CHILDREN'S DENTISTRY OF CENTRAL ALABAMA

ABOUT THE PATIENT(S)

Patient 1's Name: _____ Nickname Pt 1: _____

If Applicable, Medicaid/ALL Kids #: _____ Date of Birth: _____ Male/Female

Patient 2's Name: _____ Nickname Pt 2: _____

If Applicable, Medicaid/ALL Kids #: _____ Date of Birth: _____ Male/Female

Patient 3's Name: _____ Nickname Pt 3: _____

If Applicable, Medicaid/ALL Kids #: _____ Date of Birth: _____ Male/Female

Patient 4's Name: _____ Nickname Pt 4: _____

If Applicable, Medicaid/ALL Kids #: _____ Date of Birth: _____ Male/Female

Parent or Guardian's Name: _____

Mailing Address: _____

Phone Number: _____ **Other Phone Number:** _____

RELEASE INFORMATION

I authorize Children's Dentistry to release information concerning the patient(s) to those listed below:

☐ Myself/My Voicemail Only ☐ Those Listed Below

1. Name: _____ Relationship to Patient: _____ Phone #: _____
2. Name: _____ Relationship to Patient: _____ Phone #: _____
3. Name: _____ Relationship to Patient: _____ Phone #: _____

DENTAL INSURANCE INFORMATION

Name of Insured: _____

Insured's DOB: _____

Insured's SS#: _____

Insured's Address: _____

_____

Insured's Employer: _____

Insurance Company: _____

ID #: _____

Group #: _____

GETTING TO KNOW YOU

How did you hear about us? ☐ Phonebook ☐ Internet ☐ Children's Dentistry Website

☐ Known in Community ☐ Doctor/Dentist/Family/Friend: _____

☐ Facebook ☐ Newspaper ☐ Radio ☐ Other: _____

OVER PLEASE

Children's Dentistry of Central Alabama
PATIENT CONSENT FORM AND
ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

1. I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my Protected Health Information (PHI) to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of Children's Dentistry of Central Alabama
- Obtaining information from or release of information to (but not limited to) Dental or Healthcare providers, Pharmacies, Medicaid/Insurance Agencies, Head Start/Educational Institutions

Initial_____

2. I have also been informed of, and given the right to review and secure a copy of Children's Dentistry of Central Alabama's Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my PHI, and my rights under HIPAA.

3. I authorize the doctors and staff of Children's Dentistry to take x-rays, study models, photos and other diagnostic aids deemed appropriate by the doctor(s) to make a thorough diagnosis of the patient's dental needs.

4. I agree to the use of anesthetics, nitrous oxide and any other behavioral management techniques that are deemed necessary by the doctor(s) to treat the patient with his/her best interest in mind.

5. **Our office is excited to welcome you! We have many children who want an appointment with our practice, and so we adhere to a strict cancellation policy. We ask that you give us at least 24 hours notice when cancelling. If you fail to do this, we reserve the right to charge a $25.00 fee for each appointment you are a "no-show" for. Thank you for understanding.**

Print Name:_____

Signature:_____

Relationship to Patient:_____

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 due to:

- ☐ Individual refused to sign
- ☐ Communication or physical barriers prohibited obtaining the acknowledgement
- ☐ Other (Please Specify)

_____

_____