Lee H. Baker, DDS ● Mackenzie Craik, DDS
1243 Augusta West Pkwy
Augusta, GA 30909
Phone: (706) 855-8989
Fax: (706) 855-0321
www.CPDAugusta.com

Welcome to our practice! In order to know you and your child better, please complete the information requested as completely as you are able. If you have any questions, please ask for assistance. Thank You!

Patient Information

Child's Name: _____
Last First MI Preferred Name
☐Male ☐ Female Date of Birth: _____ Child's Social Security #: _____
Hobbies/Pets: _____
Address: _____
City: _____ State: ____ Zip Code: _____ Home Phone: _____
Names and ages of any other children in the family: _____
Do parents live together? ☐ Yes ☐ No If not, with whom does the child live? _____

Parent/Guardian Information
☐ Mother ☐ Stepmother ☐ Guardian: Name_____
Address (if different from above): _____
City: _____ State: _____ Zip Code: _____
Home # (if different from above): _____ Work: _____ Cell: _____
Date of Birth: _____ Social Security #: _____
Employer: _____ Occupation: _____
Marital Status: _____ E-mail Address: _____
Does this person have the legal right to make health care decisions for the patient listed above? ☐Yes ☐No

Parent/Guardian Information
☐ Father ☐ Stepfather ☐ Guardian: Name_____
Address (if different from above): _____
City: _____ State: _____ Zip Code: _____
Home # (if different from above): _____ Work: _____ Cell: _____
Date of Birth: _____ Social Security #: _____
Employer: _____ Occupation: _____
Marital Status: _____ E-mail Address: _____
Does this person have the legal right to make health care decisions for the patient listed above? ☐Yes ☐No

List any person(s) you **do not want** patient/family information released to: _____
_____

List any person(s) allowed to bring patient to an appointment and make dental/financial decisions for the above patient: _____

How were you referred to our practice? _____
Who is your family dentist? _____

Method of Payment
☐ Payment in full at time of treatment (Cash, Master Card, Visa, AMEX, Discover, Care Credit)
☐Insurance- All co-payments are due at time of treatment and are estimated. Any amount not covered by insurance is the responsibility of the parent accompanying the patient.
☐ Georgia Medicaid, Peachstate-**Please advise us of any additional dental insurance plans for your child.**

Primary Dental Insurance
Policy Holder: _____ Relationship to patient: _____
Policy Holders Social Security #: _____ Date of Birth: _____
Insurance Company: _____ Employer: _____
Policy #:_____Group #: _____ Member ID # _____
Insurance Company Phone #: _____
Is child covered by any other dental insurance plans (including Medicaid)? ☐Yes ☐ NO

Secondary Dental Insurance
Policy Holder: _____ Relationship to patient: _____
Policy Holders Social Security #: _____ Date of Birth: _____
Insurance Company: _____ Employer: _____
Policy #:_____Group #: _____ Member ID # _____

Dental History

Is this your child's first visit to the dentist? ☐Yes ☐No If no, please give date of last dental care: _____ Previous Dentist: _____
Do you have a copy of your child's dental records? ☐Yes ☐No
Is your child on a bottle? ☐Yes ☐No If no, at what age was it discontinued? _____
Is your child a thumb/finger sucker or ever used a pacifier? ☐Yes ☐No Age discontinued _____
Is your primary source of water from a well? ☐Yes ☐No
Does your child take fluoride in any form? ☐Toothpaste ☐Rinse ☐Tablet ☐City Water/Nursery Water
Has your child had any traumatic injury to his/her teeth? ☐Yes ☐No If yes, please explain:_____
Has your child had any problems with previous dental treatment? ☐Yes ☐No If yes, please explain:
_____
Does your child have any dental conditions you are concerned about today? ☐Yes ☐No If Yes, please explain:
_____

Medical History

Child's pediatrician: _____ Phone Number: _____

Date of last visit:_____

Has your child been hospitalized or had surgery since birth? ☐Yes ☐No If Yes, please explain:

_____

Does your child have any special needs? ☐Yes ☐No Please list: _____

Has your child ever had any of the following? (<u>Please select yes or no for each condition</u>)

Abnormal Bleeding	☐Yes ☐No	Hemophilia	☐Yes ☐No
ADD/ADHD	☐Yes ☐No	Hepatitis	☐Yes ☐No
AIDS/HIV	☐Yes ☐No	Kidney Disorder	☐Yes ☐No
Anemia	☐Yes ☐No	Learning Disabilities	☐Yes ☐No
Asperger's	☐Yes ☐No	Liver Problems	☐Yes ☐No
Asthma	☐Yes ☐No	Lung Disease	☐Yes ☐No
Autism	☐Yes ☐No	Mental/Emotional Disorder	☐Yes ☐No
Cancer/Tumors	☐Yes ☐No	Muscular Dystrophy	☐Yes ☐No
Cerebral Palsy	☐Yes ☐No	Nose/Throat Disorder	☐Yes ☐No
Cleft Lip/Palate	☐Yes ☐No	Premed Needed	☐Yes ☐No
Diabetes	☐Yes ☐No	History of RSV	☐Yes ☐No
Downs Syndrome	☐Yes ☐No	Respiratory Problems	☐Yes ☐No
Epilepsy/Convulsions	☐Yes ☐No	Sickle Cell Disease	☐Yes ☐No
Hearing Impaired	☐Yes ☐No	Sickle Cell Trait	☐Yes ☐No
Heart Condition/Murmur	☐Yes ☐No	Sinus Problems	☐Yes ☐No

Cont'd Patient Name:_____

Speech Problems	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Stomach Disorder	☐Yes ☐No	Vision Problems	☐Yes ☐No
Thyroid Disease	☐Yes ☐No		

If you answered yes to any questions above please explain or give additional details: _____

_____

Any other medical condition or concern? _____

For patients 14 and over: Any recreational use of tobacco, alcohol or history of substance abuse?

☐Yes ☐No

If yes, please provide additional details: _____

Please list all current medications-prescription, non-prescription and supplements. _____

_____

Allergies

☐None ☐ Penicillin/Amoxicillin ☐Codeine ☐Latex ☐ Ibuprofen ☐Anesthetic

☐Other (Please list): _____

Authorization and Release:

To the best of my knowledge, the questions on this form have been accurately answered. I am the parent, guardian or personal representative of this patient and have the legal right to authorize medical and dental care for this child. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical or dental status. I authorize the dentist and staff of Center for Pediatric Dentistry to perform the necessary dental services my child may need. I also authorize the dentist and staff of Center for Pediatric Dentistry to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or health practitioners. I authorize the use of radiographs and photographs for the purpose of teaching and scientific publications. I request that my insurance company pay directly to the dentist. I agree to remain on the premises while my child is being treated. I understand that my insurance carrier may pay less that the actual bill for services; therefore, I agree to be responsible for payment of all services rendered on my child's behalf. I also agree that any fees incurred on this account for finance charges, collection actions or delayed payment by myself or the insurance company will be my responsibility.

Signature of Parent/Guardian: _____ Date: _____

Printed Name of person signing: _____ Relationship to patient: _____

Does the person signing have the legal right to make health care decisions for the patient? ☐Yes ☐No

Reviewed and signed by Dr: _____ **Date:** _____

Center for Pediatric Dentistry HIPPA Acknowledgment

You May Refuse to Sign This Acknowledgment

I have read and been offered a copy of this office's Notice of Privacy Practices.

Print Name:_____

Signature:_____

Date:_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

Important Information for Our Patients

Dental Insurance:

We are glad to assist you in obtaining the maximum benefit from your dental insurance plan. Please realize that insurance coverage is a relationship between you, the insured and your insurance company. In most instances, once your plan coverage has been verified, we will accept assignment of payment from your insurance company. Most plans only cover a portion of the dental fee, which means you will be responsible for your deductible and any co-payment. Your co-payment is expected at the time you are in our office for dental care. As a courtesy to our patients and families we estimate co-payments for visits. This estimate does not guarantee that insurance will pay the remaining balance and any amount not paid by your insurance will be your responsibility. For your convenience, our office will file insurance claims on your behalf. However, any claims that remain outstanding after 60 days will become your responsibility and a finance charge will be applied to any balance due. Payment will be expected on any such claims and no further attempt will be made by our office to collect from the insurance company in this event. Please speak with us if you have questions regarding this policy.

Medicaid Patients: Your insurance will typically cover all procedures in full, unless you are specifically notified by the office and given a co-payment. Medicaid must be filed secondary to all other insurance plans.

Payment Policies:

Please be aware that the parent/guardian who brings the patient to their appointment is responsible for payment of all charges and co-payments at the time of service. For your convenience, we accept Visa, MasterCard, American Express and Discover. We are also a participating Care Credit provider. There will be a $35.00 service charge for all returned checks. Center for Pediatric Dentistry requires that all outstanding balances be paid in full within 30 days unless other arrangements have been made. Balances remaining after 30 days will be assessed a finance charge. Non-payment of your account could result in further collection actions including but not limited to transferring your account to an outside collection agency. You will be responsible for any fees incurred in collecting your account. Only emergency care will be available if your account balance is not paid within 30 days.

Appointments and Appointment Confirmations:

Our appointments are scheduled to respect your time. We reserve a specific time for your child's care and we make every effort to see you at that appointed time. We appreciate your promptness and consideration in not changing your scheduled time. However, if you need to change an appointment, a 48 hour notice is requested. Late arrivals affect our ability to see patients in a timely and efficient manner. Patients arriving 15 minutes, or more, late for an appointment may need to be rescheduled. If we are able to see the patient, we cannot guarantee all treatment will be completed. If two (2) appointments are missed without 48 hours' notice, we may no longer be able to provide dental care for your child.

Appointments will be confirmed at least 48 hours in advance. We respectfully request that appointments be confirmed by the parent or guardian. If we are unable to reach you regarding your child's scheduled appointment, it may be moved off the schedule. You can confirm your appointments by phone at 706-855-8989, by e-mail: appointments@drleebaker.com or through our automated system of e-mail and text messages. For after hours, you may leave us a message to confirm your appointment. **Please contact us during business hours to reschedule or cancel appointments.**

Electronic Communications:

For your convenience, Center for Pediatric Dentistry uses e-mails, text messaging and an automated calling system to contact our patients for appointment confirmations and reminders.

I understand the confidentiality of electronic communications (e-mail, text messages, etc.) cannot be guaranteed and Center for Pediatric Dentistry is not responsible for the confidentiality or security of any message sent to or by me. If any of my contact information changes or at any time I wish to revoke my consent, I agree to notify Center for Pediatric Dentistry in writing or in person.

***Please check "Yes" below if you will allow our office to send E-mail correspondence prior to sending automated calls and/or text messages.**

☐Yes ☐ No Text messages for appointment confirmations and notifications.
☐Yes ☐ No E-mail for appointment notifications and confirmations.*
☐Yes ☐ No E-mail for general account, insurance and/or billing questions.*

Our relationship with our patients is of utmost importance to us. We are happy to answer any questions you may have about our office. We look forward to providing an excellent experience for you and your child. Thank you for your cooperation!

Parent's signature: _____ Date:_____

Permission Form

Date: _____

Patient(s) Name(s):_____

I, _____, give the individuals listed below permission to bring my child(ren) to their dental visits and authorize Center for Pediatric Dentistry to give them any information regarding dental care for my child(ren). The have full authority to make any dental and financial decisions for my child(ren), including, but not limited to: sedation, nitrous oxide, radiographs, and fluoride treatments. I understand that payment for services rendered is due at the time of treatment and agree to make payment arrangements with Center for Pediatric Dentistry if the individual accompanying my children is not prepared to make payment in full. Center for Pediatric Dentistry will make every effort to keep the accompanying adult informed before treatment is changed, however I realize that this may not always be possible and the adult will be informed of any changes at the completion of the appointment. I understand that if I need to make any changes to this agreement I must do so in writing.

Name	Phone Number(s)	Relationship to Patient
1.		
2.		
3.		
4.		
5.		
6.		

Parent/Legal Guardian Signature: _____

COVID-19 PANDEMIC EMERGENCY DENTAL TREATMENT NOTICE AND ACKNOWLEDGEMENT OF RISK FORM

Our goal is to provide a safe environment for our patients and staff, and to advance the safety of our local community. This document provides information we ask you to acknowledge and understand regarding the COVID-19 virus.

The COVID-19 virus is a serious and highly contagious disease. The World Health Organization has classified it as a pandemic. You could contract COVID-19 from a variety of sources. Our practice wants to ensure you are aware of the additional risks of contracting COYID-19 associated with dental care.

The COVID-19 virus has a long incubation period. You or your healthcare providers may have the virus and not show symptoms and yet still be highly contagious. Determining who is infected by COVID-19 is challenging and complicated due to limited availability for virus testing.

Due to the frequency and timing of visits by other dental patients, the characteristics of the virus, and the characteristics of dental procedures, there is an elevated risk of you contracting the virus simply by being in a dental office.

Dental procedures create water spray which is one way the disease is spread. The ultra-fine nature of the water spray can linger in the air a long time, allowing for transmission of the COVID-19 virus to those nearby.

You cannot wear a protective mask over your mouth to prevent infection during treatment as your health care providers need access to your mouth to render care. This leaves you vulnerable to COVID-19 transmission while receiving dental treatment

I confirm that I have read the Notice above and understand and accept that there is an increased risk of contracting the COVID-19 virus in the dental office or with dental treatment. I understand and accept the additional risk of contracting COVID-19 from contact at this office. also acknowledge that I could contract the COVID-19 virus from outside this office and unrelated to my visit here.

I have read and understand the information stated above:

_____ _____

Signature Date

_____

Witness