PATIENT INFORMATION

Patient's Full Name: ____ Preferred Name: _________

Date of Birth: _____/_____/_____ Age: _____ Sex: _____M _____F

With whom does the patient live? ___Mother ___Father ___Both Parents ___Grandparents
___Other: ____

Mailing Address: ____ Apartment/Suite #: ______
City: _________________________________ State: _____________________ Zip Code: _____________
Patient's Social Security #: __________________________ School or Daycare: _____________________
Child's Hobbies/ Interests: ____
Are any siblings also patients of Tooth Be Told? If so, please name:________________________________

PARENT/GUARDIAN INFORMATION

First Name:_______________________________ Last Name:______________________________
Relationship to Child:_______________________ Occupation/Employer:_________________________

Mailing Address: ____ Apartment/Suite #: ______
City: _________________________________ State: _____________________ Zip Code: _____________
Cell Phone:___________________________ Email:____

INSURANCE/FINANCIAL INFORMATION

Who is responsible for payment of the account?____

Is the patient covered under any dental insurance? _____YES _____NO

Insurance Company Name:___________________________________ ID/Policy Number:___________

Name of Policy Holder:_________________________________ Relationship to Patient:_____________

Policy Holder Date of Birth:______________________ Policy Holder Social Security #:_____________

Policy Holder Employer:____

If you have a secondary policy, please share the information below:

Insurance Company Name:___________________________________ ID/Policy Number:___________

Name of Policy Holder:_________________________________ Relationship to Patient:_____________

Policy Holder Date of Birth:______________________ Policy Holder Social Security #:_____________

Policy Holder Employer:____

MEDICAL HISTORY

Name of child's pediatrician/physician:_______________________ Date of last exam: ___/___/___

Is your child being treated by a physician at this time? ___YES ___NO Reason:_________________

Is your child taking any medications? ___YES ___NO

Name/Dose/Frequency:____

Is your child up to date with immunizations? ___YES ___NO

Has your child ever been hospitalized since birth? ___YES ___NO Reason:____________________

Is your child allergic to any medications? ___YES ___NO List:_______________________________

Please read each item carefully. Check any conditions which apply to your child.

- ☐ ADHD
- ☐ Adverse Drug Reactions
- ☐ AIDS/HIV
- ☐ Allergies
- ☐ Anemia
- ☐ Artificial valve/tube
- ☐ Asthma or breathing issues
- ☐ Autism
- ☐ Blood Disorders
- ☐ Cancer/tumors
- ☐ Cerebral Palsy
- ☐ Cleft Lip/palate
- ☐ Congenital birth defects
- ☐ Diabetes
- ☐ Down's Syndrome
- ☐ Ear &/or Tonsil Surgery
- ☐ Endocrine/Growth Issues
- ☐ Vision Issues
- ☐ GI disease
- ☐ Hearing Issues
- ☐ Heart Condition/murmur
- ☐ Hepatitis
- ☐ High/low blood pressure
- ☐ Hives/rash/skin problems
- ☐ Kidney disease
- ☐ Liver diseases
- ☐ Measles/mumps
- ☐ Mental disorders
- ☐ Mental development delays
- ☐ Physical development delays
- ☐ Premature birth
- ☐ Psychological disorders
- ☐ Rheumatic Fever
- ☐ Seizures/Epilepsy/Fainting
- ☐ Sickle Cell Anemia
- ☐ Significant Injuries
- ☐ Sleep Apnea/Snoring
- ☐ Speech Disorders
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Other:____________

DENTAL HISTORY

Is this your child's first visit to the dentist? ___Yes ___No

If no, give date and treatment received:____

Have they had any dental x-rays taken? ___Yes ___No

Has your child experienced any unfavorable reaction during previous dental treatment?__Yes __No

If yes, describe:____

Does your child have any dental pain today and/or do you have any concerns __NO __YES:_______

How often are your child's teeth brushed? ______ By whom:___________

Fluoride Toothpaste: ___Yes ___No Does your child floss? ___No ___Yes, frequency:__________

What is the source of your child's drinking water? ___Public Water _____ Well Water

Did either parent wear braces?____

DENTAL HISTORY (continued)

Please read each item carefully. Check any conditions which may apply to your child.

- ☐ Grinds teeth
- ☐ Clenches teeth
- ☐ Sucks thumb or finger
- ☐ Uses pacifier
- ☐ Bites or sucks lip
- ☐ Bites nails
- ☐ Mouth breather
- ☐ Sleeps with a bottle
- ☐ Jaw Popping
- ☐ Jaw pain or tenderness
- ☐ Fever blister
- ☐ Mouth ulcers
- ☐ Injury to mouth, jaws, or face? Describe?____

Does your child take a bottle? ___Yes ___No If not, at what age were they taken off bottle?____

EXAMINATION RECOMMENDATIONS

We welcome parents/guardians to join their children for treatment. However, we recommend that you allow your child to accompany our staff independently (unless under the age of two or if they have special needs or physical impairment). We can usually establish a closer rapport with your child when you are not present. Our purpose is to gain your child's confidence and overcome apprehension.

COMMUNICATION PREFERENCES

We like to confirm appointments with parents/guardians in advance. Please let us know your preferred method of communication:

_____Text Message, Phone Number: (___)____________________

______Phone Call, Phone Number: (____)_____________________

_______Email, Address: ____

CONSENT

Please initial below for each:

_____I attest that the information I have provided on this form is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my child's he alt h. It is my responsibility to inform the dental office of any changes in my child's medical stat us.

_____I hereby authorize the dentist or dental auxiliaries under supervision, to perform any necessary dental treatment upon my child/children listed above, including but not limited to the use of x-rays, topical fluoride, local anesthetic, and/or Nitrous Oxide. I will allow photographs to be taken of my child or child's teeth for diagnostic or education purposes.

_____ (optional) I consent to having my child's photo taken and posted as part of on line social media including, but not limited to: the office website and blog; Instagram and Facebook (optional)

Signature of Parent/Guardian:____

Relationship to Patient: ____

Date: ____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Tooth Be Told Pediatric Dentistry to use and disclose protected health information (PHI) about me and/or my child/children to carry out treatment and financial transactions regarding my account. There is a more complete description of such uses available upon request.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Tooth Be Told Pediatric Dentistry reserves the right to revise its Notice of Privacy Practices at any time. By signing this form, I am consented to Tooth Be Told Pediatric Dentistry's use and disclosure of my child's/children's PHI to carry out appointment reminders, insurance items, account transactions/information and any calls/emails/faxes pertaining to my child's/children's dental care. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I did not sign this consent or later revoke it, Tooth Be Told Pediatric Dentistry may decline to provide treatment to you/your child.

Name of your child/children:____

Signature of parent /guardian:____

Relationship:_________________ Date:____

FINANCIAL AGREEMENT

Payment: Payment in full is due at the time of services unless prior financial agreements have been made. We offer several payment options including: cash, check, debit cards, Visa, MasterCard, American Express, and Discovery. There is a $40.00 fee for returned checks.

Insurance: Our office is committed to helping patients maximize their benefits. Because insurance policies vary greatly, we can estimate your coverage in good faith, but cannot guarantee it. As a service to all our patients, we will be happy to manage all claim submissions and follow up on your behalf.

Fillings: Our dental material of choice is a white (composite resin) filling. Please be aware that your insurance may not pay for a resin filling at the same level as a "silver"(amalgam) filling. You are responsible for the difference in cost. In some cases, the dentist may recommend a silver crown (stainless steel crown) instead of a white composite resin filling if a cavity or defect is too large for a filling.

Nitrous Oxide: Nitrous oxide or "laughing gas" is a very safe and reversible mild sedative and pain reliever used routinely in Pediatric Dentistry. Nitrous Oxide is not usually covered by dental insurance. We thank you for your payment on the date of service. (You will be informed if we need to use Nitrous Oxide, and your specific consent will be obtained for its use).

Fluoride and Sealants: Fluoride and Dental Sealants are two of our best weapons against cavities. We may recommend fluoride treatments more or less often than your insurance covers based on your child's risk for cavities. We may also recommend sealants for teeth, based on their risk for developing cavities, and some may not be covered by your insurance. Please review your insurance benefits and/or discuss with our front desk team.

Missed Appointments: Once an appointment has been made, that time is reserved specifically for your child. We reserve the right to charge a $35 fee for a no show appointment or last minute cancellation. We do ask that you try to give us at least 24 hours notice of cancellation. Three (3) missed/broken appointments, without at least 24 hours prior notification, may prevent further scheduling by this office.

Name of your child/children:____

Signature of parent/guardian: ____

Relationship:__________________ Date: ___________________