KidZTown Dental
5041 Dallas Highway,Building 2,Suite C
Powder Springs, GA 30127
Office:770.485.3366 Fax:770. 627.4741
Email:KidZTowndentalatl@gmail.com

Patient Information

Date___/___/___How did hear about us? Internet, Ad, Friend/Patient Other _____

Patient_____
Last name First Name MI Preferred Name

Address_____

City _____State ____Zip_____ Home Phone (____)____-_____

Work Phone (____)____-_____ Cell (____)____-_____ SSN____-____-_____

Sex_____ Age_____ Patient Birthday___/___/___

Person Responsible for account _____

Email address _____

If you have insurance please complete this section: Policyholder_____
SSN___-___-____ Birthday___/___/__ Relationship to patient_____
Address if different_____Employer_____
Ins. Company_____ Group #_____
Phone: (___)___-_____ ID#_____

Please read and sign: Assignment/Release: I understand that I am financially responsible for all charges whether paid by insurance or not. I hereby authorize Dr. Ada Nwoku/KidzTown Dental to release all information necessary to secure payment for rendered services. I authorize the use of this signature on all submissions to my insurance, both electronic and manual. I assign all benefits otherwise payable to me for services rendered, if any, to Dr. Ada Nwoku/KidzTown Dental.
Date____/____/____ Signature_____
Print_____

Minor/Child Consent: I, the parent or guardian of the patient listed above, do hereby authorize the KidzTown Dental staff to provide necessary dental services to my child, including but not limited to x-rays and the administration of fluoride, local anesthetics or nitrous oxide as deemed advisable by Dr. Ada Nwoku.
Date____/____/____ Signature_____
Print_____

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Privacy Practices

We are required by the Health Insurance Portability Act of 1996 (HIPAA) to provide you with information on how we will use and disclose information concerning your health which we obtain in the course of your treatment. The privacy of your health information is very important to us, and we will only disclose such information if we ascertain it is beneficial to your health. Besides using your information to treat you, we would also like to utilize it to communicate with you e.g. confirm your appointments, send reminders and newsletters. We will not sell your information or use it for any marketing purposes. If you have any questions or concerns feel free to request further information on this or other policies.

Our commitment to your policy. KidzTown Dental is dedicated to maintaining the privacy of your identifiable health information (PHI). In conducting our business we must create records regarding you and the treatment services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you.

We may use and disclose your PHI in the following ways:

1) Treatment. The information collected will be used to determine which treatment option best addresses your health needs. The treatment selected will be documented in your medical records and made available should we require other healthcare professionals assist in your treatment. Most of the staff in our practice, including but not limited to the doctors and assistants, may use or disclose your PHI in order to treat you or assist others in your treatment. Additionally, we may disclose your PHI to others e.g. family members who may assist in your care.

2) Payment. Our practice may use or disclose your PHI to bill and collect payment for services rendered. For example, we may contact your healthcare insurer or dental plan to verify your eligibility and benefits. We may also provide your insurer with details regarding your treatment in order to collect payment for services received. We also may use and disclose your PHI to obtain payment from responsible third parties, such as a family member. Also, we may use your PHI to bill you directly for services rendered. We may disclose your PHI to other agencies e.g. collections, in an attempt to obtain payment for services rendered.

3) Appointments and Reminders. Our practice may utilize your PHI to contact you and remind you of an appointment or follow up on treatment. For example, we may send appointment reminders via mail, phone, or e-mail.

4) Non-medical communications. Our practice may utilize your PHI to contact you for non-medical reasons, For example, we may send you a thank you card, newsletter, or other communication via phone, e-mail or mail.

5) Treatment options. Our practice may use or disclose your PHI to inform you of treatment options or alternatives.

6) Open Areas. We will attempt to discuss issues concerning your health as privately as we can. We do, however, have open areas in our office where conversations regarding you care may be overheard by others. If requested we will locate a private area for a conversation with you.

7) Release of information to family and friends. We may release your PHI to an authorized friend or family member who is involved in your care or who assists in taking care of you. For example, parents or guardians may ask a grandparent to take their child to our office for treatment and they may have access to the child's medical information.

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Health History

Bear in mind that this practice sees children of all ages. While these questions may not apply to your child directly, they are necessary to ensure the safety of all of our patients.

a) Are you currently under the care of a physician? Yes No
   If yes, for what conditions? _____
b) Are you taking any prescription or over the counter medications? Yes No
   Please list_____
c) Drug allergies/reactions? Yes No _____
d) Do you smoke Yes No

Do you currently, or have you ever had any of the following apply? Please check all that apply

___ High BP	___ Low BP	___ Heart Attack	___ Take aspirin daily
___Circulatory Problems	___ Respiratory Problems	___ Psychiatric Care	___ Radiation Treatment
___Epilepsy/Seizures	___ Asthma	___ Kidney Disorders	__Bleeding Disorders
___ Stomach Ulcers	___ Stroke	___ Diabetes	___ Cancer
___Immune Disorder (HIV)	___Hepatitis/Liver Disease	___ Chemical Dependency	___ Back problems/Arthritis

Women: Are you pregnant?____ Are you nursing?_____ Taking birth control?_____

The following questions relate to the need for antibiotic prophylaxis to prevent a potentially serious infection:

Have you ever been advised to pre-medicate before dental appointments?_____

___ Congenital Heart Defect	___ Joint Replacement	___ Rheumatic Fever
___ Artificial Heart Valves	___ Artificial Joints	___ Bacterial Endocarditis

If you have had any of these conditions, but you know that you are not required to pre-medicate, we will require a letter from your physician verifying that you do not need to pre-medicate.

Please list anything else that we should know about your medical history._____

Do you have any of the following dental conditions: Please check all that apply

___ Periodontal/gum disease	___ Head, neck, or jaw injuries	___ Bad breath
___ Bleeding	___ Clenching/Grinding	___ Sensitivity to cold/sweets
___ Mouth sores/lumps	___ Jaw clicking/popping/pain	

I certify that the above information is accurate and complete to the best of my knowledge. I understand that any errors or omissions could harm my dental treatment and/or my overall health. I will not hold Dr. Ada Nwoku or her staff responsible for the result of any errors or omissions in the information I have provided. I have read and understand the Office Policies, Privacy Practices, and Financial Guidelines of this office and all of my questions have been answered. I understand that payment is due at the time of service unless other arrangements have been made in advance. I accept responsibility for all charges not paid by my insurance within 60 days of my visit. All my questions about the privacy of my health information have been answered to my satisfaction.

Date____/____/____ Signature_____

Print_____