	Learning Difficulty ☐	Skin Disorder ☐	Breathing Problem ☐
Intestinal Problem ☐	Allergy ☐	Lung Disorder ☐	Mental Handicap ☐	Cancer ☐
Abnormal Bleeding ☐	Congenital Birth Defect ☐	Liver Disease ☐	Behavior Problem ☐	Tumor ☐
Blood Disease ☐	Heart Condition ☐	Muscle Disorder ☐	Speech Problem ☐	Epilepsy ☐
Bone Disorder ☐	Endocrine Problem ☐	Nose/Throat Disorder ☐	Kidney Problem ☐	Diabetes ☐
Seizures ☐	Physical Handicap ☐	Asthma ☐	Hepatitis ☐	ADHD ☐
		Asperger's Syndrome ☐		

YES NO Has your child ever seen a children's dentist before? If yes, approximate date of last exam: _____

YES NO Has your child ever been seen by a regular dentist before? If yes, approximate date of last exam: _____

YES NO Do you expect your child to be uncooperative?

YES NO Does your child drink unfluoridated water?

YES NO Does your child take fluoride tablets, fluoride drops, or vitamins which contain fluoride?

YES NO Has your child ever bumped any teeth? If so, when: _____

YES NO Has your child ever experienced facial pain or had problems with the jaw joints near each ear?

YES NO Is your child a "toothpaste eater?"

YES NO Has your child had a traumatic medical or dental experience? If yes, explain: _____

YES NO Would you consider your child to be a slow learner?

YES NO Does your child suck his/her thumb, finger(s), pacifier, blanket, something else? If yes, what: _____

YES NO Does your child have difficulty breathing through the nose with his/her mouth closed?

YES NO Young children only: Does your child have a bottle to go to sleep?

Is there anything else you would like us to know, or that we need to know about your child? _____
_____

THE ABOVE MEDICAL, DENTAL, & MEDICATION HISTORY IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFTY YOU OF ANY CHANGE IN THE ABOVE PRIOR TO ANY APPOINTMENT

Signed (parent/guardian) _____ **Date:** _____

Office Policies

1. *We accept cash, check, MasterCard, Visa, Discover, & American Express. A **$25.00 charge** will be assessed for returned checks.*
2. *Please try to provide **24-hour cancellation notice**. Your appointment time is set aside specifically for your child. We schedule individual time with each patient to allow us to deliver the quality, personal care that every patient deserves. We understand that illnesses and emergencies happen, however, we must know about your need to reschedule an appointment as soon as possible. **A broken appointment fee of $50.00** will be applied to the **3rd missed appointment,** if you provide less than 24-hr. notice.*
3. *We reserve the right to charge a monthly billing charge and/or interest on past due accounts in accordance with Georgia law. If the balance remains unpaid and is turned over to a collection agency and/or our attorney for collection, you agree to be responsible for all attorney fees and/or collection fees that we incur while attempting to collect on the unpaid balance, as well as all court costs should we have to file a lawsuit.*
4. Facts About Dental Insurance – *We ask that you realize that we don't work for a dental insurance company. Rather, we work completely for our patients. We feel that dental insurance can be a wonderful benefit for many families, and want you to know we will do everything in our power to insure you get every benefit allotted in your insurance contract. **The treatment we recommend and the fees we charge will always be based on your child's needs, not your insurance coverage.** Your insurance is based on a contract between the employer and the insurance company. We are not part of the contract; and, therefore, not responsible for the terms and/or benefits of your insurance company. We can only assist you in estimating your portion of the cost of treatment, and we at no time guarantee what your insurance will or will not do with each claim. If we have received all of your insurance information on the day of the appointment, we will be happy to file your claim for you. We will accept your completed insurance form, file the claim and accept payment from your insurance company under the following conditions only:*
    - We require payment in full including deductible from the parent, and can ONLY accept insurance when we receive payment for the portion which the insurance company will not cover at the time services are rendered.
    - We can ONLY accept payment from an insurance carrier, when they directly assign benefit payments to our office. *Some out of state Delta Dental plans, and all Federal Blue Cross Blue Shield plans, will send payments directly to your household. In these cases, we require payment IN FULL for all services rendered.*
    - It is the parent's responsibility to see that the insurance company makes prompt payment. **Any insurance balance over 45 days is due and payable by the parent**. Once a payment is received from your carrier, or if an overpayment occurs we will issue a check, or apply the amount to your child's account at your option.
    - If a balance remains after insurance payments have been received, we will send one statement at no charge. If more than one notice is sent, a charge of 1.5% per month (18% APR) will be added to each notice. Minimum charge of $8.00. If we utilize certified mail for communication, the current charge for each account is $12.00.
    - **Usual and Customary Rates:** Frequently, insurance companies state that the reimbursement was reduced because your dentist's fee has exceeded the usual, customary, or reasonable fee ("UCR") used by the company. A statement such as this can be very misleading, especially as insurance companies imply your dentist is "overcharging" rather than say they are "underpaying" or that their benefits are low. Insurance companies set their own schedules and each company uses a different set of fees they consider allowable. These fees may vary widely because each company collects fee information from claims it processes. The insurance company then takes this data and arbitrarily chooses a level they call the "allowable" UCR fee. Frequently this data can be three to five years old and these "allowable" fees are set by the insurance company so they can make a net 20% - 30% profit. In general, the less expensive insurance policy will use a lower, usual, customary, or reasonable (UCR) figure.

Alternate financial arrangements are always possible. Please try to make these arrangements with our office manager in advance of treatment. Our office is happy to be flexible, and we never want finances to be a barrier to excellent oral health.

Unless other arrangements are made in advance, the parent or guardian who brings the child to our office is responsible for payment in full. All statements will be sent to this individual. We welcome nannies, caregivers and relatives to bring your children to our office. For unaccompanied minors children present without their legal parent or guardian, non-emergency treatment cannot be rendered without confirmed verbal phone consent or a hand-written signed note. Thank you for understanding our financial guidelines. Please let us know if you have questions or concerns.

I have read, understand, and agree to the terms and conditions in the office policies listed above:
Signature of parent/guardian_____**Date**_____

PARENT INFORMATION

Mother's First (Mi) Last Name	Father's First (Mi) Last Name
Social Security	Social Security
Date of Birth	Date of Birth
Home Address	Home Address
City State Zip	City State Zip
Home Phone	Home Phone
Cell Phone	Cell Phone
Work Phone	Work Phone
Employer	Employer
Email Address	Email Address

Whom should we use as primary contact for your child/children? _____

What is the preferred method of contact? _____

When is best to contact you (days and times if applicable)? _____

Whom does your child live with? _____

How did you find out about our office? _____

Dental insurance: YES NO Primary Carrier Name:_____

Customer Service Phone #:_____ Group #:_____

Policy Holder:_____ Member ID:_____

Secondary Dental Insurance: YES NO Secondary Carrier Name:_____

Customer Service Phone #:_____ Group #:_____

Policy Holder:_____Member ID:_____

Insurance information: Dental benefits differ greatly from traditional health insurance. Dental insurance is never a "**pay all**" solution, but merely an aid. Many plans tell their patients, "services will be covered at 100%, 80%, or 50%," but do not clearly specify plan fee allowances, annual maximums and limitations. It is more realistic to expect some out of pocket expense to be incurred with most visits to our office. In some cases, your benefits have specific limitations based on the number or frequency of services your plan will cover. Dr. Christianson may ask for x-rays or diagnostic aids more frequently than your annual benefits allow. *We provide exceptional dentistry, and we will not recommend treatment or care regulated by your insurance contractual limitations.*

____ ***I authorize release of information to all my insurance carriers.*** ____ ***I authorize payment directly to the doctor.***
____ ***I understand that I am responsible for any part of my bill not covered by insurance.***
SIGNATURE:_____*DATE*:_____

During Most first appointments our office will:

- Perform an examination of the teeth, gums, and surrounding tissue.
- Clean your child's teeth.
- Apply a concentrated fluoride gel to the teeth (fluoride treatment).
- Take radiographic images. These films are indicated during many, but not all first appointments.
- Teach and/or review proper oral hygiene methods if 6 or older when necessary.

If you have a concern about or object to any of these procedures, please let us know before we begin.

I have read and understand the above information. The information provided is accurate, and to the best of my knowledge.

*SIGNATURE:*_____*DATE:*_____

HIPAA PRIVACY
AUTHORIZATION FOR USE AND DISCLOSURE OF
PERSONAL HEALTH INFORMATION

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. seq., and regulations promulgated thereunder, as amended from time to time (collectively referred to as "HIPAA").

This authorization affects your rights in the privacy of your personal healthcare information. Please read it carefully before signing.

Brookhaven Children's Dentistry, ("Covered Entity") will not condition treatment payment, enrollment in a health plan, or eligibility for benefits, as applicable, on your providing authorization for the requested use or disclosure. YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

By signing this authorization you acknowledge and agree that Covered Entity may use or disclose Health Information, Personal Information for the purpose(s) of treatment and insurance processing.

By signing this authorization you agree that Covered Entity or its Business Associates may disclose your personal health care information to doctors, front office staff, referring doctors, pediatricians, physicians, health care professionals, and insurance companies.

Further, by signing this authorization you acknowledge that you have been provided a copy of and have read and understand Covered Entity's HIPAA Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA. While Covered Entity has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available from Covered Entity at any of its offices or by sending a written request with return address to 1418 Dresden Dr. NE Ste. 255 Atlanta, GA 30319.

In accordance with your rights under, and subject to certain restrictions imposed by, HIPAA, you may inspect or copy your PHI in the designated record set maintained by Covered Entity for as long as the PHI is maintained in the designated record set.

You have the right to revoke this authorization, in writing, at any time, except to the extent that Covered Entity has taken action in reliance on it. A revocation is effective upon receipt by Covered Entity of a written request to revoke and a copy of the executed authorization form to be revoked at the address listed above.

This authorization shall expire upon the earlier occurrence of: (a) revocation of the authorization, (b) a finding by the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights that this authorization is not in compliance with requirements of HIPAA, (c) complete satisfaction of the purposes for which this authorization was originally obtained, to be determined in the reasonable discretion of Covered Entity, or (d) six years from the date this authorization was executed.

By signing this authorization you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for redisclosure by the recipient and no longer protected under HIPAA.

Covered Entity will provide **X**_____ **[*name of patient(S)*]** with a copy of this signed authorization.

Acknowledged and agreed to

ON BEHALF OF PATIENT:

Signature **X**_____

Print Name **X**_____

X_____
Date
***Circle*: Mother Father Legal Guardian**