Kid City Smiles
Mary Beth Tabor, DDS
107 Maple Row Blvd
Hendersonville, TN 37075
615.822.5588 615.822.3206fax

Child's Name _____ Today's Date_____

Home Address_____

City_____State_____Zip_____

Home Phone# _____Work #_____Cell #_____

Date of Birth_____ Sex: M □ F □ Social Security #_____

Age_____ Grade_____ School_____

Mother's Name: _____ Birth date: _____ SSN:_____

Home Address: _____

City_____State_____Zip_____

Home Phone# _____Work #_____Cell #_____

E-Mail Address_____

Employer_____

Father's Name: _____ Birth date: _____ SSN:_____

Home Address: _____

City_____State_____Zip_____

Home Phone# _____Work #_____Cell #_____

E-Mail Address_____

Employer_____

Name of Primary Dental Insurance Carrier_____

Name of Subscriber (Member's Name) _____

ID#_____ Group #_____ Telephone#_____

Name of Secondary Dental Insurance Carrier_____

Name of Subscriber (Member's Name)_____

ID#_____ Group #_____ Telephone#_____

Do we have your permission to?

- Contact you at these numbers? Home □ Work □ Cell □
- Leave a message at these numbers? Home □ Work □ Cell □
- Leave appointment reminders at these numbers? Home □ Work □ Cell □
- Send you email (appt reminders, newsletters, etc.)? Yes □ No □
- Send you text messages for (appt reminders or availability)? Yes □ No □

Who is accompanying child today _____

Names & ages of other children in family_____
_____

How did you hear about us? _____

DENTAL HEALTH

How often does your child brush? _____ Floss? _____

Is brushing/flossing supervised? Yes □ No □ By whom? _____

Is child's water fluoridated? Yes □ No □ Don't Know □

Is your child receiving fluoride supplements? Yes □ No □

□ Tablets □ Drops Dose: _____

Is this your child's first dental visit? Yes □ No □

Previous Dentist & City_____

Date of last visit: _____Date of last dental x-rays: _____

Any injuries to your child's teeth or jaw? Yes □ No □ When/What?_____

Has your child had recent dental pain? Yes □ No □ Explain_____

Breast feeding (until age) □ Bottle (until age) □ Thumb/finger sucking □

Pacifier □ Nail biting □ Dental grinding/clenching □ Mouth breathing/snoring □

Has your child experienced any unfavorable reaction from previous medical or dental care? Yes □ No □

Explain _____

_____

MEDICAL HEALTH

Child's physician: _____ Phone:_____

Date of last exam_____

List any medical problems, hospitalizations, surgeries the child has had: _____

_____

List all medications the child is currently taking (give reasons):_____

_____

Premedication prior to dental treatment? Yes □ No □ Why? _____

Is your child under the care of a specialist? Yes □ No □ Why?_____

Specialist's name: _____

Does your child have a physical or medical disability/delay? Yes □ No □ Please describe_____

_____

Does your child have a history of allergies/sensitivities/adverse reactions to any drugs or medications?

Yes □ No □ if yes, please describe: _____

Does your child have a history of allergies to any other substances (latex, environmental, etc.)?

Yes □ No □ if yes, please describe: _____

Is your child up to date on immunizations? Yes □ No □

Do you wish to speak to the doctor privately about a special concern? Yes □ No □

Has your child ever had any of the following?

□ AIDS/HIV	□ Diabetes	□ Pneumonia
□ Attention Deficit/Hyperactivity	□ Drug/Alcohol Abuse	□ Pregnancy
□ Anemia	□ Epilepsy	□ Psychiatric Disorder
□ Allergy/Asthma	□ Endocrine/Growth Disorders	□ Rheumatic Fever
□ Autism	□ Eye Problems	□ Scarlet Fever
□ Bleeding Abnormalities	□ Fainting/Dizziness	□ Scoliosis
□ Brain Injury	□ Hearing Loss	□ Sickle Cell Anemia
□ Bronchitis	□ Heart disease/Murmur	□ Sinus Problems/Snoring
□ Cancer	□ Hemophilia	□ Sore Throat (Frequent)
□ Cerebral Palsy	□ Hepatitis	□ Enlarged Tonsils/Adenoids
□ Chicken Pox	□ Jaundice	□ Spina Bifida
□ Cleft Lip/Palate	□ Leukemia	□ Tuberculosis
□ Communicable Disease	□ Measles	OTHER:
□ Convulsions/ Seizures	□ Mental Retardation	□ _____
□ Developmental Delay	□ Mumps	□ _____

Authorization & Release

To the best of my knowledge, the questions on this form have been accurately answered. 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 status. I also authorize the dental staff to perform the necessary dental services my child may need. I also authorize the dentist 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 other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dentist's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____

Signature of Patient (or Parent/Guardian if minor) Date

By initialing, I am consenting for Use and Disclosure of Health Information, Authorization for Treatment and Acknowledgement of Receipt of Notice of Privacy Practices.
_____ (please initial)

Please list the names of all persons with whom Dr. Mary Beth Tabor's staff may discuss your child's treatment and or other dental needs.

PERSON	RELATIONSHIP
_____	_____
_____	_____
_____	_____

Kid City Smiles ~ Financial Policy

Payment in full is expected when services are rendered. All other arrangements must be made prior to your appointment.

Insured Patients

- Although your insurance may assist you with partial payment of your treatment, the estimated portion that is not covered is due when services are rendered.
- As a courtesy to our patients, we will file your primary insurance for you. If your insurance has not paid within 90 days, you will be responsible for the entire unpaid balance and payment in full will be expected at this time. We will however, continue to work with you and your insurance company to expedite your reimbursement.
- *We do not file medical insurance.*
- Payment may be made by any of the following methods.

  Cash Check Credit Card

- Information is available upon request for third party financing through the following:

  Care Credit

If paying in full by cash or check when services are rendered, a 5% credit adjustment may be applied to your account.

- I understand and agree that I am ultimately responsible for all fees incurred for my dental treatment regardless of payment or denial of my insurance claim(s) by my insurance company.
- I agree to pay any and all unpaid balance on my account.
- I authorize all insurance benefits paid directly to Kid City Smiles.
- If payment by the insurance company is made to the insured, I agree to endorse or have the insured endorse the benefits check to Tabor Dental Associates or make payment immediately to Kid City Smiles.
- I authorize the release of information to my insurance company, attorney or legal representative to obtain reimbursement of any claim(s) or for other reasons.
- A finance charge of 1.5%will begin to accrue after 90 days from the date of service on the unpaid balance of my account even though insurance may be pending.
- A fee of $30.00 will be incurred for each returned check.
- In the event that my account is turned over to a collection agency or attorney for collection, I agree to pay collection costs, attorney's fees, court costs, and interest from the date of treatment.
- I authorize this office to discuss my account with a spouse or responsible party.
- If the patient is a minor or adult using insurance of someone other than his/her own, I authorize this office to discuss this account with the subscriber of the insurance, parent, step parent or responsible party.
- By initialing, I am consenting for Use and Disclosure of Health Information, Authorization for Treatment and Acknowledgement of Receipt of Notice of Privacy Practices. _____(please initial)

_____ _____

Signature of Responsible Party Date

Mary Beth Tabor, DDS
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NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

Our legal duty: We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in the Notice while it is in effect. The Notice takes effect 11/01/2002, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of the Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for national copies of this Notice, please contact us using the information listed at the end of this Notice.

Uses and disclosures of health information.
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing actives.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Person Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information not the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

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I, _____ legal guardian of _____, have received a copy of this office's Notice of Privacy Practices.

_____
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
- □ Communication barriers prohibited obtaining the acknowledgement
- □ An emergency situation prevented us from obtaining acknowledgement
- □ Other (Please Specify)

_____

_____

_____