Parent's Information

Today's Date: ______________________________

Person responsible for account: ______________________

Name: ____________________________________
DOB: ______________________

☐ Mother ☐ Father ☐ Step-Mother/Father ☐ Guardian

Race: __________ Language: ______________________

Address:____

____
City State Zip

SSN: _______________ DL #: _______________

Home # ( ) ____________ Cell # ( ) ____________

Email: ______________________________________

Employer: ______________________________________

Emergency Contact:__________________________

Phone: ____

If you have Private Dental Insurance for your Child, please fill out below:

Subscriber's Name: ______________________________

Subscriber ID: __________________________________

SSN: _______________ DOB: _______________

Employer: _______________________________________

Insurance Co. Name: _____________________________

Insurance Co. Phone Number: ( ) __________________

Child/Children's Information

Name: ______________________________________

____
____ / ____ / ____ Male or Female

octors your child sees: ______________________

____

Name: ______________________________________

____
____ / ____ / ____ Male or Female

octors your child sees: ______________________

____

Name: ______________________________________

____
____ / ____ / ____ Male or Female

doctors your child sees: ______________________

____

Name: ______________________________________

____
____ / ____ / ____ Male or Female

doctors your child sees: ______________________

____

******* Our office requires you to confirm your scheduled appointment or we reserve the right to replace it without notice****

GENERAL TREATMENT CONSENT

I give consent for myself/ my child (or children) to receive dental treatment deemed necessary by the providers Alabama Health/ DBA Just Kids Dental. These procedures include, but are not limited to; examinations, oral prophylaxis (cleanings), fluoride treatments, sealants, restorations (amalgam or composite fillings and crowns), periodontal (gum) treatments, endodontic (root canal) treatments, extractions and the use of local anesthetics. I understand that the use of local anesthetics carries a small risk for swelling, bruising, allergic reaction, changes in pain perception, or prolonged anesthesia. I agree that the above information along with the information on the Medical History form(s) to follow is all true and accurate. This consent shall be considered in effect until rescinded or revoked.

Authorized Signature of Parent or Guardian: ____

Child's Name: *Date of Birth:*

Has the child experienced any of the following medical problems?

Y N Abnormal Bleeding/Hemophilia
Y N ADD/ADHD
Y N AIDS/HIV+
Y N High Blood Pressure

Y N Hives
Y N Kidney Problems
Y N Liver Problems
Y N Low Blood Pressure
Y N Mitral Valve Prolapse
Y N Mononucleosis
Y N Prosthetics
Y N Rheumatic Fever
Y N Scarlet Fever
Y N Skin Rash
Y N Tuberculosis
Y N G6PD
Y N Heart Condition ____________________

Y N Heart Murmur
Y N Hepatitis
Y N Allergies
Y N Anemia

Y N Any Hospital Stays/Operations
Y N Artifical Bones/Joints/Valves
Y N Asthma
Y N Cancer
Y N Chicken Pox
Y N Congenital Heart Defect
Y N Convulsions
Y N Diabetes
Y N Epilepsy
Y N Exposed to HIV, but Neg.
Y N Handicaps/Disabilities
Y N Hearing Impairment

Please list any surgeries your child has had: ____

Please list any Allergies your child has:____

Has your child been hospitalized within the last year? Y N If yes, please explain: ________________________

Are the child's immunizations current? ☐ Yes ☐ No

Please describe the child's current physical health: ☐ Good ☐ Fair ☐ Poor

Please list any medication that the child is currently taking: ________________________________

Please list all medications that the child is allergic to: ________________________________

Y N Allergic to Latex
Y N Allergic to Metals
Y N Allergic to Nickel
Y N Allergic to Plastic

Is there anything you would like to discuss with the doctor in private? ☐ Yes ☐ No

For female patients: Are you pregnant? ☐ No ☐ Yes (Expected due date: _____________)

Please discuss any serious medical problems the child has or had in the past:

____

____

Does/did the child experience any of the following?

Y N Breast Fed
Y N Chewing on Objects
Y N Clenching/Grinding Teeth
Y N Lip Sucking/Biting
Y N Mouth Breather
Y N Nail Biting

Y N Nursing Bottle
Y N Speech Problems
Y N Thumb/finger Sucking
Y N Tongue/Cheek Sucking
Y N Tongue Thrust
Y N Used Pacifier

ACKNOWLEDGMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES
&
CONSENT FOR USE AND DISCLOSURE OF
HEALTH INFORMATION

Name: ____

Children's Name(s): ____

Address__________________________________ Telephone__________________

TO THE PARENT OR GUARDIAN GIVING CONSENT, PLEASE READ FOLLOWING STATEMENTS CAREFULLY.

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

Notice of Privacy Practices: You have received and have had the opportunity to read our Notice of Privacy Practices before you decide whether to sign the 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 out 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: Compliance Officer, Integrated Healthcare Alliance, LLC.
Address: 2100 1st Avenue North, Suite 300 Birmingham, AL 35203
Phone: 1-866-311-1830

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 below Acknowledges Receipt of Notice of Privacy Practices and Consent for the Use and disclosure of Your Health Information:

I (Please Print Name) ________________________ 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 child's protected health information to carry out

treatment, payment activities and health care operations and other uses described in the Notice of Privacy Practices that was provided to me

Signature: ____ Date ______________

Film and Photograph Release

I ___________________________, give Alabama Health Just Kids Dental permission to record and or photograph my child/ren for use in internal or external marketing purposes (i.e No Cavity Club, website, Facebook, and TV).

Child's/ Children's Name (s) _____________________________

Parent/Guardians Name _________________________________

Date: _____________________

AUTHORIZATION FOR TREATMENT AND RELEASE OF INFORMATION

I ________________________________ the parent of ________________________________ with Date of Birth ____________ authorize the following persons below to bring my child to his/her dental appointments, and Just Kids Dental to provide them with any information necessary in keeping with the patient's home care instructions. I authorize these persons to make treatment decisions and provide consent on my behalf; I recognize that there will be times when my presence and a signature will be required for certain procedures. I understand if my child is present with someone not listed below, my child will not be seen.

AUTHORIZED PERSONS TO RECEIVE INFORMATION Check each person that you approve to receive information	DESCRIPTION OF INFORMATION TO BE RELEASED Check each that can be given to person on the left in the same section.
Other Parent (provide name) ______________________	Appointment information Family Billing information Co-pays due at appointment Treatment information
Other (provide name) ______________________ Relationship to patient ______________________ Phone number: ______________________	Appointment information Family Billing information Co-pays due at appointment Treatment information
Other (provide name) ______________________ Relationship to patient ______________________ Phone number: ______________________	Appointment information Family Billing information Co-pays due at appointment Treatment information
Other (provide name) ______________________ Relationship to patient ______________________ Phone number: ______________________	Appointment information Family Billing information Co-pays due at appointment Treatment information

Rights of the Patient

In Accordance with HIPPA regulations, I understand I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Just Kids Dental. I understand any changes in this form are not effective in cases where the information has already been disclosed, but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

________________________________ ________________________

SIGNATURE OF PARENT OR GUARDIAN DATE

Form Revised: 04/28/2016

NITROUS OXIDE INFORMED CONSENT FORM

PATIENT'S NAME: _________________________________ Date of Birth: _____________________

Nitrous oxide is commonly called laughing gas, or "relaxing air," and provides relaxation through inhalation. Nitrous oxide is administered through a mask and makes your child more comfortable to receive the necessary dental care with less pain and/or anxiety.

The alternatives to nitrous oxide are:

- **No nitrous oxide:** The necessary procedure is performed under local anesthetic only.
- **Oral Conscious Sedation:** Sedation via oral form that will put a child in a minimally depressed level of consciousness (Awake but with a lowered level of awareness).
- **General Anesthetic:** A patient under general anesthetic has no awareness and must have his/her breathing temporarily supported and is performed in a hospital setting only (Child is 'asleep').

Complications/risks may include, but are not exclusive of: a tingling sensation or a feeling of heaviness, followed by a lighter floating feeling; warm feeling throughout the body, with flush cheeks; laughter or giddiness; detachment from the environment may occur; light weight or floating sensation, sluggishness and slurring and/or repetition of words; feeling of nausea; vomiting or agitation. All these complications are temporary.

I have had the opportunity to discuss nitrous oxide use in conjunction with my child's dental care, and have had an opportunity to ask questions and am fully satisfied with the answers I received.

I have informed the dentist of my child's complete medical history including any recent surgeries, mood altering medications, or changes in my child's medical history involving lung, respiratory, ear infection, or common cold. I also accept and understand that I must notify the dentist of my child's present mental and physical condition.

Signature of Parent/Guardian___________________________________

Date___________________________

Consent to the insurance bill

We welcome the opportunity to serve you and your family. Please note that required only the co-payment or coinsurance based on the procedures is completed the day of service. Your copay or safe must be submitted the day of service and courtesy you are billed to your insurance company for the rest of the finished work. **Please note: you are still responsible for the services provided in the case of your insurance company can do the payment required on your behalf.**

I ____________________________, understand that I am responsible for services rendered in the case of my insurance company not to remit payment. In addition, earnings of any safe check that I receive, if surrenders to me personally, this office for payment in my account are delivered.

Patient receiving services: ______________________________________

Parent/ guardian / guarantor: ______________________________________

Signature (Responsible Party): ______________________________________

Date: ______________________________________

Form Revised: 04/28/2016