Children's Dental Health Center

PATIENT LAST NAME:_____ FIRST:_____ INITIAL:_____

Nickname/Preferred Name:_____ DOB:_____

Parent or Legal Guardian:_____ Relationship to Child:_____

Address:_____ City:_____ State:_____ Zip:_____

Telephone (Mobile):_____ Work:_____ Home:_____

Email:_____@_____ How did you hear about our practice:_____

INSURANCE INFORMATION (*PLEASE PRESENT YOUR INSURANCE CARD TO BE PHOTOCOPIED FOR OUR RECORDS)*

Primary Insurance	Secondary Insurance
Subscriber Name _____	Subscriber Name _____
Subscriber ID _____	Subscriber ID _____
Date of Birth _____	Date of Birth _____
Relationship to Subscriber Self Spouse Child Other	Relationship to Subscriber Self Spouse Child Other
Employer Name _____	Employer Name _____
Employer Phone _____	Employer Phone _____
Insurance Company _____	Insurance Company _____
Insurance Group _____	Insurance Group _____
Insurance Phone _____	Insurance Phone _____

EMERGENCY CONTACT

Last Name:_____ First:_____ Initial:_____ DOB:_____

Address (if different above)_____ City:_____ State:_____ Zip_____

Telephone (Home):_____ (Work)_____ (Mobile)_____

Email:_____@_____ Relationship to Parent:_____

Authorization

I consent to the diagnostic procedures and dental treatment performed by my dentist, and to the release of information concerning my (or my child's) healthcare, advice, and treatment to another dentist, or for evaluating and administering any claims for insurance benefits. I consent to the direct payment of my insurance benefits to dentist or dental group and understand that my insurance benefits may pay less than the actual bill for services and that I am responsible for any services not paid or covered by my insurance benefits and any account balance.

ELECTRONIC COMMUNICATIONS. I consent to receiving HIPAA-compliant electronic communications, such as email and text messages regarding treatment, payment and health care operations. I understand that there is no obligation to receive these electronic communications. Message/data rates may apply, and I may opt-out of receiving electronic communications at any time. I attest to the accuracy of the information on this page.

*Signature:*_____ *Date:*_____
Responsible party, if under 18

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DENTAL HISTORY

PATIENT FULL NAME:_____DOB_____TODAY'S DATE_____

What is the primary concern of your child's oral health? _____

Does your child have any of the following? For any YES responses, please describe:

Inherited dental characteristics	*□yes □no*	
Mouth sores or fever blisters	*□yes □no*	
Bad Breath	*□yes □no*	
Bleeding gums	*□yes □no*	
Cavities/decayed teeth	*□yes □no*	
Toothache	*□yes □no*	
Injury to teeth, mouth or jaw	*□yes □no*	
Clinching/grinding his/her teeth	*□yes □no*	
Jaw joint (popping etc.)	*□yes □no*	
Excessive gagging	*□yes □no*	
Does someone help your child brush?	*□yes □no*	
How often does your child floss?	*NEVER OCCASIONALY DAILY*	
Does your child have a diet high in sugars and starches?	*□yes □no*	
Does/Did your child a sucking habit after one year of age?	*□yes □no*	
If yes, which: FINGER THUMB PACIFIER OTHER: _____	*For how long?_____*	

Please check all sources of fluoride your child receives: □ *Fluoride treatment in dental office*
□ *Drinking Water* □ *Toothpaste* □ *Over-the-counter rinse* □ *Prescription rinse/gel* □ *Prescription drops/tablets/vitamins*

How frequently does your child have the following:

-Candy or other sweets	*RARELY*	*1-2 times a day*	*3 or more times a day*
-snacks between meals	*RARELY*	*1-2 times a day*	*3 or more times a day*
-juices	*RARELY*	*1-2 times a day*	*3 or more times a day*
- fruit flavored drinks	*RARELY*	*1-2 times a day*	*3 or more times a day*
- c o la ' s/so d a ' s/c a rb o n a te d d rink s	*RARE LY*	*1 -2 times a day*	*3 or more times a day*
-sports drinks or energy drinks	*RARELY*	*1-2 times a day*	*3 or more times a day*

*Please note other significant dietary habits:*_____

Does your child participate in sports or similar activities	*□yes □no*	
Does your child wear a mouthguard during these activities	*□yes □no*	
Has your child been examined by another dentist	*□yes □no*	
*Date of last visit*_____		
Has your child had orthodontic treatment	*□yes □no*	
*When*_____		
Has your child ever had a difficult dental experience	*□yes □no*	
*Please describe:*_____		

PATIENT NAME PATIENT OR GUARDIAN SIGNATURE DATE

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Medical History

*Childs Full Name:*_____ *Nickname:* _____ *Date of Birth*___/____/____
*Gender: M/ F Race/Ethnicity:*_____ *Height:* _____ *Weight:*_____ *Date of last physical examination* _____
Name/address/phone of primary physician: _____
*Name/address/phone of medical specialists:*_____
Is your child being treated by a physician at this time? □*yes* □*no*
Reason _____
Is your child taking any medications? Prescriptions, over the counter, vitamins? □*yes* □*no*
*List name,dose,frequency & date started:*_____
Has your child ever been hospitalized, had surgery or a significant injury, or been treated in an emergency department? □*yes* □*no*
*List date & describe:*_____
Has your child ever had a reaction to or problem with an anesthetic? □*yes* □*no*
*Describe*_____
Has your child ever had a reaction or allergy to an antibiotic, sedative, or other medications? □*yes* □*no*
*List*_____
Is your child allergic to latex or anything else such as metals, acrylic, or dye? □*yes* □*no*
*List*_____
Is your child up to date on immunizations against childhood diseases? □ *yes* □ *no*

Please mark YES if your child has a history of the following conditions. For each "YES", provide details in the box at the bottom of this list. Mark NO after each line if none of these conditions applies to your child.

Complications before or during birth, prematurity, birth defects, syndromes, or inherited conditions □*yes* □*no*
Problems with physical growth or development □ *yes* □
no Sinusitis, chronic adenoid/tonsil infections □*yes*
□*no Sleep apnea/snoring, mouth breathing, or excessive gagging* □ *yes*
□ *no Congenital heart defect/disease, heart murmur, rheumatic fever, or rheumatic heart disease* □*yes*
□*no Irregular heart beat or high blood pressure* □ *yes*
□ *no Asthma, reactive airway disease, wheezing, or breathing problems* □*yes*
□*no Cystic fibrosis* □ *yes*
□ *no Frequent colds or coughs, or pneumonia* □*yes*
□*no Frequent exposure to tobacco smoke* □ *yes*
□ *no Jaundice, hepatitis, or liver problems* □*yes*
□*no Gastroesophageal/acid reflex disease (GERD), stomach ulcer, or intestinal problems* □ *yes*
□ *no Lactose intolerance, food allergies, nutritional deficiencies, or dietary restrictions* □*yes*
□*no Prolonged diarrhea, unintentional weight loss, concerns with weight, or eating disorders* □ *yes*
□ *no Bladder or kidney problems* □*yes*
□*no Arthritis, scoliosis, limited use of arms and legs, or muscle/bone/joint problems* □ *yes*
□ *no Rash/hives, eczema or skin problems* □*yes*
□*no Impaired vision, hearing or speech* □ *yes*
□ *no Developmental disorders, learning problems/delays, or intellectual disability* □*yes*
□*no Cerebral palsy, brain injury, epilepsy, or convulsions/seizures* □ *yes*
□ *no Autism/autism spectrum disorder* □*yes*
□*no Recurrent or frequent headaches/migraines, fainting, or dizziness* □ *yes*
□ *no Hydrocephaly or placement of a shunt (ventriculoperitoneal, ventriculoatrial, ventriculovenous)* □*yes*
□*no Attention deficit/hyperactivity disorder(ADD/ADHD)* □ *yes*
□ *no*

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Medical History Continued

Behavioral, emotional, communication, or psychiatric problems/treatment □*yes* □*no*
Abuse (physical, psychological ,emotional, or sexual) or neglect □ *yes* □
no Diabetes, hyperglycemia, or hypoglycemia □*yes*
□*no Precocious puberty or hormonal problems* □ *yes*
□ *no Thyroid or pituitary problems* □*yes*
□*no Anemia, sickle cell disease/trait, or blood disorder* □ *yes*
□ *no Hemophilia, bruising easily, or excessive bleeding* □*yes*
□*no Transfusions or receiving blood products* □ *yes*
□ *no Cancer, tumor, other malignancy, chemotherapy, radiation therapy, or bone marrow or organ transplant* □*yes*
□*no Mononucleosis, tuberculosis (TB), scarlet fever, cytomegalovirus (CMV), methicillin resistant staphylococcus aureus (MRSA), sexually transmitted disease (STD), or human immunodeficiency (HIV)/AIDS* □*yes* □*no*

PROVIDE DETAILS HERE:

_____
_____
_____
_____
_____
_____

Is there any other significant medical history pertaining to this child or his/her family that the dentist should be told? □*yes* □*no*
Please describe:

_____
_____
_____
_____
_____

Authorization & Release

I have read and answered the above questions to the best of my knowledge.

_____	_____	_____
PATIENT NAME	PATIENT OR GUARDIAN SIGNATURE	DATE

OFFICE USE ONLY:

REVIEWED BY:_____DATE_____
REVIEWED BY:_____DATE_____
REVIEWED BY:_____DATE_____
REVIEWED BY:_____DATE_____
REVIEWED BY:_____DATE_____
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CONSENT FOR SOCIAL MEDIA & ELECTRONIC COMMUNICATION

I, (print name)_____, consent for Children's Dental to use photographs or videos of myself and/or my family members on their social media tools (Instagram, Facebook, Twitter, etc.) I also consent Children's Dental to send me link for office reviews via text and/or email. I understand my information, images and/or videos will not be used for any other commercial purposes.

Signature: _____ Date: _____

Family Members included in consent:

*1.*_____ *3.*_____ *5.*_____

*2.*_____ *4.*_____ *6.*_____

PATIENT/RELATIVE HIPAA CONSENT

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out: Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment). Obtaining payment from third party payers (e.g. my insurance company). The day to day healthcare operations of your practice I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

I,_____, understand that by signing this Consent form, I am giving my consent to Children's Dental & Orthodontics to disclose
and discuss my protected health information to carry out treatment, payment activities and health care operations with the following family member:

Name:_____Relationship: _____

Children's Dental Health Center

CDO FINANCIAL POLICY

Children's Dental & Orthodontics, collectively known as "CDO" and affiliated companies are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

- **ALL PATIENTS MUST COMPLETE OUR "PATIENT INFORMATION FORM" BEFORE SEEING THE DENTALPROFESSIONAL.**
- **FULL PAYMENT IS DUE AT TIME OF SERVICE.**
- **WE ACCEPT CASH, CHECKS, AMERICAN EXPRESS, VISA, MASTER CARD, DISCOVER AND CARE CREDIT.**
- **CDO PROVIDES INSURANCE COMPANY BILLING AS A COURTESY TO OUR PATIENTS. THE PATIENT PORTION OF PARTICULAR DENTAL SERVICE(S) IS ESTIMATED AND DUE AT THE TIME OFSERVICE.**

ADULT PATIENTS

Adult patients are responsible for full payment at time of service.

MINORS ACCOMPANIED BY AN ADULT

The adult accompanying a minor, his/her parents or guardians, are responsible for full payment at time of service.

UNACCOMPANIED MINORS

The parents or guardians are responsible for full payment at time of service. Non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, or to Visa, Master Card or Discover. We do not accept American Express payments for visits by unaccompanied minors.

INSURANCE

CDO provides insurance company billing as a *courtesy* to our patients. The patient portion of particular dental service(s) is estimated and due at the time of service. This amount may be subject to adjustment when the dental service(s) claim(s) are adjudicated by the insurance company. In addition, certain insurance companies have annual limitation for the amount of dental services that can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for the full amount of dental services that exceed the particular plan's limitations. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The patient may not rely upon any information provided by CDH staff regarding his/her remaining benefit in any such benefit period.

The claims we submit to insurance companies indicate that you have assigned those benefits to CDO. However, if you are paid by the insurance company instead of CDO, you then become responsible for the total account balance and payment would be expected immediately.

If you or your family has more than one dental insurance program, we will assist you in obtaining the maximum benefits available.

You as a patient are always responsible for any charges that are not covered by your insurance.

DELINQUENT PAYMENTS

It is our policy to charge finance fees at 1.5% for outstanding patient balances after the balance has been outstanding 30 days. In addition, all payments returned due to non-sufficient funds will be subject to a NSF fee of $25.00.

MISSED APPOINTMENTS

Unless cancelled at least 48 hours in advance, our policy is to charge for missed appointments at the rate of $35.00 per each 30 minutes of missed appointment time. Please help us service you better by keeping scheduled appointments.

Thank you for understanding and accepting our Financial Policy. Please let us know if you have any questions or concerns.

Responsible party signature:_____ Date:_____

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LITTLE MONSTER FORM

NAME:_____ **AGE:**_____

SCHOOL NAME:_____

GRADE:_____ **FAV. SUBJECT:**_____

FAVORITE FOOD:_____

FAVORITE SONG/BAND:_____

FAVORITE COLOR:_____

WHEN I GROW UP, I WANT TO BE…

_____

Initial Exam, X-Rays & Cleaning Informed Consent

Patient Name: _____ **DOB:** _____

Minor Child Consent

I, being the parent or guardian of _____

_____**(minor child name(s)), do hereby request and authorize the dental staff to perform necessary dental services for my child, including x-rays, nitrous oxide (laughing gas), administration of anesthesia, and any services deemed advisable by the doctor, even if I am not present in the operatory during the dental treatment. (_____)initial**

Permission to Treat

Because your child is a minor it is necessary to have signed permission from a parent or guardian. The signature affixed below authorizes examination and treatment as necessary and the use of procedures the doctor may deem necessary during the performance of dental services. Furthermore the undersigned accepts responsibility of any financial obligations incurred for treatment of this patient. Photos and other dental records of my child may be used for teaching or instructional purposes.(_____)initial

1. **Examinations & X-rays:** I understand that the initial visit will require radiographs in order to complete the examination, diagnosis and treatment plan. I understand that Children's Dental and Orthodontics will perform an examination, resulting in patient's diagnosis and a treatment plan. It is Children's Dental and Orthodontics standard of care to perform two examinations and two sets of dental x-rays twice a year, typically every 6 months *regardless of insurance frequencies, limits, and/or payment.* (_____)initial
2. **Dental Prophylaxis & Fluoride (Cleaning-healthy mouth):** I understand that this type of cleaning is preventative in nature and intended for patients with healthy gums, and is limited to the removal of plaque and extremely light tartar and stain from the tooth structures in the absence of periodontal (gum) disease. This type of cleaning ***prevents*** gingivitis and gum disease. Fluoride is a safe and effective adjunct in reducing the risk of caries and reversing enamel demineralization. (_____)initial
3. **Sealants-** are a thin coating painted on the chewing surfaces of teeth. Sealant is a safe and effective method of reducing tooth decay in the occlusal grooves and pits of posterior teeth usually the premolars and molars (_____)initial
4. **Changes in Treatment Plan(s):** I understand that during treatment, it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during the examination, with the most common being root canal therapy following routine restorative procedures. I give my permission to Children's Dental and Orthodontics to make changes and additions as necessary.(_____)initial

_____ _____

Patient Signature (Parent/Guardian if minor child) **Date**

_____ _____

Printed Name of Parent or Guardian if minor child **Relation to Patient, if minor child**