Rock Hill
Pediatric Dentistry

Jonathan M. Mitchell, DMD, PhD, MSD

2460 India Hook Road, Suite 106
Rock Hill, SC 29732
E-mail: drj@rockhillkids.com
Tel: (803) 327-3327
Fax: (803) 327-3330

PATIENT INFORMATION

Full Name:_____ Preferred Name:_____ Male:___ Female:___
Age:_____ Date of Birth:_____Interest/Hobbies/Pets:_____
Address:_____ City, State, Zip:_____

Parent/Guardian Information
( ) Mother ( ) Father ( ) Step Mother ( ) Step Father ( ) Guardian ( ) Other: _____
Name:_____ Preferred Name:_____ Date of Birth:_____
Address:_____ City, State, Zip:_____
Home Phone:_____ Cellular Phone:_____
Employer:_____ Occupation:_____
Work Phone:_____ Email:_____
Is this person legally responsible for the health care decisions for the above patient? ( ) Yes ( ) No

Parent/Guardian Information
( ) Mother ( ) Father ( ) Step Mother ( ) Step Father ( ) Guardian ( ) Other: _____
Name:_____ Preferred Name:_____ Date of Birth:_____
Address:_____ City, State, Zip:_____
Home Phone:_____ Cellular Phone:_____
Employer:_____ Occupation:_____
Work Phone:_____ Email:_____
Is this person legally responsible for the health care decisions for the above patient? ( ) Yes ( ) No

List anyone you **do not** want patient information released to:_____

List anyone who may accompany your child to an appointment and has permission to make decisions concerning their dental treatment:
(1) Name: _____ Phone Number: _____
Email: _____ Relationship: _____
(2) Name: _____ Phone Number: _____
Email: _____ Relationship: _____

MEDICAL HISTORY

Name of Pediatrician:_____ Office Phone:_____
Address:_____ City, State, Zip:_____
Has your child been hospitalized since birth? ___Yes ___ No
If Yes, please describe:_____
_____

Has your child had any allergic reactions to the following?

Medications? ___Yes ___ No If Yes, please describe?_____

Latex? ___Yes ___ No If Yes, please describe?_____

Foods? ___Yes ___ No If Yes, please describe?_____

Other? ___Yes ___ No If Yes, please describe?_____

Does your child have any history of the following medical concerns?

General conditions

___ Arthritis
___ Asthma
Controlled?_____
Last Attack?_____
___ Diabetes
___ Gastrointestinal Disorder
___ Heart Disease
___ Heart Murmur
___ Kidney Disease
___ Rheumatic Fever

Behavior/Learning

___ ADD/ADHD
___ Anxiousness/Nervousness
___ Autism
___ Asperger Syndrome
___ Behavioral Issues
___ Learning Disabilities
___ Psychiatric Disorder

Developmental

___ Brain Injury
___ Cerebral Palsy
___ Cleft Lip/Palate
___ Developmental Delay
___ Feeding/Eating problems
___ Growth Problems
___ Hearing Loss
___ Neuromuscular Defect
___ Orthopedic Problems
___ Seizures: Type _____
___ Speech Delay
___ Spina Bifida

Hematological (Blood-related)

___ Anemia
___ Hemophilia
___ Sickle Cell Trait
___ Sickle Cell Disease
___ Blood Transfusion

Infectious

___ Hepatitis
___ HIV Infection
___ AIDS
___ Tuberculosis

Other

___ Adenoids
___ Cancer
___ Leukemia
___ Fainting
___ Headaches
___ Skin Disorder
___ Sleep Apnea
___ Snoring
___ Latex Allergy
___ Syndrome
___ Tonsils
___ Tubes in ears
___ Other

If any checked, please describe further: _____

_____

Is your child currently taking any medications? If so, please list below.

Drug	How much? How often?	Reason

Have you ever been told your child requires antibiotic prophylaxis for dental treatment due to a medical condition (e.g., heart condition)? ___Yes ___ No. If Yes, please describe:_____

Physician following condition:_____ Office Phone:_____

Address:_____ City, State, Zip:_____

CONSENT FOR TREATMENT

I am the parent, guardian, or personal representative of the patient and there are no court orders now in effect that prevent me from signing this consent. I do hereby request and authorize Dr. Jonathan M. Mitchell and his staff to perform any necessary dental services including but not limited to comprehensive examinations, cleanings, x-rays and photographs as necessary for diagnostic purposes, any necessary treatment, and the administration of anesthetics that are deemed advisable by Dr. Mitchell. I understand that dental treatment for children includes efforts to guide their behavior by helping them understand the treatment in terms appropriate for their age. Dr. Mitchell will provide an environment that will help children learn to cooperate during treatment including praise, explanations, and demonstrations of procedures and instruments, and using variable voice tones. **I understand that if my child is receiving any type of restorative treatment, such as a filling, extraction, sedation, etc., I will not be accompanying them. I understand that I will be allowed to accompany my child for routine cleanings.** I will be responsible for any charges incurred for my child for dental treatment that insurance does not cover.

FINANCIAL POLICY

We appreciate you choosing Rock Hill Pediatric Dentistry for your child's dental health needs. Please familiarize yourself with the following information regarding financial obligations. If you have any questions regarding our financial policy, please ask the administrative staff for assistance.

Fees incurred are due in full when services are rendered. Payments may be made by the following options: Cash, Money Orders, Bank Issued Checks, MasterCard, Visa, and Discover.

We also accept dental insurance and as a courtesy will file your insurance for you. We are a participating provider with most major insurance plans. Please contact your insurance company for verification of dental benefits. **You must understand that it is your responsibility to ensure that we are in network with your dental insurance company. While we accept most plans, we may not necessarily be in network**. Some insurance companies recommend a pre-treatment authorization for the dental treatment to be provided and fees to be incurred prior to determining their benefits to you. We will attempt to estimate any out of pocket expenses prior to your visit to our office. P**lease be prepared for any deductible, co-pay, or other expenses at the time of service**. If, for any reason, your insurance company does not respond with financial payment within 45 days post treatment, the balance is due and payable in full immediately by the parent/legal guardian financially responsible. The parent/legal guardian is responsible for payment of all patient accounts. We do not get involved in custody and/or financial disputes, which may or may not involve court orders. **Additionally, if we provide you with an estimate, you must understand that it is only an estimate. Insurance may pay more or less. In the event that they pay less thane estimated, you will be responsible for the balance.**

In the event of default payment (over 90 days past due), I understand that my account will be sent over to a collection agency and our family will be dismissed from the practice.

APPOINTMENT POLICY

Rock Hill Pediatric Dentistry reserves a specific time for your child according to their treatment needs and level of cooperation. We make every effort to see your child at their appointed time. Inadvertent delays, such as emergencies and unforeseen patient treatment problems, may arise causing schedule changes. Should your child's appointment time be delayed, please accept our apology. Your patience is very much appreciated under these circumstances.

If at all possible, please arrive 5 to 10 minutes prior to your child's scheduled appointment. This will allow time to complete any necessary paperwork. **If you arrive 10-15 minutes beyond your appointment time, you may be asked to reschedule for the next available appointment time.**

As a courtesy, our office will attempt to contact you to confirm your child's appointment; however, we ask that you assume responsibility for your child's appointed time. If you need to reschedule an appointment, we ask that you provide our office with a 24-hour notice so that we may extend the appointment time to another patient. **Multiple (2) broken/missed appointments without prior cancellation notice may be subject to dismissal from the practice. If a sedation or surgery appointment is broken/missed, that will result in immediate dismissal from the practice.**

I certify that all the information provided is correct and I have reviewed all of the office policies.

Signature of Parent/Legal Guardian: _____ Date:_____

AUTHORIZATION FOR RELEASE OF INFORMATION

This form must be completed by the parent/legal guardian of the patient whose protected health information is to be disclosed.

Patient Name: _____ Date of Birth: _____
I hereby authorize **Rock Hill Pediatric Dentistry** to release the following personal health information for: (check all that apply)
_____ Entire Record
_____ Financial Information
_____ Office Visit Notes
_____ X-rays

The above information may be released by:
____ Phone ____ Email ____ Fax ____ Mail

Acknowledgement
I agree that the dental practice of **Rock Hill Pediatric Dentistry** may communicate with me electronically at the email address/phone number below, including text communication and voicemail.

I understand that if information is not sent in an encrypted (secure) manner, there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.

Name: _____ Phone Number: _____
Email: _____ Relationship: _____

Name: _____ Phone Number: _____
Email: _____ Relationship: _____

Patient's Rights:

- I have the right to revoke this authorization at any time in person or in writing.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I may refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand released information may include a communicable disease diagnosis such as HIV or a diagnosis related to mental health or substance abuse.

This authorization will remain in effect until revoked by the patient in writing.

Signature of Parent/Legal Guardian: _____ Date:_____

*****FOR OFFICE USE ONLY*****

REVOKED
___ In Person on _____ (Date) If in person, signature is required.
Signature of Parent/Legal Guardian: _____
___ In Writing (Place a copy in patient's file)