dr. meade moore
1908 Exeter, Germantown, TN 38138
germantowndds4kids.com

Account #_____

Child's Name _____ Date of Birth ____/_____/_____

Sex: ____Male ____Female

Medical and Dental History

Please answer all questions. This information is important for assessing your child's dental needs.

1. Is your child in good health? ___Yes ___No
2. Is your child up to date with immunizations? ___Yes ___No
3. Is your child being treated for any medical condition at this time? ___Yes ___No
   If yes, what? _____
4. Is your child taking any medications? ___Yes ___No. If yes, what? _____
5. Has your child ever been hospitalized since birth? ___Yes ___No. If yes, give approximate date(s) and reason(s):
   _____
6. Is your child allergic to: Any medications? ___Yes ___No. If yes, what? _____
   Dental anesthetics (Novacaine)? ___Yes ___No
   Any food? ___Yes ___No. If yes, what? _____
   Latex? ___Yes ___No
   Other? ___Yes ___No. If yes, please explain _____

7. Please **circle** any conditions which apply to your child:

Heart Condition	Brain Injury	Fainting/Seizures/Epilepsy
Heart Murmur	Cerebral Palsy	Hyperactive/ADD
Rheumatic Fever	Spina Bifida	Depression
Artificial Heart Valves	Down's Syndrome	Blood Transfusion
Congenital Heart Defect	Autism	Surgeries/Operations
Scarlet Fever	Hearing Disorder	Seasonal Allergies
Cancer/Tumors/Leukemia	Nervous Disorder	Chemotherapy
Speech Disorder	Reflux	Respiratory Problems
Vision Disorder	Fever Blisters	Asthma
Mouth Ulcers	Diabetes/Hypoglycemia	Emotional Disorder
Hemophilia	Behavioral Problems	Sickle Cell Anemia
Abnormal Bleeding	Jaw Problems/TMJ/TMD	Sickle Cell Trait
Latex Allergy	Tuberculosis	Birth Control Pills
High/Low blood Pressure	Cleft Lip/Cleft Palate	Organ Problems
HIV+/AIDS/ARC	Mental Condition	Hepatitis

Other _____

8. Is this your child's FIRST visit to the dentist? ___Yes ___No
9. Does your child have a toothache or is he/she in pain or discomfort at this time? ___Yes ___No
10. Does your child require pre-medication? ___Yes ___No
11. Please **circle** any of the following that pertain to your child:

Grinds teeth	Bites or sucks lip	Mouth breathing/snoring
Clenches teeth	Bites nails	Sleeps with a bottle
Sucks thumb or fingers	Jaw pain	Uses "Sippy" cup
Uses a pacifier	Jaw popping	Injury to teeth/mouth/jaw/face

Parent or Guardian's Signature_____ Date___/____/_____

dr. meade moore
pediatric dentistry

Account #_____

PATIENT INFORMATION

Child's Name_____
(First) (Middle) (Last)
Date of Birth_____ Age_____ Sex _____M _____F
Street Address_____
City_____ State_____ Zip_____
Home Phone_____
Child's Physcian/Pediatrician_____
School_____ Grade_____
Other children in family who are patients in this office_____
With whom does the child live?_____
Who is accompanying patient today? _____ Do you have legal custody? _____
What phone number should we use to confirm appointment? _____
Email to be used for this account _____
Text number to use for this account _____
Referred by_____

PARENT INFORMATION

Mother's Information

Name_____
Address_____
City_____ST_____Zip_____
Home Phone (___) ____ - _____
Work (___) ____ - _____
Cell (___) ____ - _____
Date of Birth_____
SSN_____-_____-_____
Employer_____
Email_____

Father's Information

Name_____
Address_____
City_____ST_____Zip_____
Home Phone (___) ____ - _____
Work (___) ____ - _____
Cell (___) ____ - _____
Date of Birth_____
SSN_____-_____-_____
Employer_____
Email_____

DENTAL INSURANCE INFORMATION

Insurance company_____
Insurance Co. Phone_____
Insured's Name_____
Employer of Insured: _____
Group #_____
Insured's DOB_____
Insured's SSN_____
Insured's ID_____
Relationship of Insured to patient_____

Signature (Parent or Legal Guardian)_____Date_____

Consent for Treatment/Payment

As parent/guardian of this patient, I hereby authorize Dr Meade Moore and his staff to accomplish necessary dental treatment on this patient. Furthermore, I will be responsible for any bill incurred by the dental treatment of this child, including reasonable attorney's fees and costs of collection in the event of default. I understand that payment is expected at the time that services are rendered. There will be a $25 charge for all returned checks.

I authorize this office to file dental claims on my behalf. I give permission for insurance benefits to be paid directly to Dr S Meade Moore, III, DDS, MS, and authorize Dr. Moore's office to release all information necessary to secure dental benefit payments.

Signature: _____ Date:_____
(parent/guardian)

Cancellation/Broken Appointment Policy

To provide our patients with the highest level of dental care, it is important to maintain a mutual respect for your time and ours. We work diligently to see our patients at their scheduled appointment times. Many times, we have a waiting list of patients for specific appointment times. **Consequently, we request a 24-hour notice in you need to change your child's appointment for any reason.** This extra time will allow us to contact patients on that waiting list, and to schedule them for their dental treatment.

If your child fails to show-up for their appointment **without prior notice** ("No Show"), then a broken appointment fee of $50.00 may be charged.

If an appointment is cancelled without 24-hour notice AND it is not due to illness of family emergency, we reserve the right to charge the broken appointment fee as listed above.

Broken appointment fees are NOT covered by dental insurance. Multiple broken appointments may result in future dental appointments not being scheduled in advance and/or the dismissal of the patient from our practice.

Signed: _____ Date:_____
(parent/guardian)

Acknowledgement of Receipt of Notice of Privacy Practices

(You may refuse to sign this acknowledgement)

I, _____(Child's name), has received a copy of this office's Notice Of Privacy Practices.

Please print Parent's/Guardian's name:_____

Signature of Parent/Guardian:_____ Date:_____

For Office Use only

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

___Individual refused to sign.
___Communication barriers prohibited obtaining the acknowledgement.
___An emergency situation precented us from obtaining acknowledgement.
___Other (Please specify):

S. Meade Moore, III, D.D.S., M.S.

Notice Of Privacy Practices

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices.

We must provide this Notice to the parent of each of our patients beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient's parent. We must also have the Notice available at the office for parents of patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any parents of patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to the parent of each new patient at the time of service delivery and to any person requesting a Notice.

to use or disclosure of your child's 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 child's healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your child's 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 child's health information for marketing communications without your written authorization.

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

Abuse or Neglect: We may disclose your child's health information to appropriate authorities if we reasonably believe that your child is a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your child's health information to the extent necessary to avert a serious threat to your child's health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your child's health information to provide you with appointment reminders(such as voicemail messages, postcards, or letters).

.PATIENT RIGHTS

Access: You have the right to look at or get copies of your child's health information, with limited exceptions. **You must make a request in writing to obtain access to your child's health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. If you request copies of your child's records, you will be charged as follows:** $0 for each page, $10 for each set of copies of bitewing x-rays per child (if applicable), $10 for each panoramic xray or ceph x-ray per child (if applicable), $10 per hour for staff time to locate and copy the child's health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your child's health information in that format. If you prefer, we will prepare a summary or an explanation of your child's health information for a fee. Contact us using the information listed at the end of this Notice for a more detailed explanation of our fee structure. **We require advance payment before copying your child's health information.**

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your child's health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your child's health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your child's health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your child's health information. **(Your request must be in writing, and it must explain why the information should be amended.)** We may deny your request under certain circumstances.

to use or disclosure of your child's 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 child's healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your child's 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 child's health information for marketing communications without your written authorization.

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

Abuse or Neglect: We may disclose your child's health information to appropriate authorities if we reasonably believe that your child is a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your child's health information to the extent necessary to avert a serious threat to your child's health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your child's health information to provide you with appointment reminders(such as voicemail messages, postcards, or letters).

.PATIENT RIGHTS

Access: You have the right to look at or get copies of your child's health information, with limited exceptions. **You must make a request in writing to obtain access to your child's health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. If you request copies of your child's records, you will be charged as follows:** $0 for each page, $10 for each set of copies of bitewing x-rays per child (if applicable), $10 for each panoramic xray or ceph x-ray per child (if applicable), $10 per hour for staff time to locate and copy the child's health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your child's health information in that format. If you prefer, we will prepare a summary or an explanation of your child's health information for a fee. Contact us using the information listed at the end of this Notice for a more detailed explanation of our fee structure. **We require advance payment before copying your child's health information.**

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your child's health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your child's health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your child's health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your child's health information. **(Your request must be in writing, and it must explain why the information should be amended.)** We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your child's privacy rights, or you disagree with a decision we made about access to your child's health information or in response to a request you made to amend or restrict the use or disclosure of your child's health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your child's health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Dr Meade Moore
1908 Exeter
Germantown TN 38138

ATTN: Receptionist

Phone: 901-683-3993

Fax: 901-683-8283