Welcome

Where Rising Stars Grow Shining Smiles

John J. Haffner, D.M.D., M.S.D.
Board Certified Pediatric Dentist

Health History Form

Today's Date: _______________

NOTE: The parent or Guardian who accompanies the child is responsible for payment at the time of service.

1. Tell Us About Your Child

Child's Name ______________________________________
Last First MI

Goes by: ________________________ ☐ Male ☐ Female

Siblings that we treat ______________________________

Child's Birthdate _____/_____/_____ Child's Age ___________

School______________________________Grade___________

Child's Home # (__________)________________________

SS#____

Child's Home Address:_____________________________

____
City State Zip

Email Address:_________________________________

2. Who may we thank for referring you to our office?

____

3. Mother's Information

Name ____

Mother Stepmother Guardian Birthdate _____/_____/_____

Employer ______________________________________

Work # (__________)____________________ Ext. ___________

Home # (__________)____________________________

Cellular Phone # (_________)_________________________

SS # ______________________ DL# ____________________

4. Father's Information

Name ____

Father Stepfather Guardian Birthdate _____/_____/_____

Employer ______________________________________

Work # (__________)____________________ Ext. ___________

Home # (__________)____________________________

Cellular Phone # (_________)_________________________

SS # ______________________ DL# ____________________

5. Who is Accompanying the Child Today?

Name ____

Relationship_______________________________________

Do you have legal custody of this child? ☐ Yes ☐ No

6. Person Responsible for Account

Name____

Relationship_______________________________________

Billing Address ____________________________________

____
City State Zip

Home # (____________)______________________________

Work # (____________)______________________________

Cellular # (____________)____________________________

E-mail ____

7. Primary Dental Insurance

Insurance Co. Name ________________________________

Insurance Co. Address ______________________________

____

Insurance Co. Phone # (___________)__________________

Group # (Plan, Local, or Policy #) ____________________

Policy Owner's Name ________________________________

Relationship to Patient______________________________

Policy Owner's Birthdate ______/ ______/ ______

Social Security # ___________________________________

Policy Owner's Employer _____________________________

8. Secondary Dental Insurance

Insurance Co. Name ________________________________

Insurance Co. Address ______________________________

____

Insurance Co. Phone # (___________)__________________

Group # (Plan, Local, or Policy #) ____________________

Policy Owner's Name ________________________________

Relationship to Patient______________________________

Policy Owner's Birthdate ______/ ______/ ______

Social Security # ___________________________________

Policy Owner's Employer _____________________________

9. Dental History

Is this your child's first visit to the dentist? ________________

If not, how long since the last visit to the dentist? ____________

Previous Dentist's Name_____________________________

Were any x-rays taken at previous dental visits? ____________

Have there been any injuries to the teeth, face or mouth? _____

If yes, please explain ________________________________

____

____

Why did you bring the child to the dentist today? ____________

____

____

Does the child have any of the following habits?

Y N Lip Sucking / Biting — Y N Nail Biting

Y N Nursing / Bottle Habits — Y N Thumb / Finger Sucking

Has the child ever had a serious or difficult problem associated with previous dental work? Yes No

If yes, please explain ________________________________

____

Is the child's water fluoridated? Yes No

Is the child taking fluoride supplements? Yes No

Has the child ever had any pain or tenderness in his/her jaw/ joint? (TMJ/TMD)? Yes No

Does the child brush his/her teeth daily? Yes No

Floss his / her teeth daily? Yes No

10. Health History

Has the child ever had any of the following conditions?

Y N Abnormal Bleeding	Y N Disabilities/Special Needs
Y N Allergies to any Drugs	Y N Hearing Impairment
Y N Any Hospital Stays	Y N Heart Disease/Murmur
Y N Any Operations	Y N Hemophilia/Blood Disorders
Y N Asthma	Y N Hepatitis
Y N Cancer	Y N HIV + / AIDS
Y N Congenital Birth Defects	Y N Kidney/Liver Conditions
Y N Convulsions/Epilepsy	Y N Rheumatic/Scarlet Fever
Y N Pregnancy	Y N Allergies to Latex Product
Y N Tuberculosis	Y N Diabetes
Y N ADD/ADHD	Y N Autism

Please discuss any serious medical conditions the child has had

____

____

Please list all drugs the child is currently taking_______________

____

Please list all allergies_________________________________

____

Child's Physician _____________________________________

Phone (____________)_______________________________

Is the child currently under the care of a physician? Yes No

Please describe the child's current physical health...

Good **Fair** **Poor**

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA the CDC, and the ADA.

11.

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

____ ________________________________

Signature of Parent or Guardian — Date — Relationship to Patient

For Office Use Only

I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein.

Initials ____________ Date ______________

Doctor's Comments _____________________________________

____

____

____

Authorization To Bring Child

Childs Name:__________________________ Date of Birth:____________

We (I) hereby authorize the Dr. John Haffner and his staff members at All Stars Pediatric Dentistry, in our (my) absence, to allow the named below to bring my child to All Stars Pediatric Dentistry to provide routine dental services. I (we) understand that the child cannot have dental TREATMENT done without a legal guardian being present. This form is only for routine dental services.

Name:_____________________ Relationship to Patient:_______________

Name:_____________________ Relationship to Patient:_______________

Name:_____________________ Relationship to Patient:_______________

Please note, the person authorized to accompany your child, MUST present identification.

Parent/Legal Guardian:_____________________________
(Please Print)

Parent/Legal Guardian:_____________________________Date_____________
(Signature)

All Stars Pediatric Dentisty- Dr. John Haffner- 3480 Keith Bridge Rd. Ste A4, Cumming GA 30041
770-292-9441- Fax 770-292-9442 drjohn@allstarschildrensdentist.com

All Stars Pediatric Dentistry

Dr. John Haffner

3480 Keith Bridge Rd. • A4 • Cumming, GA 30041 • Telephone: (770)-292-9441 • FAX: (770)-292-9442

APPOINTMENT POLICY

The scheduled appointment is reserved specifically for your child. Any change in this appointment affects many patients. If a cancellation is unavoidable, please call the office **at least 48 hours** in advance so that we may give that time to another patient.

- *All restorative (fillings, extractions, etc.) procedures are scheduled in the morning for children 6 years and younger .* Children, as well as adults, are more prepared and do better in the morning for these types of procedures.

- *We strive to see all patients on time* for their scheduled appointment. There are times when our schedule is delayed in order to accommodate an injured child or an emergency. Please accept our apology in advance should this occur during your appointment. We will do the exact same if your child is in need of emergency treatment.

- *If you arrive 10-15 minutes late for your appointment, you may be asked to reschedule for the next available appointment time.*

- ***Please call at least 48 hours in advance if a cancellation is unavoidable*** **so that we may give it to another patient.**

- *Broken or missed appointments affect many people*. **If two (2) broken/missed appointments occur or two (2) cancellations without 48-hour notice, our office reserves the right to NOT schedule any subsequent appointments and/or charge a $75.00 broken appointment fee.**

- *A parent or legal guardian (with official documentation) must be present during all appointments that the child patient is in the office.*

If at any time you have questions, please feel free to ask our staff or call our office. We are here to help in any way we can. We appreciate you entrusting your child's dental health to us. Thank you!

Signature: Date:

All Stars Pediatric Dentsitry

3480 Keith Bridge Rd. • Suite A4 • Cumming, GA 30041 • Telephone: (770) 292-9441 • FAX: (770) 292-9442

John J. Haffner, DMD

FINANCIAL POLICY

Thank you for choosing our office for your child's dental treatment. We are committed to their successful treatment! Please understand that *payment of your bill is considered a part of your child's treatment.*

- Please be aware that the parent bringing the child to All Stars Pediatric Dentistry is *legally responsible for payment of all charges*. We cannot send statements to other persons.

- **Payment is expected in full for each appointment as services are rendered.** For the convenience of our patients, we accept cash, MasterCard, VISA or DISCOVER.

Dental Insurance

If we have received all of your insurance information on the day of the appointment, we will be happy to file your claim for you. You must be familiar with your insurance benefits, as we will collect from you the estimated amount insurance is not expected to pay. By law your insurance company is required to pay each claim within 30 days of receipt. We file all insurance electronically, so your insurance company will receive each claim within days of the treatment. You are responsible for any balance on your account after 30 days, whether insurance has paid or not. If you have not paid your balance within 60 days a re-billing fee of 1.5% will be added to your account each month until paid. We will be glad to send a refund to you if your insurance pays us.

PLEASE UNDERSTAND that we file dental insurance as a courtesy to our patients. We do not have a contract with your insurance company, only you do. We are not responsible for how your insurance company handles its claims or for what benefits they pay on a claim. We can only assist you in estimating your portion of the cost of treatment. We at no time guarantee what your insurance will or will not do with each claim. We also cannot be responsible for any errors in filing your insurance. Once again, we file claims as a courtesy to you.

Emergency Treatment – all emergency treatment must be paid in full at the time the service is rendered.

We recognize that under unusual circumstances an account balance may be incurred. All Stars Pediatric Dentistry requires that all outstanding balances *be paid in full within thirty (30) days* unless other arrangements have been made. Also note, if we have not received payment or you have not contacted us within thirty (30) days, further action may be taken. Thank you in advance for your understanding of our financial policy!

______________________________ ____________________

Parent/Legal Guardian Date

HIPAA ACKNOWLEGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as the business aspects of running the practice on a daily basis.

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent at any time, except to the extent that you have taken action relying on this consent.

Signature: Date:

Relationship to patient:____

Please list anyone that you give permission to access dental records below: