

**DR MILES MAZZAWI
DR. ANTHEA DREW MAZZAWI**

205 Waleska Rd. Suite 2-B
Canton, GA 30339
(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!

PATIENT INFORMATION

Child's Name: _____
Last First Middle Nickname

Male Female Date of Birth ____/____/____. Hobbies: _____

Address: _____
Street Apt # City State Zip

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

E-mail Address: _____

How would you prefer us to contact you for confirming your child's appointments? _____

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

PARENT'S INFORMATION

Mother Stepmother Guardian Name: _____

Address (if different from above): _____

Home # (if different from above): _____ Work #: _____ ext _____ Employer: _____

Father Stepfather Guardian Name: _____

Address (if different from above): _____

Home # (if different from above): _____ Work #: _____ ext _____ Employer: _____

INSURANCE INFORMATION

Policy Holder: _____ Relationship to patient: _____

Policy Holder Social Security #: _____ Date of Birth: ____/____/____

Insurance Co: _____ Employer: _____

Policy #: _____ Group #: _____ ID#: _____

Patient Name: _____

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: _____

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: _____

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

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

Girls, are you pregnant? Yes No

MEDICATIONS

Please list any medications your child is currently taking and the correlating diagnosis:

ALLERGIES

None Penicillin/Amoxicillin Latex Aspirin Sulfa Local Anesthetic Lidocaine

Other (Please list): _____

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: _____

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.

If your account is not paid within 90 days, you will be liable for all collection fees, legal, and court fees, interest charges, and any other expenses incurred while collecting your account.

I hereby authorize all insurance benefits, if any, 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.

Parent/Guardian: _____ Date: _____

CONFIRMATION & MISSED APPOINTMENT POLICY

We are dedicated to provide 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 parent's 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 way. When a parent is *late* or *fails* to make a scheduled appointment, this may jeopardize all the children's treatment. It also affects other parent's schedules that have children scheduled after your child that day.

- Parents may change or cancel their child's appointment with at least 48 hours notice (2 business days).
- 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 treatment will be completed.
- There may be a \$50 fee charged to your account for all appointments that are cancelled and/or broken within less than 24 hrs.
- After having 3 missed or broken appointments, we will 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.

All appointments must be confirmed *48 hours in advance*. Cherokee Children's Dentistry will call to confirm your child's appointment. If no one can be reached at the time of the call, it is the parent's responsibility to call our office to confirm your appointment. Please call **770-479-1717** at any time, day or night, by 9:00AM two business days prior to your child's appointment to confirm. It is okay to leave a message on our voicemail.

Parent/guardian: _____ Date: _____



DR. MILES MAZZAWI

DR. ANTHEA DREW MAZZAWI

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

Health Insurance Portability and Accountability Act (HIPAA)

Child/Children's Names: _____

Parent/Guardian's Name: _____

Preferred 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.

Signature _____ Date: _____