

**Pediatric Dental Specialists**  
Samuel S. Kwon, D.M.D.  
3635 Braselton Hwy. Ste C  
Dacula, GA 30019  
**CHILD'S REGISTRATION**

Patient Name: _____	Birth Date: _____ / _____ / _____
First                      Middle                      Last	
Patient Name: _____	Birth Date: _____ / _____ / _____
First                      Middle                      Last	
Patient Name: _____	Birth Date: _____ / _____ / _____
First                      Middle                      Last	
Patient Name: _____	Birth Date: _____ / _____ / _____
First                      Middle                      Last	

<b>Patient lives with:</b> <input type="checkbox"/> Both Parents <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other: _____	
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced
<b>Father's Name:</b> _____	<b>Mother's Name:</b> _____
First                      Middle                      Last	First                      Middle                      Last
Street Address: _____	Street Address: _____
City: _____ Zip: _____	City: _____ Zip: _____
S.S.#: _____ DOB: _____	S.S.#: _____ DOB: _____
Home Phone: _____	Home Phone: _____
Work Phone: _____	Work Phone: _____
Mobile Phone: _____	Mobile Phone: _____
Employer: _____	Employer: _____
Occupation: _____	Occupation: _____

<b>Who is Accompanying the Child Today?</b>	Whom may we thank for referring you to our office?
Name: _____	_____
First                      Middle                      Last	
Relationship: _____	
Do you have legal custody of this child? <input type="checkbox"/> Yes <input type="checkbox"/> No	

<b>DENTAL INSURANCE INFORMATION</b>
Subscriber Name: _____
Ins. Co. Name: _____
Group Plan/Employer's Name: _____
Insurance Co. Address: _____
Insurance Co. Phone #: _____
Group #: _____
Insured ID #: _____

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**PRIVACY POLICY ACKNOWLEDGEMENT STATEMENT**

I have been told that **Pediatric Dental Specialists** has a Privacy Policy in place according to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). As a patient of Pediatric Dental Specialists, I understand and acknowledge the following:

- ◆ **Pediatric Dental Specialists** has a privacy policy in effect in their office.
- ◆ **Pediatric Dental Specialists** has made this policy available to me and has made me aware, that as a patient, I am entitled to a copy of this privacy policy if I desire a copy for my personal files.

After reading these statements please sign at the bottom acknowledging that you have been advised of the privacy policy implemented by **Pediatric Dental Specialists**, and have read and understand the acknowledgement form. If you would like a copy of the privacy policy, please ask for one at our front desk.

\_\_\_\_\_ **No, I do not want a copy of the policy but I do acknowledge that it exists.**

\_\_\_\_\_ **Yes I have requested and been given a copy of the privacy policy.**

\_\_\_\_\_  
Patient Name Date

\_\_\_\_\_  
Patient Name Date

\_\_\_\_\_  
Patient Name Date

\_\_\_\_\_  
Patient Name Date

\_\_\_\_\_  
Parent/Guardian Signature Date

For more information, please contact Pediatric Dental Specialists at (678) 714-7575.

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Office Contact Person: Dr. Samuel S. Kwon (678) 714-7575

**AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION**

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

I authorize the professional office of my dentist named above to release health information identifying me [including if applicable information about HIV infection or AIDS, information about substance abuse treatment and information about mental health services] under the following terms and conditions:

- 1. Detailed description of the information to be released:
- 2. To whom may the information be released [name(s) or class(es) of recipients]:
- 3. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state at the request of the individual" as the purpose, if desired by the individual):
- 4. Expiration date or event relating to the individual or purpose for the release:

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

[For marketing authorizations, include, as applicable: We will receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.]

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated \_\_\_\_\_ Patient/Guardian signature \_\_\_\_\_

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to patient \_\_\_\_\_ Print Name \_\_\_\_\_

Source of Authority \_\_\_\_\_