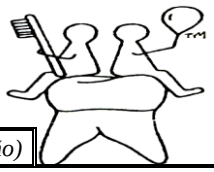
Welcome



Neighborhood Pediatric & Adult Dentistry
5460 Lilburn Stone Mountain Rd
770-923-2232

Tell us about your child *(Díganos acerca de su niño)*

Today's date *(La fecha de hoy)* _____
Child's name *(Nombre)* _____ Child likes to be called _____
Child's birth date *(Fecha del nacimiento)* _____ Age *(Edad)* _____ ☐Male *(Macho)* ☐Female *(Hembra)*
Address*(Dirección)*_____ City*(Ciudad)* _____ Zip Code*(Código postal)*_____
School *(Escuela)* _____ Grade*(Grado)*_____ Child's Home#*(Teléfono)* _____

Who is accompanying the Child Today? *(¿Quién acompaña el Hoy de Niño?)*

Name *(Nombre)* _____ Relation *(Relación)* _____
Do you have legal custody of the child? *(¿Tiene custodia legal del niño?)* ☐ Yes *(Sí)* ☐ No *(No)*
Other family members seen by us *(Otros miembros de la familia vistos por nosotros)* _____
Pediatrician's Name _____Ph# _____
(El médico/el Nombre de Pediatra y Número de teléfono)
Previous/Present Dentist _____ Ph#_____ Last visit Date _____
(Anterior/Presenta a Dentista) *(Teléfono)* *(Ultima Fecha de visita)*
Emergency Contact_____ Ph# _____ Relation _____
(Nombre de Contacto de emergencia) *(Teléfono)* *(Relación)*
Whom should we thank for referring you? _____ Ph# _____
(¿Quién debemos dar gracias nosotros para le referirse?) *(Teléfono)*

Parents' Information *(La Información de padres)*

Mother's Name_____ DOB _____ SSN# _____
(El nombre de madre) *(Fecha del nacimiento)* *(número del seguro social)*
Cell#_____ HM#_____ Work# _____
(Teléfono cellular) *(Teléfono en casa)* *(Trabaje teléfono)*
E-Mail *(Correo electrónico)*_____
Employer*(Empleador)*_____ Occupation*(Ocupación)* _____

Parents Marital Status *(Cría Estado civil):* ☐ Single *(Soltero)* ☐ Married *(Casado)* ☐ Divorced *(Divorciado)* ☐ Separated *(Separado)* ☐ Widowed *(Enviudado)*

Father's Name_____ DOB _____ SSN# _____
(El nombre de padre) *(Fecha del nacimiento)* *(Número del seguro social)*
Cell#_____ HM#_____ Work# _____
(Teléfono cellular) *(Teléfono en casa)* *(Trabaje teléfono)*
E-Mail *(Correo electrónico)*_____
Employer*(Empleador)*_____ Occupation*(Ocupación)* _____

Dental Insurance Information *(Información dental de Seguro)*

Insurance Company Name _____ ID# _____ Group# _____
(Compañía de seguros) *(Identificación)* *(Agrupe número)*
Insured's Name _____ Insured's SSN#_____DOB _____
(El Nombre de Insured) *(El número del seguro social de Insured)* *(Fecha del nacimiento)*
Insurance Co. Phone # _____ Insured's Employer _____
(Número de teléfono de Compañía de seguros) *(El Empleador de Insured)*
Do you have dual dental insurance? ☐ No ☐ Yes If Yes: Insurance Company _____
(¿Tiene seguro doble?) *(No)* *(Sí)* *(Compañía de seguros)*

***** ***It is important for you to understand that your Dental insurance coverage is an agreement between you and your insurance company and your doctor's bill for the services provided to you is an agreement between you and your doctor*** *****

We DO NOT bill for secondary insurance unless the patients' secondary coverage is Medicaid or any state funded insurance. It becomes the responsibility of the patient to submit to all other secondary insurance. Patients are responsible for all balances following primary insurance payment

Physician's Name _____ Phone# _____ Date of last visit: _____
Have you had any serious illness or conditions? ☐ No ☐ Yes: Explain: _____
Are you currently under physician care? ☐ No ☐ Yes: If Yes, Explain: _____
Have you had any blood transfusions? ☐ No ☐ Yes: If Yes, Dates: _____

Women: Are you pregnant? ☐Yes ☐No Nursing? ☐Yes ☐No Taking birth Control? ☐Yes ☐No

Medical History

☐Yes☐No Allergies	☐Yes☐No Epilepsy/Neurological	☐Yes☐No Mental Retardation
☐Yes☐No Anemia	☐Yes☐No Eye Problems	☐Yes☐No Orthopedic Problems
☐Yes☐No Asthma	☐Yes☐No Exposed to AIDS	☐Yes☐No Reflux or Gerd
☐Yes☐No Autism	☐Yes☐No Fainting	☐Yes☐No Rheumatic Fever
☐Yes☐No Blood Transfusions	☐Yes☐No Gastrointestinal Problems	☐Yes☐No Scoliosis
☐Yes☐No Brain Injury	☐Yes☐No Hearing Loss	☐Yes☐No Sexually Transmitted
☐Yes☐No Bronchitis or Pneumonia	☐Yes☐No HIV +	☐Yes☐No Sickle Cell Anemia
☐Yes☐No Cancer, Radiation Therapy	☐Yes☐No Heart Disease/Murmur	☐Yes☐No Sinus Problems
☐Yes☐No Cerebral Palsy	☐Yes☐No Hepatitis	☐Yes☐No Skin Problem
☐Yes☐No Cleft lip/Palate	☐Yes☐No Hypertension	☐Yes☐No Speech Problem
☐Yes☐No Convulsion/Seizures	☐Yes☐No Jaundice	☐Yes☐No Tuberculosis
☐Yes☐No Diabetes	☐Yes☐No Kidney/Bladder Problems	☐Yes☐No Use of Tobacco
☐Yes☐No Drug or Alcohol abuse	☐Yes☐No Leukemia	
☐Yes☐No Endocrine Disorders	☐Yes☐No Osteopenia/Osteoporosis	Other: _____

Allergies

☐Yes☐No Antibiotics	If so, which one? _____
☐Yes☐No Aspirin	☐Yes☐No Lidocaine
☐Yes☐No Codeine	☐Yes☐No Novocain
☐Yes☐No Latex	☐Yes☐No Other _____

Current Medications taking: _____
_____
Is there anything else we should know about you or your family? _____
_____

ACKNOWLEDGEMENT OF PATIENT INFORMATION/ AUTHORIZATION FOR INITIAL EVALUATION

The information I have given is correct to the best of my knowledge. I understand that all information is confidential, and it is my responsibility to inform this office of any changes in myself or my child's medical status. I authorize the dental staff to perform the necessary dental services to myself or my child for an initial evaluation. Any other dental services required will be explained and authorize by me after the initial visit.

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

***** ***As a courtesy, we verify your insurance benefit prior to the appointment. The response from insurance is NOT an authorization for, nor a guarantee of, eligibility, benefits, or payment. Actual benefits are determined only when the claim is received by the insurance*** *****

I certify that myself and/or I my child is covered by insurance and assign directly to *Dr. Kiran Kamdar/ Neighborhood Pediatric & Adult Dentistry* all insurance benefits, otherwise payable to me for services rendered. ***I understand that I am financially responsible for all charges not covered by dental insurance.*** I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Payment is expected at time of treatment. Patients with insurance may pay only their portion, including deductible. However, it is the patient's responsibility to see that the insurance company makes prompt payment. Any insurance balance over 30 days is due and payable by the parent, legal guardian or responsible party. In the event that my account becomes delinquent and/or is turned over to a third party for collection, I am responsible for any and all billing fees, finance charges, legal fees, and collection cost.

CONSENT FOR ELECTRONIC COMMUNICATIONS

When necessary, this practice emails dental x-rays, records, and/or dental photographs to your insurance company and dental specialists or laboratory technicians involved in your treatment. My signature below gives this practice permission to email my dental records when necessary without encrypted.

NO SHOW / MISSED APPOINTMENT / LATE ARRIVAL POLICY

It is the policy of this office for patients to reschedule or cancel appointments **48 hours** in advance or there will be a **$45.00 to $100.00** charge for late cancellation. Patients are expected to arrive on time for their appointments. Appointments are made to your convenience. Please understand your responsibility in regards to the policies listed.

HIPAA

I have review this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of Privacy Practices.

Parent's Name: _____ Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____