Brent E Herrin DMD
3020 Roswell Road, Suite 110, Marietta, GA 30062

Herrin Pediatric Dentistry
Phone: (678)813-3202

Demographic Information

Patient_____ Today's Date_____
Name child would like to be called_____ Home Phone_____
Birthday_____ Age_____ Sex_____ Cellphone_____
Guardian's Email_____
Home Address_____
Street APT # city state zip code
Guardian 1:_____ Relation to patient_____
Employer_____ Phone_____
Guardian 2:_____ Relation to patient_____
Employer_____ Phone_____
Who has legal custody of patient? _____ Dental Insurance: _ Yes _ No
Person responsible for payment of account_____ SS#_____DOB_____
Name of child's physician/group_____ City/St_____ Ph. #_____

Provider Preference

_ I prefer to see Dr. Herrin only
_ I prefer to see Dr. Kim only
_ I will see either doctor and do not have a preference

Health History

_ Yes _ No Is your child in good health? Date of last physical exam_____
_ Yes _ No Has your child ever had a health problem? _____
_ Yes _ No Has your child ever been hospitalized? Please give reason and dates_____
_ Yes _ No Is your child allergic to anything? _____
_ Yes _ No Is your child currently taking any medications? Please give medication, dose and reason_____
_ Yes _ No Were there any problems at birth? _____

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

Heart disease	Bleeding/transfusions	Asthma/Breathing Problems	Blood Disorder
Liver/GI disease	Anemia	Diabetes	HIV/AIDS
Kidney disease	Rheumatic fever	Hepatitis	Mental delays
Speech/hearing	Seizures	Cleft lip/palate	Physical delays
Eyesight	Congenital birth defects	Personality/social	Other problem
Cancer/tumors	Recurrent headaches	Frequent infections	Adverse Drug reactions
Cerebral palsy	Significant injuries	Endocrine/growth	Autism
ADD/ADHD	Neuromuscular Disorder	Genetic Disorder	Sickle Cell Disease/Trait

Please elaborate on any items circled: _____
_____
_____

Dental History

_ Yes _ No Has your child ever been to the dentist?
Date of last x-rays (if taken) _____
Name of dentist and date_____
_ Yes _ No Has your child experienced any unfavorable reaction from previous dental care? Explain
_ Yes _ No Does your child suck a finger, thumb or pacifier?
_ Yes _ No Does your child have pain with chewing, yawning, or wide opening?
_ Yes _ No Does your child's jaw make noise and is pain associated with the sounds?
Please check if your child is having problems with any of the following:

_ Cavities	_ Toothache	_ Teeth Sensitive
_ Trauma	_ Gum Infections	_ Color of teeth
_ Orthodontics	_ Jaw Sounds	_ Other

Comments:_____
_____

Consent for Dental Treatment

I request and authorize Dr. Herrin to examine, clean, and provide dental treatment on my child's teeth. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Herrin to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or child's teeth for diagnostic or educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr. Herrin 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 hereby authorize any payment of dental benefits to be made directly to Herrin Pediatric Dentistry. I also understand that any amount not covered by my insurance policy is my responsibility and is due at the time of treatment. I authorize treatment to be rendered and assume financial responsibility.

_____I acknowledge the notice of privacy policies and understand that I may receive a copy upon request.
_____I understand I may refuse to sign this acknowledgement.
(Initial)

Signature_____ **Date**_____

Parental Permission to Consent

Please provide the names of any persons whom you consent to bring your child to dental appointments. Keep in mind that this person will be able to consent for treatment and will be financially responsible for any payments at that day of service.

_____
_____
_____

Signature: _____ **Date** _____

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although this revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

Signature: _____ Date _____

Financial Responsibility

Herrin Pediatric Dentistry is happy to file your primary dental insurance for your visit. Unfortunately, we cannot be liable for changes to your plan benefit coverage (which can happen unknowingly) and for inaccurate quotes by your insurance representative; therefore, you will be responsible for whatever the patient portion is on your Explanation of Benefits.

I understand that the treatment plan is our best estimate of insurance coverage. However, after insurance processing, I understand and agree that I am responsible for the remaining balance and will be billed accordingly.

I acknowledge that all non-current balances and accounts over 60 days will be charged a service charge of 1.5 % per month (18% per year) on the unpaid balance. The cost incurred in collecting this account including court costs, agency fees and attorney fees will be added to the balance due.

Under most insurance plans, Nitrous Oxide is not a covered benefit. In the event you elect to use Nitrous Oxide and it is not a covered benefit, we will collect the $80.00 at the time of service and will not bill your insurance.

I also understand that the provider reserves the right to charge office fees for non-covered services per Georgia law House Bill 189.

Parent signature: _____ Date: _____

Cancellation Policy

Herrin Pediatric Dentistry (HPD) requires more than 24 business hour notice to cancel or reschedule any appointments. Failure to provide timely notice will result in a broken appointment. After two broken appointments in a family's chart, HPD will only schedule a same day or next day appointment. HPD reserves the right to dismiss patients at any time. By signing below, I acknowledge that I have read and understood this policy.

Parent signature: _____ Date: _____