YOUR CHILD

Name: _____ _____ _____
Last Name First Name Middle Initial
Birthdate: _____ Age: _____ Soc. Sec #: _____ Home Phone: _____

Child's Home Address:

_____
Street City State Zip

RESPONSIBLE PARTY

Name _____ Relationship _____

Mailing Address :_____

Soc. Sec. # _____ D.O.B. _____ Home Phone _____

Email
Address:_____

PRIMARY DENTAL INSURANCE

Insured's Name:_____ Relationship:_____
Insured's Address (if different)

_____
Insured's Phone: _____Insured's DOB:_____ Insured's Soc. Sec #:_____

Employer :_____ Insurance Company:_____

SECONDARY DENTAL INSURANCE

Insured's Name:_____ Relationship: _____
Insured's Address (if different)

_____
Insured's Phone:_____ Insured's DOB: _____ Insured's Soc. Sec #: _____

Employer :_____ Insurance Company:_____

Circle One : MOTHER STEPMOTHER LEGAL GUARDIAN
Name: _____ Soc. Sec. #: _____
Home Phone: _____ Cell Phone:_____ Work Phone:_____

Date of Birth: _____ Employer: _____

FATHER STEPFATHER LEGAL GUARDIAN
Name :_____ Soc. Sec. #: _____
Home Phone:_____ Cell Phone:_____ Work Phone:_____

Date of Birth:_____ Employer :_____

HEALTH HISTORY

Has your child ever had any of the following:

☐ Asthma
☐ Rheumatic Fever
☐ Cancer
☐ Mitral Valve Prolapse
☐ Hepatitis
☐ Handicaps/Disabilities
☐ HIV/AIDS
☐ Convulsions/Epilepsy
☐ Hemophilia
☐ Tuberculosis
☐ Diabetes
☐ Abnormal Bleeding
☐ Allergies
☐ Heart Murmur

ALLERGIES

☐ Aspirin
☐ Latex
☐ Codeine
☐ Local Anesthetic
☐ Iodine
☐Penicillin
☐ Sulfa
☐Other: _____

Has your child ever been hospitalized? _____ Reason:_____

Please explain any medical problems that your child has:_____
_____

MEDICATIONS:

List any medications your child is currently taking:_____
_____

Pharmacy Name: _____ Phone Number:_____

Former Dentist:_____ Phone Number:_____

Have you ever visited a specialist (Oral Surgeon, Orthodontist, Endodontist) If Yes:_____

AUTHORIZATION AND 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 authorize the Dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the Dentist or dental group insurance benefits otherwise payable to me. I understand that my dental 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 of my dependents. I also understand that Farni and Farni Dentistry is a Non Amalgam practice and I may be responsible for the difference between amalgam and composite fillings. I also accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all costs of collection, (33%), attorney fees and/or court costs, if such be necessary. I waive now and forever my rights of exemption under the laws of the constitution of the State of Alabama and any other State. I also give Farni and Farni Dentistry, its employees and/or agents "express prior consent" to contact me at any/all phone numbers, including cell phone numbers (by phone call or text message), for the purpose of treatment, insurance, or payment.

_____Date: _____
Signature of Parent or Guardian of Minor

Farni & Farni Family Dentistry L.L.P

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

CONSENT FOR USE AND DISCOLOSURE OF HEALTH INFORMATION

Purpose of Consent: By signing this form you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide to sign this consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it completely and carefully before signing this Consent.

We reserve the right to change our privacy practices as they are described in our Notice of Privacy Practices. If we change our privacy practices we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information we maintain.

I have had full opportunity to read and consider the contents of this Consent form and Notice of Privacy Practices. **I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations only.**

*_____Please

Print Patient's Name Date

*_____

Patient's Signature/Guardian of Minor Date

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

REVOCATION OF CONSENT: Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. **I understand that my revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.**

*_____

Please Print Patient's Name Date

*_____

AUTHORIZATION AND RELEASE

I understand that it is my responsibility to inform the dental office of any changes in my medical status or insurance coverage. I authorize the Dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the Dentist or dental group insurance benefits otherwise payable to me. I understand that my dental 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. Our practice no longer does amalgam (metal fillings). We now only use composite or tooth colored fillings. I understand that Farni and Farni Dentistry is a Non Amalgam practice and I may be responsible for the difference between amalgam and composite fillings. I also accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all costs of collection, (33%), attorney fees and/or court costs, if such be necessary. I waive now and forever my rights of exemption under the laws of the constitution of the State of Alabama and any other State. I also give Farni and Farni Dentistry, its employees and/or agents “express prior consent” to contact me at any/all phone numbers, including cell phone numbers (by phone call or text message), for the purpose of treatment, insurance, or payment.

Patient Signature:_____Date_____