tennyson PEDIATRIC DENTISTRY

FAMILY INFORMATION

PATIENT

Child #1 Name: _____ DOB: _____
Child #2 Name: _____ DOB: _____
Child #3 Name: _____ DOB: _____
Child #4 Name: _____ DOB: _____

Names and Ages of Other Children in Household:_____
How did you hear about our office? _____

PARENT/LEGAL GUARDIAN #1

Name: _____ Relationship to Patient: _____
Birthdate: _____ Social Security #: _____
Home Address: _____ City:_____ State:_____ Zip:_____
Home Phone: _____ Cell: _____ Work: _____ Preferred: _____
Email Address: _____ Occupation: _____

PARENT/LEGAL GUARDIAN #2

Name: _____ Relationship to Patient: _____
Birthdate: _____ Social Security #: _____
Home Address: _____ City:_____ State:_____ Zip:_____
Home Phone: _____ Cell: _____ Work: _____ Preferred: _____
Email Address: _____ Occupation: _____

Preferred Parent to contact: _____
Is email and text messaging okay for appointment reminders? □ Email □ Text □ Neither
Patient Lives With: □ Both Parents □ Mother □ Father □Other: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____
Phone Number: _____

INSURANCE

Primary Dental Insurance (please provide card): _____
Name of Insured: _____

Secondary Dental Insurance (please provide card): _____
Name of Insured: _____

***We may need additional information to verify/submit insurance claims.

Parent/Guardian Signature: _____ Date:_____

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PATIENT INFORMATION

Patient Name: _____ Preferred Name_____
Date of Birth: _____ □ Male □ Female
Daycare/School: _____ Grade: _____

Pediatrician / Family Physician: _____ Date of Last visit:_____
Does your child see any other healthcare providers? □No □ Yes Name: _____

Is your child allergic to anything? □ No □ Yes: _____
Is your child taking any medications? □ No □ Yes:_____
Does your child take a multivitamin? □No □ Yes: _____

Please mark if your child has ever had any of the following?

□ Abnormal Bleeding
□ ADD / ADHD
□ Asthma, or other respiratory
□ Autism Sprectrum
□ Cancer
□Cardiac (heart disease, murmur)
□Congenital Birth Defects
□Developmental Delays/Disabilities
□Diabetes
□Hearing Impariment
□Hemophilia/Blood Disorders
□Hepatitis
□HIV + / AIDS
□ Hospital Stays
□Kidney/Liver Conditions
□ Neurological Disease
□Reflux / GI Problems
□Seizures
□ Sickle Cell Trait/Disease
□ Speech Delay
□ Surgery

Please elaborate any above, or additional medical conditions we should know about:
_____

What is the main reason you are bringing your child to our office? _____
Is your child having any dental pain? □No □Yes:_____ _____
Is this your child's first dental visit? □No □ Yes
If no, name of previous dentist: _____ Dental xrays taken? □ No □Yes
Was Previous dental experience positive? □ No □ Yes:_____
Has your child experienced any dental injuries? □ No □Yes: _____
Does your child have any oral habits: □Pacifier□ Thumb □ Other
□Current □ Previous Age Stopped: _____

Brushing Frequency: □AM □PM □Other **Flossing:** □ Daily □Occasional □Never
Toothpaste Used: □Fluoride□ Non-Fluoride □Unsure □Not used
Brushing / Flossing Done by: □Child □Parent □Both

The information provided is correct to the best of my knowledge. I understand it is my responsibility to inform this office of any changes to my child's medical/dental status.
Signature: _____ Relationship to Child:_____ Date: _____

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INFORMED CONSENT

Before we can begin treatment on your child, we must obtain written consent from a parent or legal guardian. By signing this document, you are consenting for the dentists and staff at Tennyson Pediatric Dentistry to treat your child. Our initial examination may include taking dental radiographs (x-rays) depending on your child's age and specific needs, as well as a dental prophylaxis (cleaning) and fluoride treatment. If additional treatment is recommended after examination, we will create a treatment plan for your child outlining their dental needs.

Your child's treatment plan may consist of restorative and surgical treatment. Restorative treatment may include fillings, crowns, nerve treatment and/or space maintainers. Surgical treatment may include extraction of teeth or gum surgery. Local anesthetic and/or nitrous oxide (laughing gas) may be used to help make your child more comfortable. Physical restraint will only be used when necessary to protect your child from self-injury, and only with parental consent. If we recommend any alternative methods to administer dental treatment (sedation, general anesthesia), we will discuss these with you.

Your child's specific treatment plan will be explained to you and reviewed prior to each appointment. We request that you ask questions if you do not completely understand our recommendations. The treatment plan may change if additional needs are noted during treatment. We will discuss this with you. By signing this, you are acknowledging that dental treatment is being done to improve your child's dental health. However, there is not guarantee that treatment will be successful and your child may need additional treatment in the future.

Patient(s): _____

Parent/Guardian Signature: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse To Sign This Acknowledgement

I, _____, have read Tennyson Pediatric Dentistry's Notice of Privacy Practices and have received a copy if requested.

Parent/Guardian Printed Name: _____

Signature: _____ Date:_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

□ Individual Refused to Sign
□ Communication Barriers Prohibited obtaining the acknowledgement
□ An emergency situation prevented us from obtaining the acknowledgement
□ Other (Please specify): _____

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APPOINTMENT & FINANCIAL POLICY

Your child's appointment is reserved for them. If you need to change the appointment for any reason, we request 24 hours notice. After 2 missed or late cancel appointments, we will require a $75 deposit to reschedule any appointments. If the appointment is not kept for any reason, the deposit will not be returned.

If your child has Dentaquest/ CHP+, we are not able to charge deposits for appointments. Your child will be dismissed from our office after 2 missed appointments.

If someone other than parent/legal guardian listed on paperwork is to bring the patient to appointments, we need your authorization in writing.

Payment for dental services is due at the time of service.

If your child has dental insurance, we will submit a claim for you. Our office does our best to ***estimate*** your portion of your child's dental cost after insurance has paid. Any ***estimated*** patient balance (deductible and copay) paid at the time of treatment.

It is your responsibility update our office with any insurance changes.

The **parent/guardian that brings the child to the appointment is responsible for payment on day of service**, regardless of any parental/custodial arrangements. Any other agreement is to be discussed and agreed upon with our office prior to treatment, and in writing.

If you have a remaining balance after insurance is paid, we will send a bill. All outstanding balances are to be paid within 60 days following treatment. After 60 days a 1.5% monthly interest charge is applied to outstanding balance. Our office will do our best to work with you. But in the event of non-payment, we may need to send you to collections and you will be responsible for all collection agency or attorney fees.

In the event that insurance pays more than estimated, your account will have a credit. You can request these funds to be used at a future appointment, or refunded to you. The refund will be provided in the same manner as paid (check / credit card). Unless advised otherwise, credits of $10 or less will be left on your child's account.

I have read this form and understand the contents. In addition, I understand that I am responsible for payment of any bills incurred during my child's dental treatment.

Patient(s): _____

Parent / Legal Guardian Printed Name: _____

Signature: _____ Date: _____