Issaqueena Pediatric Dentistry

Camille W. Horton, DMD R. Dolan Frye, DMD Michelle McInnis, DMD
314 Union Station Drive • Seneca, SC 29678 • Telephone: (864) 482-7900 • Fax: (864) 482-7510
620 Issaqueena Trail • Central, SC 29630 • Telephone: (864) 722-9013 • Fax: (864) 722-9014

Patient Information

Today's Date: _____ ❑Male ❑Female

Child's Name: _____ Nickname: _____

Date of Birth: _____ Age: _____ Weight: _____ Ethnicity: _____ SS#_____

Home Phone _____ Home Address _____
Street City State ZIP

Name and ages of other children in family _____

Has/Have your child/children been under our care before? ❑Yes ❑No

School Attending_____ Grade _____

Who may we thank for referring you to us? _____

Parent: _____(relationship)_____ Date of Birth: _____

Address: (if different than patient's) _____ SS#: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail address: _____ Permission to contact by email? Yes_____ No_____

Employer's Name: _____ Occupation: _____

Employer's Address: _____

Parent: _____ _____(relationship)_____ Date of Birth: _____

Address: (if different than patient's) _____ SS#: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail address: _____

Employer's Name: _____ Occupation: _____

Employer's Address: _____

In case of emergency, notify (other than parents): _____ Phone _____ Relationship _____

If parents are not living together, who has legal custody? _____ Relationship _____

* Have you provided our office with legal documentation (ex., Safety Plan, court documents, etc.?) ❑Yes ❑No

Insurance Information

Insurance Company Name: _____

Parent/Insured's Name: _____ Employer: _____

Group #: _____ Policy/ID#: _____

Medicaid: ❑Yes ❑No Medicaid # _____

Person responsible for payment of account _____

Patient Name: _____ Date of Birth: _____

Health History

Name of child's physician / group _____Phone # _____

❑Yes ❑No Is your child in good health? Date of last physical exam _____

❑Yes ❑No Has your child ever been hospitalized? Reasons/dates:_____

❑Yes ❑No Is your child current on his/her immunizations?

❑Yes ❑No Does your child have any **allergies?** Please explain_____

❑Yes ❑No Is your child currently taking any medications? Please give medication, dose, and reason:_____

❑Yes ❑No Were there any complications at birth? _____

❑Yes ❑No Is your child adopted?

Please check if your child has been treated for any of the following:

❑ Adverse Drug Reactions	❑ Congenital birth defects	❑ Liver / GI disease
❑ ADD / ADHD	❑ Diabetes	❑ Mental delays
❑ AIDS/HIV	❑ Downs Syndrome	❑ Personality / social
❑ Anemia	❑ Endocrine / growth	❑ Physical delays
❑ Asthma (last attack _____)	❑ Eyesight	❑ Recurrent headaches
❑ Autism / sensory disorder	❑ Frequent infections	❑ Rheumatic fever
❑ Bleeding / transfusions	❑ Hepatitis	❑ Seizures
❑ Cleft lip / palate	❑ Kidney disease	❑ Cancer / tumors
❑ Speech / hearing	❑ Cerebral palsy	❑ Other _____

❑ Heart problems (please explain) _____

Dental History

What is the reason for your child's dental visit? _____

Please check if your child is having problems with any of the following:

❑ Cavities	❑ Orthodontics	❑ Gum Infections	❑ Sensitive Teeth
❑ Trauma	❑ Toothache	❑ Jaw / TMJ	❑ Color of Teeth

Has your child ever been to the dentist? ❑Yes ❑No
Name of dentist and date _____ Date of last x-rays _____
Has your child experienced any unfavorable reaction from previous dental care? ❑Yes ❑No
Please explain _____
Is the child's mother or father afraid of dental care? ❑Yes ❑No
Does your child suck a finger, thumb, or pacifier? ❑Yes ❑No If yes, how often_____
Was/is your child bottle fed? ❑Yes ❑No Until what age? _____ mos.
Was/is your child breast fed? ❑Yes ❑No Until what age? _____mos.

❑Yes ❑No ❑ Don't Know Is your home water supply fluoridated?

❑Yes ❑No ❑ Don't Know Does your child use toothpaste with fluoride? What kind? _____

Patient Name: _____ Date of Birth: _____

Consent

I certify the truth of all information given. I also authorize the release of pertinent information to those persons requiring it for treatment of my child or for the purpose of payment of the account or credit references.

Furthermore, since your child is a minor, it becomes necessary that a signed permission is obtained from a parent or legal guardian before any and/or all dental services can be started and accomplished by Dr. Camille Horton and/or Dr. R. Dolan Frye and/or Dr. Michelle McInnis. Such authorization is hereby granted to administer any treatment, anesthetics, and perform such operations or otherwise manage my child as may be deemed necessary or advisable. I understand I will be consulted before any treatment is rendered. I do, however, give specific consent to do an examination, take appropriate x-rays, clean the teeth, give a fluoride treatment, and provide oral hygiene instructions if deemed necessary. I also authorize the use of photographs, radiographs, other diagnostic materials, and treatment records for the purpose of teaching, research, and scientific publications. I also give permission to provide emergency care, if needed.

I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment for children in terms appropriate for their age. Dr. Camille Horton and/or Dr. R. Dolan Frye and/or Dr. Michelle McInnis will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation, and demonstration of procedures and instruments, and using variable voice tone. I will be responsible for any charges incurred on this child for dental treatment.

Appointment and Financial Policy

The scheduled appointment is reserved specifically for your child. Any change in this appointment reflects many patients. If a cancellation is unavoidable, please call the office at least 24 hours in advance so that we may give that time to another patient.

- Most restorative (fillings, extractions, etc.) procedures are scheduled in the morning. Children, as well as adults, are prepared and do better in the morning for these types of procedures.
- We strive to see all patients on time for their scheduled appointment. There are times when our schedule is delayed in order to accommodate an injured child or an emergency. Please accept our apology in advance should this occur during your appointment. We will do the exact same if your child is in need of emergency treatment.
- Please plan to arrive 10 minutes or more before your scheduled appointment. This will allow time for parking and to complete any additional paperwork and see your child on time.
- If you arrive 10-15 minutes late for your appointment, you may be asked to reschedule for the next available appointment time.
- Again, please call at least 24 hours in advance if a cancellation is unavoidable so that we may give it to another patient.
- Broken or missed appointments affect many people. If two (2) broken/missed appointments occur or two (2) cancellations without 24-hour notice, our office reserves the right to NOT schedule any subsequent appointments and/or apply a $40.00 broken appointment fee.
- A parent or legal guardian (with official documentation, not a notarized letter) must be present during all appointments that the child patient is in the office.
- Please be aware that the parent bringing the child to Issaqueena Pediatric Dentistry is legally responsible for payment of all charges. We cannot send statements to other persons.
- There is no direct relationship between our office and your insurance company. The type of plan chosen by you, and/or your employer determines your insurance benefits. Because insurance policies vary greatly, we can only estimate your coverage in good faith, but cannot guarantee coverage due to the complexities of insurance contracts. Your estimated patient portion must be paid at the time of service. As a service to our patients, we will bill insurance companies for services to render payment.
- Emergency Treatment – all emergency treatment must be paid in full at the time the service is rendered.

If at any time you have questions, please feel free to ask our courteous staff or call our office. We are here to help in any way we can. We appreciate you entrusting your child's dental health to us. Thank you!

Signature _____ Date _____

Patient Name: _____ Date of Birth: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

NOTICE OF PRIVACY PRACTICE SUMMARY

This summary discloses how Healthcare information about you may be used by Dr. Camille W. Horton and/or Dr. R. Dolan Frye and/or Dr. Michelle McInnis. A full notice of your privacy rights has been provided to you.

Treatment, Payment, Operations. We may use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

Uses and Disclosures for Appointment Reminders. We may use and disclose your Healthcare information to contact you as a reminder that you have an appointment at the office. If you request that such communications be made confidentially, please contact our office in writing. We will accommodate all reasonable requests.

Authorization for Use and Disclosure. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

Public health, research, health and safety, government, works compensation. We may disclose your information for public health activities, research, health and safety, governmental function, and in order to comply with workers compensation laws and regulations.

Rights. You have a right to inspect and copy information used to make decisions about your care, to request an amendment of the information, to an accounting of disclosures, to request communication with you by alternate means, to request restrictions on the information we use, and to revoke your authorization for release of information.

Complaints. You may complain to the Department of Health and Human resources if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Organization duties. We must maintain the privacy of protected health information, provide you with notice of our legal duties and privacy practice with respect to your health information, abide by the terms of the notice, notify you if we are unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations, and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

"I acknowledge that I have received the full Privacy Notice."

_____ _____ _____
Name (print) Signature Date