Welcome. The benefits of a happy healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out these forms completely. The better we communicate, the better we can care for you.

PATIENT INFORMATION

Child's Name
First_____Last_____Middle_____
Date of Birth_____ Gender: Male_____ Female_____

PARENT / GUARDIAN INFORMATION

Parent / Guardian Name_____
Date of Birth_____ Social Security Number_____
Address_____ Apt#_____
City_____ State_____ Zip_____
Email Address_____
Home Phone (_____)_____ Cell Phone (_____)_____
Employer_____ Employer's Phone_____
In the event of an emergency who should we contact?_____
Relationship_____ Emergency Contact Phone_____

CHILD'S MEDICAL HISTORY

Does your child have a physician? Yes ☐ No ☐
Physician's Name_____ Physician's Phone_____
May we have permission to contact your child's physician if necessary? Yes ☐ No ☐
Is your child up to date on immunizations? Yes ☐ No ☐
Does your child snore? Yes ☐ No ☐ Does your child have exposure to tobacco smoke?
Does your child wet the bed? Yes ☐ No ☐
Has your child ever been hospitalized, had surgery, or been treated in the emergency department? If yes, please explain
_____
Please list all medications (prescriptions or OTC) vitamins and/or supplements child is currently taking
_____

Are you allergic to or have you had an adverse reaction to any of the following:

Amoxicillin ☐ Aspirin☐ Codeine☐ Dental Anesthetics ☐	Epinephrine☐ Erythromycin☐ Latex☐	Metals☐ Penicillin☐ Sulfa Drugs☐ Tetracycline ☐

Other **allergies**, please list_____

Does your child have any of the following diseases or medical problems? **PLEASE CHECK**

__Heart Murmur	__Asthma/Wheezing Breathing Problems	__Anemia	__High Blood Pressure
__Low Blood Pressure	__ Drug /Alcohol Abuse	__Hemophilia	
__Cancer/Chemotherapy	__Tuberculosis TB / MRSA	__Diabetes	
__Cystic Fibrosis	__Complications during or after birth	__HIV+ / AIDS	
__Gerd/Intestinal Problems	__ Bladder/Kidney Infections	__Rash/Hives/Eczema	
__Developmental Disorders	__Autism Spectrum	__Frequent Headaches	
__ Sinus/Tonsil Infections	__Jaundice/Hepatitis	__Sickle Cell Disease/Anemia	

I, the undersigned, do hereby authorize Morrison Dental Associates, PC to exam and treat the patient as deemed necessary by the dentist. If the undersigned is not the patient, he/ she assumes all responsibility for the accurateness of the medical and dental information furnished on this form. I further affirm that the medical and dental information is correct, and the patient does not have any communicable disease which would be infectious to those providing services for him/her or others coming in contact with the patient in the office. This authorization is good for two years.

X Parent /Guardian Signature _____ **Date**_____

If the information on the first page does not belong to the person signing the form above, please fill out the following.

Print name of signer _____Relationship to patient_____
Address of signer _____ City _____State_____
Phone Number _____
Employer_____ Employer's Phone Number_____

PATIENT/ PROVIDER AGREEMENT

This is to advise you that Morrison Dental Associates, P.C. is privately owned and operated. As providers of care and owners of this corporation, we reserve the right to discontinue services to patients who:

- Are unwilling to follow medical recommendations or treatment plans.
- Are unwilling to schedule recommended follow-up visits or tests as prescribed by our providers or repeatedly miss scheduled appointments.
- Use vulgar, demanding, or abusive speech towards our staff, providers, or other visitors to our facility.
- Demonstrate abuse of medication, equipment, or supplies.
- Damage our property or grounds.
- Display threatening behavior (by phone or in person) of any kind toward staff, providers, or other visitors to our practice.
- Enter the clinical areas unescorted or otherwise violates patients' privacy act as outlined under HIPPA.
- Are disrespectful of the needs of other patients visiting our practice.

In Addition to the above, should any visitor accompanying a patient display any of the above behaviors, we reserve the right to discontinue service to the patient.
We feel the above actions are necessary to ensure a friendly, safe, and secure environment as well to ensure respectful and efficient business operations.

Minor Patients: A parent or legal guardian must accompany all minors before treatment can be provided.

Your initial indicates your understanding of this policy. **X** _____

DENTAL INSURANCE INFORMATION

If you wish to file dental insurance or Medicaid please tell the receptionist so we can obtain the information necessary to file for you.

The undersigned understands that insurance or Medicaid coverage does not relieve him/her of the responsibility of payment of the entire account if third party payment is not received. Estimates given by our staff are not a guarantee of the insurance or Medicaid payments as these third parties will not guarantee payments until a claim is received. Estimates are based on information we have at the time regarding your coverage.

We will bill participating insurance companies as a courtesy to you. Therefore, we will request a copy of your insurance card at each visit. Please understand that insurance is a contract between you and your carrier. Therefore, you are ultimately responsible for your bill. You are responsible for knowing the coverage, limitations, waiting periods, and exclusions specific to your insurance policy.

The undersigned is responsible for the payment of services rendered in addition to the head of household. If the patient is a minor BOTH parents are responsible. If the undersigned is not the patient it is understood that the patient is also responsible for payment of services provided for him/her.

In event of nonpayment resulting in default of the account should Morrison Dental Associates, PC refer this account to an attorney, I agree to pay and indemnify Morrison Dental Associates, PC against legal cost and charges including, but not limited to, reasonable attorney's fees, court cost and disbursements. I further grant permission to release information contained on this information sheet to any attorney in order to collect the amount due. Interest shall accrue on the account at the rate of 1.5% per month, 18% annum, on the unpaid balance. Payment in-full is due at the time of service. Any account not paid at the time of service is due in-full within thirty (30) days of services. If account is not paid at the time of service, Morrison Dental Associates, PC is authorized to obtain a report from a credit reporting agency regarding my credit history.

***** Member Equifax Credit Reporting Services*****

As required by law, you, hereby notified that a negative credit report reflecting on your credit records may be submitted to a credit reporting agency if you fail to fulfill the terms of your credit obligations.

If insured through Georgia Health Partnership (All Medicaid Plans)

Georgia Health Partnership requires all insurance claims to be filed through private insurance before they will accept the claim.

- I understand that failing to provide private insurance information will result in Medicaid/Medicare denying services and therefore I will be responsible for all charges.

  Does patient have private insurance? YES □ NO □

  (If yes, please provide receptionist with the insurance information)
- I will be responsible for any charges that Medicaid /Medicare does not pay for due to patient being ineligible or insurance denying services.

X_____

Parent /Guardian Signature **Date**

Child's Name_____ Date of Birth_____

Insurance Company_____

Insurance Company Address_____
Insurance Company Phone Number_____
Member ID #_____Group #_____Policy # _____
Relationship to insured: ***Self*** ***Spouse*** ***Child*** ***Dependent***
Insured's Name_____ Date of Birth_____
Insured's Social Security #_____/_____/_____
Employer_____ Employer's Phone_____

Patient's co-pays and or payments are required at the time services are rendered. Please be aware that any payment is always an estimate and will not be determined until a claim has been received.

We will bill participating insurance companies as a courtesy to you. Therefore, we will request a copy of your insurance card at each visit. Please understand that insurance is a contract between you and your carrier. Therefore, you are ultimately responsible for your bill. You are responsible for knowing the coverage, limitations, waiting periods, and exclusions specific to your insurance policy.

If charges have been filed and we have not received a payment from your insurance company within 90 days of the date billed, the balance will become the patient's responsibility. After insurance payment has been received, your billing statement will reflect the actual payment due.

I authorize the release of any information relating to dental procedures provided for the patient to the insurance company or any of their authorized representatives. I hereby, authorize payment directly to Morrison Dental Associates P.C. of the group benefits otherwise payable to me. If my current policy prohibits direct payment to the doctor, I hereby instruct and direct the insurance company to make the check payable to me and mail it as follows: C/O Morrison Dental Associates, P.C., P.O. Box 13083 Savannah, GA 31416

X

Parent /Guardian Signature **Date**

CANCELLATION/BROKEN APPOINTMENT POLICY

Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. If you need to cancel or reschedule your appointment, we ask that you kindly give us a 24 hours' notice. Cancellations made with less than 24 hours' notice will be considered a broken appointment.

If a patient misses 2 appointment – or cancels with less than 24 hours of that appointment, the patient will not receive another appointment. That patient is still welcome at Morrison Dental however the patient must call the office the morning he or she would like to be seen, and the patient will receive a "same day appointment" based on availability.

Your initial indicates your understanding of this policy.

Initial **X** _____

MORRISON DENTAL ASSOCIATES

Acknowledge of Notice of Privacy Practices

The Department of Health and Human Services has established a "Privacy Rule" to help ensure the personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patient's consent for uses and disclosures of health information about the patient, to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal dental records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support our full access to your personal dental records as provided by the Georgia Code. We may have indirect treatment relationships with you (such as laboratories that only interact with doctors and not patients) and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you, should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in the document, at some future time, you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken, which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent, in writing, after you have reviewed our privacy notice.

My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practices*.

Patient's Name_____Date_____

Print Name of Person Signing_____

X Parent / Guardian Signature_____

Witness Signature_____

HIPAA Release Form

I, _____, authorize the release of information of
(PRINT PATIENT / GUARDIAN NAME)

_____, including the diagnosis, records,
(PATIENT NAME)
examination and treatment rendered to above patient, ledger and billing, and claims information.

This information may be released to (check those that apply):

( ) Spouse _____

( ) Child(ren)_____

( ) Other_____

( ) Information is not to be released to anyone. (Initial Here) _____

In further consideration for this, Morrison Dental Associates, PC. Agrees to the same stipulations. This release of information will remain in effect until terminated by me in writing.

Messages and communication from our office:

If we are unable to speak directly to you concerning matters pertaining to your care, please check one of the following preferences:

( ) You may leave a detailed message
( ) Please leave a message asking me to return your call
( ) Other _____

The best phone number to reach me at:_____

X Parent/Guardian Signature:_____ Date: _____/_____/_____

Witness:_____ Date: _____/_____/_____