

DR. MILES MAZZAWI
DR. ANTHEA 'DREW' MAZZAWI
DR. NIRALI PROCTER

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	<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: N/A

ALLERGIES

None Penicillin/Amoxicillin Latex Aspirin Sulfa Local Anesthetic Lidocaine

Other (Please list): _____



CHEROKEE Children's Dentistry

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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, Procter 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, Dr. Procter 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 & Procter. 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: _____