



742 North Dean Road  
Auburn, AL 36830  
Phone: (334) 321-0780

**THE FOLLOWING INFORMATION IS NECESSARY FOR US TO UNDERSTAND AND ADEQUATELY TREAT YOUR CHILD. THANK YOU FOR COMPLETING IT IN FULL.**

**Patient Information:**

Name \_\_\_\_\_ Preferred Name \_\_\_\_\_ Age \_\_\_\_\_  
Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_ Child's Social Security # \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
E-mail \_\_\_\_\_  
Preference of confirmation E-mail \_\_\_\_\_ Text \_\_\_\_\_ Phone Call \_\_\_\_\_  
Person and phone # to contact in case of emergency (not living in same household) \_\_\_\_\_  
With whom does the patient live \_\_\_\_\_  
Other children in your family that we have seen \_\_\_\_\_  
Child's interests and hobbies \_\_\_\_\_  
School child attends \_\_\_\_\_

**Parent/Guardian Information:**

Parent's Marital Status:  Married  Widowed  Divorced  Separated  Single

Father:	Mother:
Name _____	Name _____
Date of Birth _____ SS# _____	Date of Birth _____ SS# _____
Drivers License # _____	Drivers License # _____
Employer _____	Employer _____
Address _____	Address _____
Occupation _____	Occupation _____
Business # _____ Ext. _____	Business # _____ Ext. _____
Dental Ins. _____	Dental Ins. _____
Group # _____	Group # _____

Responsible Party \_\_\_\_\_  
Billing Address if different from residence \_\_\_\_\_  
How did you hear about us? Please circle one  
Newspaper Phone Book Internet  
Referring Doctor \_\_\_\_\_ Friend \_\_\_\_\_  
We Visited your child's school or day care Other \_\_\_\_\_

**Please fill out completely**

**Medical History:**

Name of Child's Pediatrician \_\_\_\_\_

\_\_\_\_ Yes \_\_\_\_ No Does your child have regular medical examinations?

\_\_\_\_ Yes \_\_\_\_ No Is your child up to date on immunizations?

\_\_\_\_ Yes \_\_\_\_ No Does your child have any significant medical problems or a medical diagnosis?

If yes, please list and explain.

\_\_\_\_ Yes \_\_\_\_ No Is your child taking any medications? If so, please list.

\_\_\_\_ Yes \_\_\_\_ No Has your child ever been hospitalized or seen in the emergency room? If so, please explain.

\_\_\_\_ Yes \_\_\_\_ No Is your child allergic to any **food, medication or latex**? If so, please list.

Please place a check if your child has ever had problems with any of the following.

- |                      |                              |                   |                          |
|----------------------|------------------------------|-------------------|--------------------------|
| ____ Heart           | ____ Liver                   | ____ Muscles      | ____ Speech              |
| ____ Heart Murmur    | ____ Hepatitis               | ____ Asthma       | ____ Mental/Neurological |
| ____ Rheumatic Fever | ____ Kidney                  | ____ Lungs        | ____ Autism              |
| ____ Bleeding        | ____ Bones                   | ____ Tuberculosis | ____ Digestive Problems  |
| ____ ADHD            | ____ Seasonal Allergy        | ____ Seizures     | ____ Diabetes            |
| ____ Acid Reflux     | ____ Developmentally Delayed | ____ HIV Positive | ____ Other               |

**Dental History:**

\_\_\_\_ Yes \_\_\_\_ No Is this your child's first dental visit? If not, date of last visit \_\_\_\_\_

\_\_\_\_ Yes \_\_\_\_ No Do you expect your child to be a cooperative dental patient?

\_\_\_\_ Yes \_\_\_\_ No Has your child had an unfavorable visit at another office?

\_\_\_\_ Yes \_\_\_\_ No Have you ever given your child tablets or drops containing fluoride?

\_\_\_\_ Yes \_\_\_\_ No Does your child suck fingers or thumb or have a similar habit such as a pacifier?

\_\_\_\_ Yes \_\_\_\_ No Has your child ever experienced trauma to the teeth, face or jaws?

Is there any information that we should be aware of before providing dental care to your child?

Reason for today's appointment:

\_\_\_\_ Check up and cleaning      \_\_\_\_ Exam only      \_\_\_\_ Evaluate Crowding

\_\_\_\_ Toothache      \_\_\_\_ Second opinion

**Permission:**

**Since \_\_\_\_\_ is a minor, it becomes necessary that signed permission be obtained from the parent or guardian before any and/or all dental services can be performed by East Alabama Pediatric Dentistry, P.C. Authorization is hereby granted to East Alabama Pediatric Dentistry, P.C. and shall remain in force and effect until cancelled by either party.**

**Signed \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_\_\_**

## FINANCIAL POLICY

- 1) Insurance Patients: We understand the value of dental insurance benefits. We will gladly process your claim for you and will also estimate the portion that is not covered by insurance. This copayment is due at the time services are rendered. Our estimates are based on information that you have furnished us regarding the benefits of your company plan.
- 2) Non-insurance Patients: Payment is due at the time services are rendered unless other arrangements have been made with our financial coordinator.
- 3) Payment Options: cash, Money Orders, Personal Checks, Visa, Mastercard and Discover

### **I HAVE READ AND UNDERSTAND THE CONTENTS OF THIS FORM AGREEMENT TO PAY**

The undersigned accepts the fee charged as a lawful debt and promises to pay said fee including the cost of collection, attorney fees, and court costs if such be necessary, waiving now and forever the right to claim exemption under the constitution and laws of the State of Alabama, or any other state.

Parent's Signature \_\_\_\_\_

Child's Name \_\_\_\_\_

Reviewed By \_\_\_\_\_ Date \_\_\_\_\_

## GENERAL INFORMATION AND CONSENT

We are pleased to receive your child as a patient in our office and feel honored by the confidence you have placed with us. We sincerely desire to make his or her visits as pleasant as possible. We feel that we can better establish a patient-doctor relationship if our parents and patients are familiar with the service and procedures of this office.

**PARENT POLICY:** We respectfully ask that parents remain in the reception room during treatment times. It has been our experience that children are much more cooperative and have a more positive outcome when parents are not in the room. There are exceptions to this policy, such as very young children (age 2 and under), and children with special needs. Parents will generally be called to the back after treatment and are welcome to tour the office. We appreciate your trust and confidence regarding this policy.

**INITIAL VISIT:** Each child receives a thorough examination on their first appointment. It usually includes a prophylaxis (cleaning of the teeth), topical fluoride, and dental x-rays, if they are needed. Oral hygiene instructions will be given to the patient and reviewed with the parent along with dietary recommendations. We employ all procedures available to reduce radiation risk including thyroid and gonadal lead apron, collimated x-ray machine and the fastest film available today. We feel that it is extremely important for a child to have a full mouth x-ray (panorex) starting around the age of 5 or 6 to check for any problems such as extra permanent teeth, congenitally missing teeth, cysts or eruption problems.

**COMPOSITE (WHITE) FILLINGS:** Our office only places white, composite resin fillings. We do not use the amalgam (silver) filling material at all. You should be aware that insurance companies may cover these fillings differently. Please feel free to speak with our office staff if you have questions about your particular coverage.

**PREMEDICATION:** It is often necessary for certain dental procedures to premedicate patients with heart problems or joint replacements using antibiotics. Please make us aware if your child has ever had any of these conditions.

**NITROUS OXIDE (LAUGHING GAS):** Frequently, we will employ the "Happy Air Nose" (nitrous oxide) to help reduce anxiety and fear of dental procedures. It is tremendously effective when treating children and is very safe.

**HOSPITAL DENTISTRY:** Some young or handicapped children requiring extensive treatment would benefit by having their work done under general anesthesia in the hospital setting. If we feel this is a necessary way to treat your child, we will thoroughly discuss hospital dentistry with you.

**ORAL CONSCIOUS SEDATION:** Children with considerable anxiety about undergoing dental treatment may benefit from use of an oral sedative. If we feel that this might be helpful in your child's case, we will thoroughly discuss it with you and set up a time for such a procedure.

**ORTHODONTICS:** At each six month hygiene appointment your child will be checked for proper eruption of teeth an/or any malocclusion that may be developing. We will inform you of any treatment that we feel is necessary for your child.

**CHILDREN'S TIME:** Although we schedule appointment times for the treatment of your child, our office operated on "children's time." This means that occasionally some of our patients who are not particularly interested in getting their dental work done may take extra time to be made more comfortable and less apprehensive. This will invariably play havoc with our schedule and cause some delays. So let me personally apologize for running behind now! We are guilty of letting our patients manipulate the schedule somewhat when we are trying to give them the best possible dental experience. We also see many emergencies since children may have accidents at home, school or play.

**PLEASE LET US KNOW IF YOU OBJECT TO THE USE OF FLUORIDE AND/OR X-RAYS.** We intend to render dental services to your child as we would our own. If at any time you have questions concerning your child's dental health, please feel free to ask us.

East Alabama Pediatric Dentistry

Dr. Keri L. Miller

- Consent for Treatment
- Assignment of Benefits/Financial Responsibility
- Release of Information
- Notice of Privacy Practice Acknowledgement

I consent for medical treatment by East Alabama Pediatric Dentistry & Orthodontics to apply for insurance benefits on my behalf for covered Services rendered and I authorize the release of medical information for insurance claims, and release of past medical payment history, if needed. I understand that I am responsible for co-pays, deductibles and co-insurance at the time services are rendered. I also, understand I am responsible for any non-covered services. Patients also are responsible for any collection and legal fees in the events of default.

I authorize the release of any medical information necessary to process my insurance claim. I also, certify that the information I have reported with regard to my insurance coverage is correct.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is federal program that requires that all medical records and health information used by us in any form are kept confidential. This Act, gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for misuse of personal health information. If you wish to review a copy of the **(HIPAA) Privacy Practice** we will be glad to provide you with a copy.

**You have the following rights with respect to your Health information.**

1. This right to, access, inspect and copy your health information.
2. The right to request an amendment to your health information.
3. The right to receive an accounting of certain disclosures of your health information
4. The right to receive confidential communications.
5. The right to request restrictions on disclosures concerning your health information. \_\_\_\_ (Initial Here)

\*\*\*\*\*I hereby consent that medical information and treatment can be discussed with the following person or persons. If you want this information only discussed with you leave the following blank. An example would be Spouse, parents etc.

\_\_\_\_\_

\_\_\_\_\_

\*\*\*\*\*I hereby consent that appointment reminders can be left on answering machine or with a family member.

(Initial) \_\_\_\_\_ (HM #) \_\_\_\_\_ (Cell #) \_\_\_\_\_

E-mail address \_\_\_\_\_

Signature of Guardian (must be 18) \_\_\_\_\_ Date \_\_\_\_\_

Please list patient that this applies to:

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

## Informed Consent

According to the Alabama Medicaid Provider Manual, it is necessary for us to have the consent of the child's parent or legal guardian prior to rendering dental services. Therefore, your signature below declares East Alabama Pediatric Dentistry and staff have discussed the diagnosis, treatment, treatment alternatives, risks, and prognosis of \_\_\_\_\_'s dental therapy.

\_\_\_\_\_  
Signature of parent or legal guardian

\_\_\_\_\_  
Date signed

# East Alabama Pediatric Dentistry

## Medicaid Patient Policies

*\*Please initial in the boxes after you have read each of the following:*

### Scheduling

New patients and those returning for their 6 months check up and cleaning appointment are scheduled on Tuesdays from 8:00-11:00 and 1:00-2:30 and on Thursday from 8:00-11:00.

Patients that need treatment will be scheduled Monday –Thursday, 8:00-11:00 and Tuesday and Wednesday, 1:00-4:30. If you need to cancel or change your appointment we ask that you give us a 24 hour notice so that we can offer this time to someone else.

### Broken Appointments

We try to remind patients by telephone prior to the appointment, **but please do not depend on this courtesy.** If we are unable to reach you, your appointment card will serve as confirmation of your appointment and implies your obligation to keep your appointment. That appointment time has been reserved especially for your child. **We reserve the right to charge \$25.00 for broken appointments.** Exceptions to this policy can be determined only on an individual basis according to circumstances. Occasionally, children’s illnesses or other unexpected emergencies make it necessary to cancel an appointment with less than 24 hours notice. Please contact our office immediately and we will do our best to accommodate your situation.

After **2** broken or missed appointments, you will be dismissed from our office and we will no longer be able to treat your child.

### Late Arrivals

Because we schedule appointments every 30 minutes it is very important that you arrive at your appointment time. If you arrive more than 10 minutes late for your child’s appointment, you may be asked to reschedule for the next available appointment time.

### T-Shirts

Our office’s T-shirts, with the alligator logo, are for sale for \$10.00.

**I have read and understand East Alabama Pediatric Dentistry’s Medicaid Patient Policies.**

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Patients Full Name

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Signature of Legal Guardian

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Date Signed

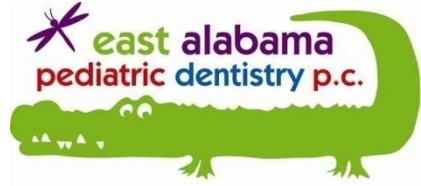
Dr. Keri L. Miller, DMD

742 North Dean Road

Auburn, AL

(334)321-0780

# Photography Release/Consent Form



Here at EAPD, we make every effort possible to make our patients feel special. We like to put our patients on “display” by clipping newspaper articles involving our patients; as well as, pictures from any drawings or prize winnings and posting them in the office. Also, on our website, we will have a monthly listing for all children that are members of our No Cavities Club. Please check one of the following boxes and sign below.

**I AGREE and hereby grant full permission** to East Alabama Pediatric Dentistry and Dr. Keri Miller to use either myself or my child /children’s name(s) and photograph in any publication or advertising materials (printed or electronic). This consent also serves to waive all rights of privacy or compensation which I may have in connection with the use of my photograph and/or my child’s photograph and/or name.

**I DO NOT AGREE** to have mine or my child’s information used.

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Child’s Full Name

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Legal Guardian’s Name (Print) Relationship to Child

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Signature Date

# East Alabama Pediatric Dentistry

## APPOINTMENT POLICIES

Welcome to East Alabama Pediatric Dentistry! We are glad you have made an appointment for your child for important oral health care. Regular dental visits every 6 months, including examinations, cleanings, fluoride treatments, dental sealants, and fillings are important to keep teeth healthy. It is especially important that you keep your appointment! Valuable time has been reserved for your child's care. A missed appointment results in lost time which could be used for another patient waiting to receive treatment. Every effort is made to keep on schedule so we respectfully ask patients to be prompt and keep their appointments. Our standard office policy regarding appointments is as follows:

### BROKEN/MISSED APPOINTMENTS

We try to remind patients by telephone prior to the appointment, but **please do not depend on this courtesy**. If we are unable to reach you, your appointment card will serve as confirmation of your appointment and implies your obligation to be present. That appointment date and time has been reserved especially for you. **We reserve the right to charge \$25.00 for office visits canceled or broken without 24 hours advance notice**. Exceptions to this policy can be determined only on an individual basis according to the circumstances.

Occasionally, children's illnesses or other unexpected emergencies make it necessary to cancel an appointment with less than 24 hours of notice. Please contact our office immediately and we will do our best to accommodate your situation.

### LATE ARRIVALS

If you arrive more than 10 minutes late for your child's appointment, you may be asked to reschedule for the next available appointment time.

### APPOINTMENT DELAYS

We strive to see all patients on time for their scheduled appointment. We make every effort to stay on schedule. Occasionally, 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 child's appointment. We will provide the same courtesy if your child is in need of emergency treatment.

I have read and understand East Alabama Pediatric Dentistry's appointment policy.

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Parent or Guardian signature

Child's name

Date