Patient Information/ Información Del Paciente

First Name /Primer Nombre	M.I	Last Name/ Apellido	DOB/ Fecha de Nacimiento	Sex/ Sexo	Age/ Edad
Address/ Direccion		City/ Ciudad	State/ Estado	Zip Code/ Codigo Postal	
SSN/ Seguro Social		Cell Number/ Numero de Celular	Other Phone #/ Otro # de Tel.	Email Address/ Dirección de Email	
Pediatrician Name/ Nombre del Pediatra		Pediatrician's #/ Numero de Telefono del Pediatra	Pediatrician's Address/ Dirección del Pediatra		
Nearest Relative/ Pariente más cercano		Phone #/ Numero de Teléfono	Relationship to Patient/ Relación al Paciente		

Responsible Party (Mother/ Father) Personas Responsables (Madre/Padre)

Name/ Nombre	DOB/ Fecha de Nacimiento	SSN/ Seguro Social	Relationship to Patient/ Relacion al Paciente
Name/ Nombre	DOB/ Fecha de Nacimiento	SSN/ Seguro Social	Relationship to Patient/ Relacion al Paciente

Patient Medical History/ Historia Medica del Paciente

YES/NO

SI/NO

○ ○ ADHD/ ADD
○ ○ Asthma/ Asma
○ ○ Autism/ Autismo
○ ○ Heart Murmur: If yes, Do you require Premedication? Soplo Cardiaco, Si contesta si, Requiere antibióticos antes de su tratamiento dental?
○ ○ Heart Surgery/ Cirugía del Corazón
○ ○ Artificial joints or Implants/ Collonturas artificiales o Implante
○ ○ Excessive Bleeding/ Sangramiento Prolongado
○ ○ Thyroid/ Tiroides
○ ○ Diabetes/ Diabetes
○ ○ Bone Disorders/ Problema de huesos
○ ○ Hepatitis or Liver Problems/ Hepatitis o Enfermedad del hígado
○ ○ TB/ Tuberculosis
○ ○ AIDS/HIV VIH/ SIDA
○ ○ Speech Problems/ Problemas de Hablar
○ ○ Ulcers/ Ulceras
○ ○ High blood Pressure/ Alta presión
○ ○ Radioation or Chemo Therapy. Tratamiento de radioterapia o chimioterapia
○ ○ inusitis
○ ○ Herpes/ Herpes
○ ○ Migraine or headaches/ dolores de cabeza/ migrañas
○ ○ Kidney Problems/ Problemas de Riñones
○ ○ Depression/ Depression
○ ○ Down Syndrome/ Sindrome de Down
○ ○ Sickle Cell/ Célula Falciforme
○ ○ Epilepsy/ Seizures/ Epilesia o Convulsiones
- If yes, when was the last episode/ Cuando fue el ultimo episodio

_____

○ ○ Do you grind your teeth? Rechina los dientes?
○ ○ Do you suck your thumb, lip, or tongue? Se chupa el dedo o los labios?
- ○ Skin Conditions/ Condiciones de la piel

_____

○ ○ Fever within the last 24 hours/ Fiebre en las últimas 24 horas?
○ ○ Other Condition not Listed/ Alguna otra condicion no mencionada

_____

○ ○ Allergies to Latex/ Alegia con Latex
○ ○ Allegies to Medications/ Alergias a medicinas

_____

○ ○ Other Allegies/ Alguna otra alergia no mencionada?

_____

○ ○ Is the Patient taking any Medications? Esta tomando algun medicamento?

_____

Last Cleaning? Fecha de su última limpieza dental?

_____

Dental Concerns at this time/ Tiene preocupaciones dentales en este momento?
_____

_____

Medical Consent/ Consentimiento Medico

I give my consent to needed dental services, local anesthetics, nitrous oxide (laughing gas) and use of proper and acceptable methods to complete same and accept responsibility of the payment of services rendered to _____ (Patient's Name). I also certify that the above information is complete and accurate.

Doy mi consentimiento a servicios dentales necesarios, anestésicos locales, oxido nitroso, y el uso de métodos aceptables y apropiados para completar el tratamiento. De igual modo acepto la responsabilidad por el pago de tales servicios ofrecidos a _____ (nombre del paciente). También certifico que la información es completa y correcta.

Signature (firma) _____ Relationship to patient (relación al paciente) _____ Date(fecha) _____

FOR OFFICE USE ONLY

I have reviewed the patient's information form and did not find any discrepancies

Dentist Signature _____ Date_____

SIX MONTH RECALL UPDATE

PLEASE REVIEW THE ABOVE INFORMATION AND IF THERE ARE NO CHANGES IN THE MEDICAL HISTORY, PLEASE SIGN BELOW
(Revise la información anterior, si no hay ningún cambio en el historial medico por favor firme abajo)

Signature_____ **Relationship to patient** _____ **Date**_____ **Dentist Initial**_ _____ **Hygienist Initial** _____
Firma Relación al Paciente Fecha

Signature_____ **Relationship to patient** _____ **Date**_____ **Dentist Initial**_ _____ **Hygienist Initial** _____

Firma Relación al Paciente Fecha
Signature_____ **Relationship to patient** _____ **Date**_____ **Dentist Initial**_ _____ **Hygienist Initial** _____
Firma Relación al Paciente Fecha

Vital Smiles GA 1030 A WEST GORDON AVE, ALBANY GA, 31701 PHONE: 229-432-9555 FAX: 229-432-0907

Vital Smiles GA 6000 SINGLETON RD. NORCROSS, GA, 30093 PHONE: 770-248-9059 FAX: 770-248-9130

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I UNDERSTAND THAT UNDER THE Health Insurance Portability & Accountability Act of 1996 (HIPPA). I have certain rights to privacy regarding my protected health Information.

PATIENT RIGHTS

Access: you have the right to look at or get copies of your health information, with limited exceptions. Contact us using the information listed at the end of this Notice for full explanation of time and fees involved.

Disclosure Accounting: you have the right to receive a list of instances in which we or our business associated disclosed your health information purposes, other than treatment, payment, healthcare operations and certain other activities for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost- based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we will abide by our agreement (except in an emergency).

Amendment: You have the right to request that we amend your health information (your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our website of by electronic mail (email), you are entitled to receive this Notice in written form.

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

Patient Name: _____ Relationship to Patient_____

Signature_____ Date: _____

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the US Department of Health and Human Services. We will provide you with the address to file your complaint with the US Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in anyway if you choose to file a complaint.

Contact Officer: Shianna Scruggs Office: 229-432-9555 Fax:229-432-0907
Albany Office: 1030 A West Gordon Ave, Albany, Ga 31701

Contact Officer: Hetal Patel Office: 770-248-9059 Fax: 770-248-9130
Norcross Office: 6000 Singleton Rd. Norcross, GA 30093

Authorization for additional disclosure: I am the "personal representative: of (generally parent or legal guardian) and have legal authority to make health care decisions about the following minor patient:

Patient Name: _____

As the "personal representative" of (the above named patient.) I authorize the following individuals to accompany my child and have access to health information and make decisions regarding treatment.

Name: _____ Relationship: _____

_____ _____

_____ _____

_____ _____

Personal Representative (Parent/ Legal Guardian) Date

FOR OFFICE USE ONLY

I have reviewed the patient information form and did not find any discrepancies.

Front Desk initials _____Date_____Hygienist Initials_____Date_____Dentist Initials_____Date_____

We are happy to have the pleasure of meeting your child's dental needs at Vital Smiles Georgia PC. Please read carefully and sign the following agreement of terms in order to be accepted into our office.

- I understand that I must have a current VITAL SMILES GA PC form present each visit in order for my child to be seen.
- I understand that if I do not give a 24-hour notice to cancel or change an appointment, I may not be able to reschedule an appointment with Vital Smiles Georgia PC.
- If I cannot be reached due to disconnected telephone or change of address, I am responsible for notifying Vital Smiles Georgia PC within 24 hours to confirm my appointment; otherwise another child will be given my appointment time.
- I understand that I am responsible for notifying Vital Smiles Georgia PC of any changes in my address or telephone number.
- I understand that a parent or guardian must accompany my child.
- I understand that my presence in the office is required while my child is being treated at Vital Smiles Georgia PC and that I shall stay in the building at ALL TIMES
- I understand that I am responsible for notifying Vital Smiles Georgia PC of any other insurance coverage for my child.
- I understand that I am responsible for any charges not covered by my insurance due to frequency, any non-approved procedures or lack of coverage.
    - Examples:
        - A panoramic (full mouth) x-ray will not be covered if one was taken at another dental office in the previous three years.
        - Emergency exams during office hours are only covered twice per year. The parent of guardian will be responsible for payment of any other emergency exam for the remainder of the year.

Payment is expected in full prior treatment at each visit for any procedure not covered by my insurance; these items will be explained to you before they are done for your child.

By signing, I agree and fully understand the terms stated in this contract. If at any time I do not abide by these terms, my child will not be rescheduled at Vital Smiles Georgia PC

Parent or Guardian: _____ Date: _____

It is our intent that all professional care delivered in our dental operations shall be of the best possible quality that we can provide for each child, providing a high quality of care can sometimes be made very difficult, or even impossible, because of the lack of cooperation of some patients. Among the behavior that can interfere with the proper provision of quality dental care are: hyperactivity, resistive movements, refusing to open mouth, keep open long enough to perform the necessary dental treatment, and even aggressive and/or physical resistance to treatment, such as kicking, screaming, and grabbing at the dentist/hygienist's hand, or at the sharp instruments. All efforts will be made to obtain the cooperation of child dental patients by the use of warmth, friendliness, persuasion, humor, charm, gentleness, kindness, and understanding.

Methods used:

1. **Tell/show/do**: The dentist or Assistant explains to the child what is to be done by using simple terminology and repetition and then show the child what is to be done by demonstrating with instruments on a model or the child's dentist's finger. Then the procedure is performed in the child's mouth as described. Praise is used to reinforce cooperative behavior.
2. **Positive Reinforcement**: This technique rewards the child who displays any behavior, which is desirable. Rewards include compliments, praise, pat on the back, a hug, and a prize.
3. **Voice Control**: changing the tone or increasing the volume of the dentist's voice gains the attention of a disruptive child, content of the conversation is less important that the abrupt or sudden nature of the command.
4. **Mouth props**: a rubber or plastic device is placed in the child's mouth to prevent closing when a child refuses or has a difficulty maintaining an open mouth.
5. **Hand over mouth exercise**: the disruptive, screaming child is told that a hand will be placed over the mouth. When the hand is in place, the dentist speaks directly into the child's ear and tells the child that if the noise stops the hand will be removed and the child is praised for cooperation. lf the noise resumes, the hand is again placed over the child's mouth and the exercise is repeated.
6. **Physical restraint by the dentist**: the dentist restrains the child from movement by holding down the child's hand or upper body, stabilizing the child's head between the dentist's arm and body, or positioning the child firmly in the dental chair.
7. **Physical restraint by the assistant**: the assistant restrains the child from movement by holding the child's hand, stabilizing the head, and or controlling leg movements.
8. **Papoose boards and Pedo-wraps**: these are restraining devices for limiting the disruptive child's movement to prevent injury and to enable the dentist to provide the necessary treatment. The child is wrapped in the device and placed in a reclined dental chair.
9. **Nitrous oxide**: Nitrous oxide is a safe and effective sedative agent that is mixed with oxygen and inhaled through a small mask that fits over your nose to help you relax. Nitrous oxide, sometimes called "laughing gas." It is offered to help make your child more comfortable during dental procedures.
10. **Photo digital camera**: usage of camera may be used for extra diagnostic and evaluation purposes and procedures. Sometimes x-ray findings are unable to show us preventative treatment.

*PLEASE BE ADVISED ONLY ONE PARENT MAY ACCOMPANY THE CHILD/CHILDREN.

Note: if you do not agree with the above methods listed, please let us know so that we may talk to you about them, but realize that it may not be possible to complete any dental work for your child in a safe environment.

I have read the above information and understand the Pediatric Dentistry Patient Management Techniques and give my consent for their uses.

Signature: _____ Date: _____

SEALANTS PERMISSION FORM

IT IS OUR GOAL TO PROVIDE EXCELLENT SERVICE BY MEETING YOUR CHILD'S DENTAL NEEDS INCLUDING PROVIDING PREVENTATIVE SERVICES.

SEALANTS ARE A PREVENTATIVE SERVICE WE PROVIDE!

WHAT IS A DENTAL SEALANT? A **WHITE/TOOTH COLORED** PROTECTIVE BARRIER PLACED IN THE PITS AND GROOVES ON CHILDREN'S TEETH THAT "SEALS" OUT FOOD AND BACTERIA THAT CAN CAUSE CAVITIES.

YOUR CHILD MAY BE ELGIBLE FOR SEALANTS AFTER THEIR CLEANING ON HIS/HER 1ST AND/OR 2ND PERMANENT MOLARS IF NO DECAY (CAVITY) OR DENTAL RESTORATION (FILLING) IS PRESENT!

PLEASE SELECT ONE OF THE FOLLOWING:

- YES, I GIVE PERMISSION FOR MY CHILD TO HAVE SEALANTS PLACED IF HE/SHE IS ELGIBLE.
- NO, I DO NOT WANT SEALANTS PLACED ON MY CHILD'S TEETH.

PARENT/GUARDIAN SIGNATURE: _____

DATE: _____