Patient and Family Information

Child's Name _____ Preferred Name _____

Social Security # _____ Birthdate _____ Age _____ Male/Female

Home Address _____ City _____ State _____ Zip _____

What number would you like us to use to confirm child's appointment? _____

Responsible Party/Relationship to Child _____

How did you hear about our office? _____

Name of Mother/Guardian _____ Birthdate _____

Social Security # _____ Home# _____ Cell # _____

Home Address _____ City _____ State _____ Zip _____

Employer _____ Business# _____

Mom's Email: _____

Name of Father/Guardian _____ Birthdate _____

Social Security # _____ Home# _____ Cell # _____

Home Address _____ City _____ State _____ Zip _____

Employer _____ Business# _____

Dad's Email: _____

Child's Dental History

Former Dentist _____ Last Visit _____ Last X-Rays _____

How often does your child Brush/Floss? _____

Dental Concerns _____

Has your Child ever had anyHead/Neck/MouthTrauma _____

Please check all that apply to your child:

- ☐ Thumb/Finger /Pacifier sucking
- ☐ Lip or Cheek Biting
- ☐ Fingernail Biting
- ☐ Jaw Difficulty : Clicking and/or Pain
- ☐ Grinding Teeth
- ☐ Bottle/Sippy Cup

Child's Medical History

Please check all that apply to your child:

- ☐ ADHD
- ☐ Allergies
- ☐ Anemia
- ☐ Asthma
- ☐ Autism
- ☐ Cancer
- ☐ Developmentally Disabled
- ☐ Diabetes
- ☐ Epilepsy
- ☐ G.E. Reflux
- ☐ HIV/AIDS
- ☐ Heart Murmer
- ☐ Hepatitis – Type _____
- ☐ Other _____

Peditrician _____

Surgeries _____

Medications Currently Taking _____

Drug Allergies _____

Primary Dental Insurance

Person Responsible for Account_____

Relationship to Patient_____ Birthdate_____

Social Security #_____ Home Phone_____

Address_____

City_____ State_____ Zip_____

Employer_____ Business Phone_____

Business Address_____ Occupation_____

Insurance Company_____

Insurance Company Address_____

Subscriber I.D. #_____ Group #_____

Additional Insurance

Person Responsible for Account_____

Relationship to Patient_____ Birthdate_____

Social Security #_____ Home Phone_____

Address_____

City_____ State_____ Zip_____

Employer_____ Business Phone_____

Business Address_____ Occupation_____

Insurance Company_____

Insurance Company Address_____

Subscriber I.D. #_____ Group #_____

Assignment and Release

I hereby authorize payment directly to Dr. Cook
for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

* Signature of Responsible Party_____ * Date_____

PARENT BRINGING PATIENT TO OUR OFFICE IS RESPONSIBLE FOR PAYMENT OF ACCOUNT

PERMISSION:

Since _____ is a minor, it becomes necessary that signed permission be obtained from the parent or guardian before any and/ or all necessary dental service can be performed by Dr. Henry W. Cook. Authorization is hereby granted as such. Furthermore, I will be responsible financially for any bill incurred on this patient for dental treatment.

* Signed_____

* Date_____ Relationship_____

CONSENT FOR INTERNET COMMUNICATIONS

PATIENT NAME:_____ DATE:_____

EMAIL ADDRESS:_____

CELL PHONE #:_____

(We use Email and Text for appointment reminders)

****

I grant permission to Pediatric Dentistry of Brandon to upload and store confidential patient information – including account information, appointment information and clinical information – to the secured web site for Pediatric Dentistry of Brandon. I also understand State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand that Pediatric Dentistry of Brandon will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my patient information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that Pediatric Dentistry has the right to monitor, retrieve, store, upload, send emails and text, and use my patient information in connection with the operation of such services, and is acting on my behalf in uploading my patient information.

****

I have read the information above and regarding the secured uploading of patient information to the secure website/appointment notification company for Pediatric Dentistry of Brandon, and grant Pediatric Dentistry of Brandon permission to securely upload my patient information to the web site.

_____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN

****

PEDIATRIC DENTISTRY OF BRANDON

142 Gateway Drive
Brandon, MS 39042
Telephone 601-824-1950
Fax 601-824-1953

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Parent

SECTION A: ~~PATIENT~~ GIVING CONSENT

Parent Info

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient #: _____ Social Security #: _____

SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

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

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this 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 our 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: Any Office Personnel

Telephone: (601) 824-1950 Fax: (601) 824-1953

E-mail: _____

Address: 142 Gateway Drive, Brandon, MS 39042

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

I, _____, 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 protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.

PEDIATRIC DENTISTRY OF BRANDON

142 Gateway Drive
Brandon, MS 39042
Telephone 601-824-1950
Fax 601-824-1953

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
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 because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

MISSED APPOINTMENT OFFICE POLICY

EFFECTIVE: 01/01/2023

APPOINTMENT WITHOUT 24 HOUR NOTICE

Our new missed appointment policy without 24 hour notice of cancellation is as follows:

1st Occurrence – Parents will receive a letter of missed appointment without 24 hr notice given to our office.

2nd Occurrence – A $75 FEE will be billed to address on file for missed appointment without 24 hr. notice given to our office.

3rd Occurrence – WILL NOT BE RESCHEDULED IN OUR OFFICE.

We understand the value of your time and are confident that you will return the courtesy. You can expect us to be on schedule for you. We make every effort to notify our patients' parents of changes or delays in the daily schedule as timely as possible.

We appreciate that you have selected our dental team to provide your children with excellent dental health. We take pride in and are committed to providing your children with quality oral health care in a comfortable, gentle, and professional environment.

Parent signature:_____Date:_____

Parent printed name:_____

CHILD(children's) name:_____