S. Kimberly Jones, DDS, PA
1204 N. Center Street
Hickory, NC 28601
(828) 327-9029

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 _______ Race ________ Date of Birth __________ Home Phone ____________ Cell Phone ___________

Address ____

Child's Social Security Number ____

Number to confirm future appointments (Please indicate if business or residence) ______________________

Child lives with: Both parents mother father other

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 Name: ______________________________ Mother Name: ______________________________

Date of Birth: __________ SS # ________________ Date of Birth: __________ SS # ________________

Employer______________________________ Employer ______________________________

Occupation______________________________ Occupation ______________________________

Business # ______________________________ Business # ______________________________

Responsible Party ____

Billing Address (if different from residence) ____

Whom may we thank for referring you to our office?_____________________________________

Medical History

Child's weight ______________________

Question		
Is your child in good health?	Yes	No
Does your child have regular medical exams?	Yes	No
Is your child up to date with immunizations?	Yes	No
Is your child taking any medications? If so, please list ______________	Yes	No
Has your child been hospitalized since birth? Date________ Reason ____________	Yes	No
Has your child had any unfavorable reactions to any medicines? If so, please list:__________	Yes	No
Is your child presently undergoing medical treatment? Reason: ______________	Yes	No
Does your child have any infectious diseases? If yes, list ______________	Yes	No

Child's Physician: ______________

Dental History

Question		
Is this your child's first dental visit? If not, date of last visit ____________	Yes	No
Has your child had an unfavorable experience at another dental office?	Yes	No
Is your child presently on a fluoride supplement?	Yes	No
Is your child a finger sucker?	Yes	No
Does your child use a pacifier?	Yes	No
Has your child ever experienced trauma to the face or jaw?	Yes	No
Was your child bottle-fed? Age discontinued ______________	Yes	No

What is your water source?
Private Well _______ Public System ________
County where water source is located __________

Question		
Does your child brush his/her teeth daily?	Yes	No
Do you assist child with tooth brushing?	Yes	No
Is dental floss used?	Yes	No

Comments

____

____

____

Check any of the following that may pertain to your child:

________ Food Allergies
________ Seasonal Allergies
________ Anemia
________ Asthma
________ Autism
________ Bleeding Disorder/Hemophilia
________ Brain injury
________ Bronchitis
________ Cancer/Chemotherapy
________ Cerebral Palsy
________ Chronic cough
________ Chronic fatigue
________ Congenital heart defect
________ Convulsions/Epilepsy
________ Diabetes
________ Drug/Alcohol Abuse
________ Emotional Disorder
________ Fainting
________ Handicap/Disabilities
________ Hearing Disorder
________ Heart Disorder
________ Heart Murmur
________ Hepatitis
________ HIV/Aids
________ Hyperactive
________ Kidney Disorder
________ Latex Allergy
________ Leukemia
________ Liver Disorder
________ Lung Problems
________ Mental Disorder
________ Nervous Disorder
________ Night Sweats
________ Pregnant
________ Recurrent headaches
________ Recurrent mouth sores
________ Retardation
________ Rheumatic fever
________ Sickle cell anemia
________ Speech problems
________ Spina bifida
________ Transfusions
________ Tumors/Growths
________ Vision Disorder

Reason for Today's Appointment
Check up and cleaning _________ Exam _________ Evaluate Crowding _________ Toothache _________ Other _________

Thank you for your help. If there is any information that you think may be of value to us in treating your child, please feel free to comment.

I agree to needed dental services and use of proper and acceptable methods to complete such procedures on the patient named above. I accept responsibility for payment of services performed.

Signed: ______________________________ Relationship______________ Date:__________

Medical History

S. Kimberly Jones, DDS

Acknowledgement of Receipt of Notice Of Privacy Practices

Patient Name & Address: ______________________________

____

____

I have received a copy of the Notice of Privacy Practices for the above named practice.

______________________________ Signature

______________________________ Date

______________________________ Relationship

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ☐ An emergency existed and a signature was not possible at the time.
- ☐ The individual refused to sign.
- ☐ A copy was mailed with a request for a signature by return mail.
- ☐ Unable to communicate with the patient for the following reason:

____

- ☐ Other: ______________________________

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Prepared by ______________________________

Signature ______________________________

Date ______________________________

Compound Authorization for Release of Information

Name of Patient: ______________________________ Date of Birth: ____________

Dr. S. Kimberly Jones is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information. Check each person/entity that you approve to receive information.	Description of information to be released. Check each that can be given to person/entity on the left in the same section.
❑ Voice Mail ❑ Postcards through mail	❑ Appointment date and time ❑ Other ____________
❑ Give information to parent employer ❑ Give information to school	❑ Appointment absentee information
❑ Parent (provide name) ____________ ____________________	❑ Family billing information ❑ Financial ❑ Dental as follows: ____________
❑ Other (provide name) ____________ ____________________	❑ Financial ❑ Dental as follows ____________

Rights of the Patient

I understand that I have the right to revoke this authorization at any time and that 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 Dr. S. Kimberly Jones. I understand that a revocation is 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 redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

______________________________ Date ______________

Signature of Patient or Personal Representative

Description of Personal Representative's Authority

____

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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 in us. We sincerely desire to make his or her visits as pleasant as possible. We feel that we can better establish patient-doctor relationships if our patients are familiar with the service and procedures of this office.

Initial Visit: Each child receives a thorough examination on their first appointment which includes a prophylaxis (cleaning of the teeth), topical fluoride, and dental x-rays, if they are needed. Tooth-gum brushing instructions will be given to the patient and reviewed with the parent along with dietary recommendations. Your child may receive treatment in an open bay. We employ all procedures available to reduce radiation risk including 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.

Parents May Accompany Their Child: Generally, we feel, as most parents do, that children cooperate better if parents are not present during actual treatment. We explain everything to the child so that they can understand what we are going to do, consequently reducing their fears and anxieties about dental treatment. Sometimes we cannot accomplish this with the parents present because they will not listen properly. However, if you have a strong desire to come back to the operatory with your child, simply let one of our dental assistants know. We have an open door policy in our practice.

Nitrous Oxide (Laughing Gas): Frequently we will employ the "elephant nose" (nitrous oxide) to help reduce anxiety and fear of dental procedures. It is tremendously effective when treating children and is very safe.

Premedication: It is sometimes necessary to premedicate young children with sedatives in order to successfully perform certain dental procedures. If we recommend premedication, the medications and anticipated side effects will be carefully explained before the procedure. Children who have been premedicated will have their vital signs monitored throughout the procedure.

Hospitalization: Some very young children requiring extensive treatment would benefit by having their work done under general anesthesia in the hospital. If we feel that this is a necessary way to treat your child, we will thoroughly discuss with you.

Preventive Dentistry: Preventive dentistry is extremely important. To achieve the goal of optimum oral health, it is recommended that preventive care begin in infancy. Our staff along with the American Academy of Pediatric Dentistry recommends the first dental visit no later

than 12 months of age. We recommend fluoride to help strengthen the teeth as they develop. We also highly recommend sealants for permanent molars as soon as they erupt.

Orthodontics: We offer limited orthodontic treatment in our office. At each six month hygiene appointment your child will be checked for proper eruption of teeth and/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 time for the treatment of your child, our office operates 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 emergencies since children may have accidents at home, school or play.

Appointment Policy: As growing pediatric dental practice, our schedule is sometimes booked several months in advance. Because of these factors, our appointment policy states that if you miss TWO consecutive appointments without notice we will have to refer you to another dentist in the area. While we understand that some appointments can't be kept, we would like the courtesy of a phone call notifying us so that we may give that appointment to another child.

PLEASE LET US KNOW IF YOU OBJECT TO THE USE OF FLUORIDE, NITROUS OXIDE, AND/OR X-RAYS.

We intend to render dental services to your child as we would our own. If at any time you have a question concerning your child's dental health, please feel free to ask us.

FINANCIAL POLICY

We respectfully request payment at the time of each visit. Payment may be made in full by cash, check, or credit card. We accept Visa and Mastercard. Many people have dental insurance which reimburses them for some expenses. Our staff will be happy to assist you in achieving your maximum insurance benefits.

I HAVE READ AND UNDERSTAND THE CONTENTS OF THIS FORM.

Parent's Signature ______________________ Child's Name ____________________

Reviewed by ______________________________ Date ____________________

TO OUR PATIENTS WITH DENTAL INSURANCE:

Dental insurance and plans are designed to help with PART of your dental expenses and may not always cover every dental need. The typical plan includes limitations and exclusions, meaning the plan does not cover every aspect of dental care. This can relate to the type or number of procedures, the number of visits or age limits. (Example: Fluoride 1x per yr, or sealants) These limitations and exclusions are carefully detailed in your plan booklet and warrant your attention.

The patient/parent is personally responsible for paying for your dental treatment. However, we will assist you in filing your dental claim. Our office will try to get reimbursement from your dental insurance. If after 2 months we have not received payment, the balance will be due and payable.

If you have any concerns in regards to your child's benefits, please notify office staff or your dental assistant PRIOR to treatment.

Signature of Parent_______________________________Date:__________________

Patient Name____