Parent's Information

Today's Date: _____

Person responsible for account: _____

Name: _____

DOB: _____

☐ Mother ☐ Father ☐ Step-Mother/Father ☐ Guardian

Race: _____ Language: _____

Address:_____

_____

City State Zip

SSN: _____ DL #: _____

Home # (___) _____ Cell # (__) _____

Email: _____

Employer: _____

Emergency Contact:_____

Relationship to patient(s)_____

Phone: _____

If you have Private Dental Insurance for your Child, please fill out below:

Subscriber's Name: _____

Subscriber ID: _____

SSN: _____ DOB: _____

Employer: _____

Insurance Co. Name: _____

Insurance Co. Phone Number: (__)_____

Child/Children's Information

Child's Name:_____

Nickname:_____

SSN: _____

DOB: ___ / ___ / ___ Male or Female

List all doctors your child sees: _____

_____

Child's Name:_____

Nickname_____

SSN: _____

DOB: ___ / ___ / ___ Male or Female

List all doctors your child sees:_____

_____

Child's Name:_____

Nickname:_____

SSN: _____

DOB: ___ / ___ / ___ Male or Female

List all doctors your child sees: _____

_____

Child's Name:_____

Nickname:_____

SSN: _____

DOB: ___ / ___ / ___ Male or Female

List all doctors your child sees:_____

Child's Name:_____

Nickname:_____

SSN: _____

DOB: ___ / ___ / ___ Male or Female

List all doctors your child sees: _____

**** Our office requires you to confirm your scheduled appointment or we reserve the right to replace it without notice****

GENERAL TREATMENT CONSENT

I give consent for myself/ my child (or children) to receive dental treatment deemed necessary by the providers Alabama Health/ DBA Just Kids Dental. These procedures include, but are not limited to; examinations, oral prophylaxis (cleanings), fluoride treatments, sealants, restorations (amalgam or composite fillings and crowns), periodontal (gum) treatments, endodontic (root canal) treatments, extractions and the use of local anesthetics. I understand that the use of local anesthetics carries a small risk for swelling, bruising, allergic reaction, changes in pain perception, or prolonged anesthesia. I agree that the above information along with the information on the Medical History form(s) to follow is all true and accurate. This consent shall be considered in effect until rescinded or revoked.

Authorized Signature of Parent or Guardian: _____ **Date:**_____

Health **History**

Child's Name: *Date of Birth:*

Information

Has the child experienced any of the following medical problems? ***(PLEASE mark either YES or NO on every question)***

Y N	*Abnormal Bleeding/Hemophilia*	*Y N*	*Heart Murmur/Condition*_____
Y N	*ADD/ADHD*	*Y N*	*Hepatitis*
Y N	*AIDS/HIV+*	*Y N*	*Allergies*
Y N	*High Blood Pressure*	*Y N*	*Anemia*
Y N	*Hives*	*Y N*	*Any Hospital Stays/Operations*
Y N	*Kidney Problems*	*Y N*	*Artificial Bones/Joints/Valves*
Y N	*Liver Problems*	*Y N*	*Asthma*
Y N	*Low Blood Pressure*	*Y N*	*Cancer*
Y N	*Mitral Valve Prolapse*	*Y N*	*Chicken Pox*
Y N	*Mononucleosis*	*Y N*	*Congenital Heart Defect*
Y N	*Prosthetic*	*Y N*	*Convulsions*
Y N	*Rheumatic Fever*	*Y N*	*Diabetes*
Y N	*Scarlet Fever*	*Y N*	*Epilepsy*
Y N	*Skin Rash*	*Y N*	*Exposed to HIV, but Neg.*
Y N	*Tuberculosis*	*Y N*	*Handicaps/Disabilities*
Y N	*G6PD*	*Y N*	*Hearing Impairment*
Y N	*Other:*_____		

Please list any surgeries your child has had:_____

Please list any Allergies your child has:_____

Has your child been hospitalized within the last year? Y / N If yes, please explain:_____

_____

Are the child's immunizations current? ☐ Yes ☐ No

Please describe the child's current physical health: ☐ Good ☐ Fair ☐ Poor

Please list any medication that the child is currently taking: _____

Please list all medications that the child is allergic to: _____

Y / N Allergic to Latex Y / N Allergic to Metals

Y / N Allergic to Nickel Y / N Allergic to Plastic

Is there anything you would like to discuss with the doctor in private? ☐ Yes ☐ No

For female patients: Are you pregnant? ☐ No ☐ Yes (Expected due date: _____)

Please discuss any serious medical problems the child has or had in the past:

Does/did the child experience any of the following?

Y N	*Breast Fed*	*Y N*	*Nursing Bottle*	Y N	Used Pacifier
Y N	*Chewing on Objects*	*Y N*	*Speech Problems*	Y N	Nail Biting
Y N	*Clenching/Grinding Teeth*	*Y N*	*Thumb/finger Sucking*	*Y N*	*Tongue Thrust*
Y N	*Lip Sucking/Biting*	*Y N*	*Tongue/Cheek Sucking*	*Y N*	*Mouth Breather*

Office Policy Regarding Patient Treatment

Our goal in treating your child, is to provide the highest quality of care utilizing the most up to date techniques and materials in a safe, friendly environment by our experienced, caring, and well trained staff. It is also our goal to prevent decay and to have all patients "cavity free". The following are our guidelines for treatment. If you have any questions or concerns regarding these guidelines, please feel free to ask one of our dentists or staff member at anytime for clarification.

Treatment

We will treat your child the same way we would treat one of our children. We provide dental care in an honest, sincere fashion without sedation or general anesthesia. We do use nitrous, local anesthesia and various patient management techniques. We feel these are the safest and most effective approaches to treating your child.

Since many adults have a fear of dentistry, they wait until they have serious problems to seek treatment. Most of the treatment we perform on children, such as sealants and small fillings, are to prevent these more serious problems. Our goal is to reinforce to our patients that dentistry is a healthcare service that can provide a lifetime of healthy teeth and gums and that visiting the dentist can be a positive experience. Our job is to educate your child about dentistry and to establish trust and confidence in your child.

Since every child is unique and handles new situations differently, it is necessary to have your child's undivided attention. Therefore, we do ask for parents to wait in the reception room during their treatment appointment. This allows the dentist to establish a direct and close rapport with your child. When a parent is in the room, your child's attention is divided and it is difficult to gain his/her confidence. However, if you feel a strong desire to accompany you child, or if the dentist sees a need for your presence in the treatment room, that can be arranged. It's not our intent to keep you out of the treatment area during your child's visit, we only want what's best for your child and to offer him/her the most pleasant experience possible.

One of our staff members will come out to the reception area and accompany your child to the treatment room. The staff member will stay with your child during treatment and accompany him/her back to the reception room after treatment is completed. **While you may feel it is comfort for your child "to walk them back to the room" we have found this to be a greater problem for your child because you are "leaving them". If your child knows you are "waiting for them out front" and that they will join you at the end of their treatment, then you have not "left" or "gone away".**

I, the parent/guardian, of said patients below, acknowledge that I have read and understand the above policy. All of my question have been answered to my satisfaction.

Please name all patients: _____

Signature Parent/Guardian: _____

Relationship to patient: _____

DATE: _____

ACKNOWLEDGMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES
&
CONSENT FOR USE AND DISCLOSURE OF
HEALTH INFORMATION

Parent/Guardians Name: _____

Please list ALL children/patients: _____

TO THE PARENT OR GUARDIAN GIVING CONSENT, PLEASE READ FOLLOWING STATEMENTS CAREFULLY.

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

Notice of Privacy Practices: You have received and have had the opportunity to read our Notice of Privacy Practices before you decide whether to sign the 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 out 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: Compliance Officer, Integrated Healthcare Alliance, LLC.
Address: 2100 1st Avenue North, Suite 300 Birmingham, AL 35203
Phone: 1-866-311-1830

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 below Acknowledges Receipt of Notice of Privacy Practices and Consent for the Use and disclosure of Your Health Information:

I (Please Print Name) _____ 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 child's protected health information to carry out treatment, payment activities and health care operations and other uses described in the Notice of Privacy Practices that was provided to me

SIGNATURE: _____ **DATE** _____

NITROUS OXIDE INFORMED CONSENT FORM

(Nitrous is usually used during treatment, not cleanings)

Please list ALL children/patients: _____

List each date of birth: _____

Nitrous oxide is commonly called laughing gas, or "relaxing air," and provides relaxation through inhalation. Nitrous oxide is administered through a mask and makes your child more comfortable to receive the necessary dental care with less pain and/or anxiety.

The alternatives to nitrous oxide are:

- **No nitrous oxide:** The necessary procedure is performed under local anesthetic only.
- **Oral Conscious Sedation:** Sedation via oral form that will put a child in a minimally depressed level of consciousness (Awake but with a lowered level of awareness).
- **General Anesthetic:** A patient under general anesthetic has no awareness and must have his/her breathing temporarily supported and is performed in a hospital setting only (Child is 'asleep').

Complications/risks may include, but are not exclusive of: a tingling sensation or a feeling of heaviness, followed by a lighter floating feeling; warm feeling throughout the body, with flush cheeks; laughter or giddiness; detachment from the environment may occur; light weight or floating sensation, sluggishness and slurring and/or repetition of words; feeling of nausea; vomiting or agitation. All these complications are temporary.

I have had the opportunity to discuss nitrous oxide use in conjunction with my child's dental care, and have had an opportunity to ask questions and am fully satisfied with the answers I received.

I have informed the dentist of my child's complete medical history including any recent surgeries, mood altering medications, or changes in my child's medical history involving lung, respiratory, ear infection, or common cold. I also accept and understand that I must notify the dentist of my child's present mental and physical condition.

Signature of Parent/Guardian: _____

DATE: _____

Film and Photograph Release

I _____(parent), give Alabama Health Just Kids Dental permission to record and or photograph my child/children for use in internal or external marketing purposes (i.e No Cavity Club, website, Facebook, and TV).

Child's/ Children's Name (s): _____

Signature (Responsible Party): _____

Date: _____

Consent to the insurance bill

We welcome the opportunity to serve you and your family. Please note that required only the co-payment or coinsurance based on the procedures is completed the day of service. Your copay or safe must be submitted the day of service and courtesy you are billed to your insurance company for the rest of the finished work. **Please note: you are still responsible for the services provided in the case of your insurance company can do the payment required on your behalf.**

I _____(parent), understand that I am responsible for services rendered in the case of my insurance company not to remit payment. In addition, earnings of any safe check that I receive, if surrenders to me personally, this office for payment in my account are delivered.

Patient receiving services: _____

Parent/ guardian / guarantor: _____

Signature (Responsible Party): _____

DATE: _____

AUTHORIZATION FOR TREATMENT AND RELEASE OF INFORMATION

I _____ the parent of _____ with

Date of Birth(s)_____authorize the following persons below to bring my child to his/her dental appointments, and **Just Kids Dental** to provide them with any information necessary in keeping with the patient's home care instructions. **I authorize these persons to make treatment decisions and provide consent on my behalf**; **I recognize that there will be times when my presence and a signature will be required for certain procedures. I understand if my child is present with someone not listed below, my child will not be seen.**

AUTHORIZED PERSONS TO RECEIVE INFORMATION Check each person that you approve to receive information	**DESCRIPTION OF INFORMATION TO BE RELEASED** Check each that can be given to person on the left in the same section.
Other Parent (provide name):_____ **Phone number:** _____	Appointment information Family Billing information Co-pays due at appointment Treatment information
Other (provide name) _____ Relationship to patient _____ Phone number: _____	Appointment information Family Billing information Co-pays due at appointment Treatment information
Other (provide name) _____ Relationship to patient _____ Phone number: _____	Appointment information Family Billing information Co-pays due at appointment Treatment information
Other (provide name) _____ Relationship to patient _____ Phone number: _____	Appointment information Family Billing information Co-pays due at appointment Treatment information

Rights of the Patient

In Accordance with HIPPA regulations, I understand I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Just Kids Dental. I understand any changes in this form are not effective in cases where the information has already been disclosed, but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

_____ _____

SIGNATURE OF PARENT OR GUARDIAN DATE