DR. MILES MAZZAWI
DR. ANTHEA 'DREW' MAZZAWI

205 Waleska Rd. Suite 2-B
Canton, GA 30114

(770) 479-1717

Today's Date: ______/______/______

We are so pleased to welcome you and your child to our practice!
Please take a few minutes to fill out this form as completely as you can. If you have any questions, we will be glad to assist you. We look forward to working with you in maintaining your child's dental health!

PLEASE PROVIDE COPIES OF YOUR DENTAL ID CARD AND DRIVERS LICENSE

PATIENT INFORMATION

Child's Name: ____
Last First Middle Nickname

School: ______________________________

☐ Male ☐ Female Date of Birth____/_____/_____ Hobbies: ______________________________

Address: ____
Street Apt # City State Zip

Home Phone #: ____________________ Mom's Cell #: ____________________ Dad's Cell #: ____________________

E-mail Address: ____

Whom may we thank for referring you to our practice? ______________________________

PARENT'S INFORMATION (Please enter ALL information)

☐ Mother ☐ Stepmother ☐ Guardian Name: ______________________________

Address (if different from above): ______________________________

Best Phone # (if different from above): ____________________ Social Security #: ____________________

Employer: ______________________________ Work #: ____________________ Ext_______

☐ Father ☐ Stepfather ☐ Guardian Name: ______________________________

Address (if different from above): ______________________________

Best Phone # (if different from above): ____________________ Social Security #: ____________________

Employer: ______________________________ Work #: ____________________ Ext_______

INSURANCE INFORMATION (Please enter ALL information)

Policy Holder: ______________________________ Relationship to Patient: ____________________

Policy Holder Social Security #: ____________________ Policy Holder Date of Birth: _____/_____/______

Insurance Co: ______________________________ Employer: ______________________________

Policy #: ____________________ Group #: ____________________ ID #: ______________________________

Patient Name: ____ **DOB:** ______________________

DENTAL HISTORY

Last dental visit: ______/______/______ Last cleaning: ______/______/______ Last X-Rays: ______/______/______

Previous Dentist: ____ Do you have a copy of previous X-rays? ☐ Yes ☐ No

My child brushes his/her teeth ______ times a day.

Do you ever help your child brush his/her teeth? ☐ Always ☐ Sometimes ☐ Never

Does your child floss every day? ☐ Yes ☐ No Is fluoride taken in any form? ☐ Yes ☐ No

Is there a history of bad dental experiences? ☐ Yes ☐ No Any injuries to the mouth/teeth? ☐ Yes ☐ No

Does your child have any mouth habits? (Please circle all that apply)

Thumb/Finger sucking Grinding during sleep Pacifier Sleeping with bottle Other: ________________________

Has your child ever had any dental trauma? ____

MEDICAL INFORMATION

Child's Pediatrician: _____________________________ City/State: __________________________ Phone #: ______________________

Date of last physical exam: ____/_____/______

Has he/she ever been hospitalized or had surgery? ☐ Yes ☐ No If so, why?: ____

Any handicaps/disabilities? ☐ Yes ☐ No Please list: ____

Please place a mark on "yes" or "no" if your child has had any of the following:

ADD/ADHD	☐ Yes	☐ No	Drug/Alcohol Abuse	☐ Yes	☐ No	Mumps	☐ Yes	☐ No
AIDS/HIV	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fainting	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Seizure Disorders	☐ Yes	☐ No
Autism	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Sickle Cell Disease	☐ Yes	☐ No
Bladder issues	☐ Yes	☐ No	Heart Valve Replacement	☐ Yes	☐ No	Sinus Problems	☐ Yes	☐ No
Bleeding issues	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Cancer/Tumors	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Cerebral Palsy	☐ Yes	☐ No	Kidney/Liver Disease	☐ Yes	☐ No	Other :________________________		
Hearing loss	☐ Yes	☐ No	Learning Disabilities	☐ Yes	☐ No	______________________________		
Chicken Pox	☐ Yes	☐ No	Measles	☐ Yes	☐ No	______________________________		
Diabetes	☐ Yes	☐ No	Mental Problems	☐ Yes	☐ No	______________________________		

Girls, are you pregnant? ☐ Yes ☐ No

MEDICATIONS

Please list any medications your child is currently taking and the correlating diagnosis: ☐ N/A

____

____

ALLERGIES

☐ None ☐ Penicillin/Amoxicillin ☐ Latex ☐ Aspirin ☐ Sulfa ☐ Local Anesthetic ☐ Lidocaine

☐ Other (Please list): ____

CHEROKEE
Children's Dentistry

DR. MILES MAZZAWI | DR. ANTHEA DREW MAZZAWI

205 Waleska Road, Suite 2-B, Canton, GA 30114 ~ Phone: (770) 479-1717 ~ Fax: (770) 479-1747

FINANCIAL INFORMATION

Our policy requires payment in full at the time of service.

For those families utilizing insurance benefits, we are happy to file your insurance claim as a courtesy. However, 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. As such, we have no say in the selection of your insurance company, no control over the terms of your contract, the methods of reimbursement or the determination of your insurance benefits. Reimbursement for covered services is subject to maximum allowable fees, deductibles, and co-payments. Your responsibility is *estimated* and *due at the time of treatment*. It is also your responsibility as a parent/guardian to pay any remaining balance on your account after any and all insurance benefits have been collected.

Please initial below:

_____ I hereby authorize any and all insurance benefits to be assigned directly to Cherokee Children's Dentistry, otherwise payable to me for services rendered. I authorize the release of any information required to process insurance claims, including the use of my signature on all insurance submissions.

_____ I understand that in order for Cherokee Children's Dentistry to file an insurance claim on my behalf, proof of insurance will be required at least 24 HOURS before my child(ren)'s scheduled appointment(s). If they are unable to verify my benefits before the appointment, Cherokee Children's Dentistry will collect in full prior to services being rendered and I will be reimbursed once the claim payment is received at the dental office.

_____ I understand and agree that any credit granted shall be paid promptly in accordance with terms and agreements, that the credit grantor may add one and one half percent (1 ½%) per month to any balance owed, and in the event of default, to pay reasonable collection charges and/or court costs and attorney fees.

_____ I understand that if my account is not paid within 90 days, I will be liable for a collection fee of 35%, legal and court fees, interest charges, and any other expenses incurred while collecting the balance on my account.

Parent/Guardian: ____ Date: _______________________

Printed Name: ____

Social Security Number (required for insurance filing): ________________________________

CONSENT FOR TREATMENT

The information that I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform Cherokee Children's Dentistry of any changes in my child's medical status. I authorize Drs. Mazzawi and/or associates to perform the necessary dental procedures including, but not limited to, the use of Nitrous Oxide (laughing gas), local anesthetic (like Lidocaine), and any necessary x-rays needed on my child.

ALL PROCEDURES WILL BE DISCUSSED WITH YOU PRIOR TO ANY DENTAL TREATMENT.

Parent/Guardian: ____ Date: ______________________

CONFIRMATION AND MISSED APPOINTMENT POLICY

Dr. Miles, Dr. Drew and our staff here at Cherokee Children's Dentistry are dedicated to providing the best dental care possible for your child. We want to give your child the time and INDIVIDUAL attention they deserve. In a sincere effort to acknowledge the importance of each parent's time, and to remain on time during our busy schedule, we must ask that parents ARRIVE ON TIME FOR THEIR CHILDREN'S APPOINTMENTS. This allows us to be able to see all the children that are scheduled in a timely and efficient manner. When a parent is *late* or *fails* to make a scheduled appointment, this may jeopardize other children's treatment time. It also effects other parent's schedules that have children scheduled after your child that day.

We know that traffic is impossible to predict, so please allow extra driving time.

All appointments must be confirmed at least 48 hours in advance. You will receive a text and/or email to confirm your child(ren)'s appointment(s). If no confirmation is made through the automated system, you will receive one courtesy call. If no one can be reached at the time of the call and the call is not returned by the end of the business day, **your child may be removed from the schedule** in order to accommodate other patients waiting to be seen. Please feel free to call **770-479-1717** at any time, day or night, to confirm your child's appointment. It is okay to leave a message on our voicemail to confirm; cancellations must be received 48 hours in advance.

Please initial, acknowledging the below:

_____ If a patient is more than 15 minutes late, we may need to reschedule the appointment. If we are able to see the child, we cannot guarantee that all scheduled treatment will be completed.

_____ Parents may change or cancel their child's appointment with at least 48 hours' notice (2 business days).

_____ A $50 fee will be charged to your account for all appointments that are cancelled and/or broken within 24 hours of your scheduled appointment time.

_____ After having 3 missed or broken appointments, we may no longer be able to provide your child with dental care. If this happens, you will be notified by mail of your child's dismissal from our practice. We will continue to provide emergency dental care for your child for up to 30 days following the dismissal.

In an effort to serve ***all children*** that have dental needs, we must ask that you acknowledge our missed appointment policy. If a patient fails to make their appointment, they will be rescheduled only once. If a second appointment is missed, we ask that you call our office when you are available and we can advise of any open appointments on that day. We will no longer be able to reserve an appointment time in advance.

Thank you for respecting the time of our doctors, our staff, and the other families that are a part of our practice.

Parent/Guardian: ____ Date: ______________________

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Health Insurance Portability and Accountability Act (HIPAA)

Child/Children's Names: ____

Parent/Guardian's Name: ____

Preferred Phone #: ____

Alternate Phone #: ____

Address: ____

E-Mail:____

In General, the HIPAA privacy rule gives individuals the right to request a restriction of their health information.
The individual is also provided the right to request confidential communications or that a communication of PHI (Protected Health Information) be made by alternative means, such as, sending information to the individual's office instead of their home.

I wish to be contacted in the following manner (Check all that apply):

Home Telephone:
- OK to leave message with details ☐
- Leave message with only call back # ☐
- OK to speak to spouse/sibling ☐

Cell Phone:
- OK to leave message with details ☐
- Leave message with only call back # ☐

Written communication:
- OK to mail to my home ☐
- OK to mail to my work ☐
- OK to fax to designated # ☐

E-Mail:
- OK to write E-mail with details ☐
- Write E-mail with only call back # ☐

Work Telephone:
- OK to leave message with details ☐
- Leave message with only call back # ☐

I give Cherokee Children's Dentistry permission to use and disclose PHI necessary to carry out TPO (Treatment Payment or Operations); this also indicated a "Good Faith Effort" was made on behalf of Drs. Mazzawi. By signing this form, I understand that the privacy practices of the office have been disclosed to me. This information will stay on record for six years.

Parent/Guardian: ______________________________________ Date: ____________________