ABOUT OUR OFFICE

APPOINTMENT TIMES

Our office makes every attempt to make scheduling your child's appointment as easy as possible. We have implemented a few guidelines in order to accommodate the majority of our patients.

Cleaning Appointments:
All children 6 years old and under will always be seen in the morning. This includes all children in kindergarten and preschool. This will allows us to see older patients in the afternoon time when it is more important not to miss school.

Filling Appointments:
Generally, children 8 years old and younger will be seen in the morning for filling appointments. The purpose for this is, children of this age tend to be too tired for late day appointments and do not handle the treatment as well. Also the office tends to be a bit slower in the morning which allows extra time for children that might be fearful.

Promptness:
Please schedule times that you are able keep. Many of our parents schedule after school appointments in which they wait for their child to get home from the bus or do not factor after school traffic. This often results in our patients arriving 10 to15 minutes late. The result is our schedule not running as assigned which is unfair to patients who arrive on time. Please take the appropriate measures to see that your child arrives on time to their visit. As a general rule patients that arrive more than 10 minutes late may not be seen.

DENTAL X-RAYS

We follow the guidelines established by the American Academy of Pediatric Dentistry for all treatment. We do not take dental x-rays every year just for the sake of it. Each child is treated as an individual, if your child has a dental decay history we tend to take them every year. If your child has no dental decay than we tend to take x-rays every 18 months to 24 months.

If you are present with your child we will always ask before we take dental x-rays. If you are not present with your child (a grand parent, family member or older sibling brings your child) we will update your child's x-rays if they are deemed necessary.

PAYMENT AND INSURANCE

Payment is expected at the time of treatment. Payments may be made by cash, check or credit card. If you are covered by a insurance plan any portion not covered by your insurance is expected at the time of treatment including deductibles and/or patient portions. Any account balance 60 days old will be subject to a finance charge of 1.5 % per month (18% per year) on the unpaid balance.

Pediatric Dental Associates is not responsible for the determination of benefits provided by your insurance company. Currently we estimate that we accept approximately one thousand insurance plans. Our office will make every effort to help you with your benefits. If your insurance carrier does not allow for the payment of a particular treatment than you will be responsible for the payment. If your company only recognizes a percentage of our fee you will be responsible for the difference.

NOTICE OF PRIVACY PRACTICES

Our office follows all HIPAA regulations concerning the confidentiality of patient records and information.
I have received a copy of this office's Notice of Privacy Practices, and give consent for the use and disclosure of health information to carry out treatment, payment activities and healthcare operations.

I the under signed have read and understand the policies and practices of Pediatric Dental Associates

_____

Your signature **Date**

PEDIATRIC DENTAL ASSOCIATES

GENERAL PARENT INFORMATION

The child lives with [ ]mother [ ]father [ ]both parents [ ]other_____

FATHER:
Name_____
SSN _____ DOB _____
HOME ADDRESS:
STREET_____
CITY _____STATE____ ZIP_____
HOME PHONE: _____CELL_____
OCCUPATION: _____
EMPLOYER: _____
BUSINESS ADDRESS: _____
BUSINESS PHONE: _____

MOTHER:
Name_____
SSN _____ DOB _____
HOME ADDRESS:
STREET_____
CITY _____STATE____ ZIP_____
HOME PHONE: _____CELL_____
OCCUPATION: _____
EMPLOYER: _____
BUSINESS ADDRESS: _____
BUSINESS PHONE: _____

DENTAL INSURANCE INFORMATION

PRIMARY CARRIER

INSURANCE COMPANY _____
EMPLOYEE _____
GROUP NO. _____
SUBSCRIBER NO. _____

SECONDARY CARRIER

INSURANCE COMPANY _____
EMPLOYEE _____
GROUP NO. _____
SUBSCRIBER NO. _____

MEDICAL INSURANCE INFORMATION

INSURANCE COMPANY _____
EMPLOYEE _____
GROUP NO. _____
SUBSCRIBER NO. _____

In order to comply with most insurance companies, we ask you to sign below so that we may keep your signature on file.
I have reviewed the following treatment plan. I authorize release of any information relating to this claim I hereby authorize payment directly to Pediatric Dental Associates insurance benefits otherwise payable to me.

_____
Signature of insured person

Pediatric Dental Associates

Child's Name: _____ Nickname: _____ Sex: ☐ M ☐ F
Age: ____ Birthdate: _____ Hobbies/Interests/Pets: _____
Mailing Address: _____ City: _____ State: ___ Zip: _____
Home Telephone: _____ Cell Phone: _____
Whom may we thank for referring you? _____

Child's Physician/Pediatrician: _____ Phone: _____
Address: _____
Child's Previous Dentist: _____

Medical History

1. Were there any difficulties during the pregnancy, delivery (e.g. prematurity) or 1st year of your child's life?
☐ Yes ☐ No If yes, describe _____
Was your child bottle fed? ☐ Yes ☐ No If yes, until what age? _____
Was your child breast fed? ☐ Yes ☐ No If yes, until what age? _____
Is your child allowed to carry a bottle or cup throughout the day containing something other than water?
☐ Yes ☐ No If yes, describe. _____

2. Does your child have any history of the following? (*Check all that apply.*)

General conditions
☐ Arthritis
☐ Asthma
☐ Bladder problems
☐ Diabetes
☐ Gastrointestinal disorders
☐ Heart disease
☐ Heart murmur
☐ Kidney disease
☐ Rheumatic fever
☐ Sinus problems
☐ Sleep apnea
☐ Sleep problems
☐ Snoring
☐ Thyroid 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 problems
☐ Spina Bifida

Behavior/LearningBlood-related
☐ ADHD
☐ Anxiety/Nervousness
☐ Autism
☐ Behavior issues
Type:_____
☐ Emotional disability
Type: _____
☐ Learning disability
Type: _____
☐ Psychiatric disorder
Type: _____

Substance use/Abuse
☐ Drug use
☐ Tobacco use
☐ Abuse (physical/sexual)

☐ Anemia
☐ Bleeding (prolonged)
☐ Hemophilia
☐ Sickle cell disease
☐ Blood transfusion

Infectious
☐ Hepatitis
☐ HIV/AIDS
☐ Tuberculosis

Other
☐ Fainting/Headaches
☐ Cancer: _____
☐ Syndrome: _____
☐ Other: _____
_____

If any boxes are checked, please describe further: _____
_____
_____

3. Is your child CURRENTLY taking any medications? ☐ Yes ☐ No

Drug	*How much and how often?*	*Reason*

4. Has your child had any allergic reactions to: Medications? ☐ Yes ☐ No Latex? ☐ Yes ☐ No
Foods? ☐ Yes ☐ No Other? ☐ Yes ☐ No _____

5. Development/Special Needs:
Can your child speak and understand at his/her age level? ☐ Yes ☐ No
Does your child attend a special class or school? _____ ☐ Yes ☐ No

6. Are your child's immunizations current? ☐ Yes ☐ No

7. Does your child need to take antibiotics before dental treatment? ☐ Yes ☐ No

8. Has your child ever been hospitalized? ☐ Yes ☐ No
When? _____ Where? _____ Reason? _____

9. Has your child had any surgery? ☐ Yes ☐ No
When? _____ Why? _____ Was general anesthesia used? ☐ Yes ☐ No
Any complications? _____

Dental History

10. Why is your child here today? _____

11. If your child has been to a dentist: Date of last visit _____ Have X-rays been taken? ☐ Yes ☐ No
How did your child react? _____

12. Is fluoride taken in any of the following forms?
Fluoride tablets or fluoride multivitamins ☐ Yes ☐ No Drinking water ☐ Yes ☐ No
Toothpaste ☐ Yes ☐ No Fluoride rinse ☐ Yes ☐ No

13. Does your child brush his/her own teeth? ☐ Yes ☐ No
When does your child brush? ☐ AM ☐ PM ☐ After meals # of times/day _____
Do you help brush your child's teeth? ☐ Yes ☐ No # of times/day _____
Does your child use floss? ☐ Yes ☐ No # of times/week _____
What kind of toothbrush does your child use? ☐ Manual ☐ Battery-powered/Electric
Does your child swallow toothpaste? ☐ Yes ☐ No

14. Does your child snack frequently? ☐ Yes ☐ No # of times/day _____
If yes, what do those snacks usually consist of? _____
Does your child drink juice? ☐ Yes ☐ No How much? _____
Does your child drink soda? ☐ Yes ☐ No How much? _____
Does your child drink sports drinks (e.g. Gatorade, Propel)? ☐ Yes ☐ No How much? _____
Does your child chew gum? ☐ Yes ☐ No

15. Have your child's teeth ever been injured? ☐ Yes ☐ No When (age)? _____
Which teeth? _____ Injury? _____
Treatment? _____

16. Does your child have any of the following habits?
Thumb/finger sucking ☐ Yes ☐ No Pacifier ☐ Yes ☐ No Grinding ☐ Yes ☐ No
Bottle to sleep or nap ☐ Yes ☐ No Mouth Breathing ☐ Yes ☐ No Nail biting ☐ Yes ☐ No
Tongue thrusting ☐ Yes ☐ No Lip sucking ☐ Yes ☐ No

17. Has your child had any unhappy dental experiences? ☐ Yes ☐ No

18. Is there anything else you'd like to tell us? _____
_____

Signature: _____ Relationship: _____ Date: _____ Dr. _____