First Tooth, First Visit

CARLY THOMAS, DDS
Specialist in Pediatric Dentistry
Fellow, American Academy of Pediatric Dentistry

Patient Information

Patient's Name: _____ Today's Date: _____

Home address: _____ Nickname: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Email Address: _____

Person bringing child: _____ Relationship to patient: _____

Legal Guardian for Medical Care: _____

Date of Birth: _____ Age: _____ Circle one: Male Female

Medical History

Current physician(s) treating your child:
_____

Physician(s) phone number: _____

Any medical concerns:
_____
_____
_____
_____

Allergies:
_____

Is your child taking any medications? Yes No
If so, please list:
_____

Comments or Concerns:
_____
_____
_____

Consent for Dental Treatment

I request and authorize Dr. Carly Thomas and her office staff to examine and provide my child with comprehensive dental treatment. I will allow photographs to be taken of my child and/

or my child's teeth for diagnostic and educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in appropriate terms for their age. Dr. Carly Thomas will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation, and demonstration of procedures and instruments and using variable voice tones. I understand that I will be responsible for any charges incurred on this child for dental treatment.

Signature: _____ Date: _____

Notice of Privacy Practice- HIPPA

Disclosure of Health Information

We use and disclose health information about your child for treatment, payment and healthcare operations. We may disclose your child's information to a healthcare provider treating him/her. You may give us written authorization to disclose health information to anyone for any purpose. This may be revoked in writing. We need written permission before any health information is disclosed to any caregivers besides the child's legal guardian. In the event of an emergency, we will disclose information based on professional judgement. We will not use health information for marketing purposes. If we suspect a possible victim of abuse, neglect, or domestic violence, we may disclose your child's health information as the law requires. We may disclose your child's health information to provide you with appointment reminders or treatment recommendations (such as postcards, voicemails, emails or letters).

Patient Rights

Access: You have the right to look at our get copies of your health information. If you request copies, we will charge you for each page for staff time to locate and copy the information and postage if mailed.
Restriction: You have the right to request that we place additional restrictions on our use or disclosure of information.
Alternative Communication: You have the right to request that we communicate with you about your child's health history in alternative means.
Amendment: You have the right to request that we amend your health information. We may deny your request under certain circumstances.

Questions and Complaints

If you are concerned that we may have violated your privacy rights, or disagree with a decision we made about access to your health information or in response to a request to amend or restrict the disclosure of health information, you may submit a written complaint to the US Department of Health and Human Services. If you have any further questions about our privacy practices please contact Dr. Carly Thomas.

Signature: _____ Date: _____