Demographic Information

Patient_____ Today's Date_____
First MI Last

Name child would like to be called_____ Home Phone_____
Birthday_____Age_____Sex_____ Cell Phone_____
Parent Email: _____ **Text ☐ or Email ☐** appt confirmation **OK?**

*Please note for email communication, please review and accept disclosure: ☐ I choose to receive email or text communication as selected and I understand that if information is not relayed in an encrypted manner, there is a risk of it being accessed inappropriately.

Emergency Contact (name & phone) _____

School _____Grade _____

Legal Guardian 1: _____Relation to patient_____DOB_____
Home Address_____
street *town* *state* *zip code*

Employer_____Wk Phone_____

Legal Guardian 2: _____Relation to patient_____DOB_____
Home Address_____
street *town* *state* *zip code*

Employer_____Wk Phone_____

Name of legal guardian accompanying child today_____DOB_____
I give permission to the following people to bring my child to his/her future appointments:_____
_____

Dental Insurance: ☐ Yes ☐ No
Insurance Company_____Group#_____ID#_____
Name of policy holder_____DOB_____SS#_____
Name of child's physician/group_____City/St_____Ph #_____
Names and ages of other children in family_____
Whom may we thank for referring you to us?_____
What is the reason for your child's dental visit?_____

Health History

☐ Yes ☐ No Is your child in good health? Date of last physical exam_____
☐ Yes ☐ No Has your child ever had a health problem?_____
☐ Yes ☐ No Has your child ever been hospitalized? Please give reason and dates_____
_____
☐ Yes ☐ No Is your child allergic to anything?_____
☐ Yes ☐ No Is your child currently taking any medications? Please give medication, dose and reason
_____
_____
☐ Yes ☐ No Were there any problems at birth?_____

Please mark if your child has been treated for any of the following:

☐ AIDS/HIV
☐ Adverse drug reactions
☐ Anemia
☐ Asthma/breathing
☐ Autism
☐ Bleeding/transfusions
☐ Blood dyscrasias
☐ Cancer/tumors
☐ Cerebral palsy
☐ Cleft lip/palate
☐ Congenital birth defects
☐ Diabetes
☐ Down's Syndrome
☐ Endocrine/growth
☐ Eyesight
☐ Frequent infections
☐ Heart disease/murmur
☐ Hepatitis
☐ Kidney disease
☐ Liver/GI disease
☐ Mental delays
☐ MRSA
☐ Personality/social
☐ Physical delays
☐ Reflux/GERD
☐ Rheumatic fever
☐ Seizures
☐ Speech/hearing
☐ Other problems

Do you consider your child to be:

☐ advanced in the learning process ☐ progressing normally ☐ slow in the learning process

Was your child:

☐ breast fed ☐ bottle fed at what age was it stopped?_____

Dental History

☐ Yes ☐ No Has your child ever been to the dentist? Date of last xrays (if taken)_____
Name of dentist and date_____

☐ Yes ☐ No Has your child experienced any unfavorable reaction from previous dental care? Explain_____

☐ Yes ☐ No Does your child suck a finger, thumb or pacifier?_____

☐ Yes ☐ No Does your child have pain with chewing, yawning, or wide opening?

☐ Yes ☐ No Does your child's jaw make noise and is pain associated with the sounds?

Please check if your child is having problems with any of the following:

☐ Cavities	☐ Toothache	☐ Teeth Sensitivity
☐ Trauma	☐ Gum Infections	☐ Color of teeth
☐ Orthodontics	☐ Jaw Sounds	☐ Other

Comments: _____

_____

Office Use Only
- ☐ Fl- City Water
- ☐ Pvt. Well
- ☐ Public Well ____ppm
- ☐ H_2O test kit given

Fluoride History

☐ Yes ☐ No Do you have well water at your home?

☐ Yes ☐ No Does your child use a fluoride toothpaste?

☐ Yes ☐ No Do you give your child any other form of fluoride? What?_____

Consent for Dental Treatment

I request and authorize Dr. Amy C. Davidian to examine, clean, and provide dental treatment on my child's teeth. I further request and authorize the taking of dental x-rays as may be considered necessary by the dentist to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or child's teeth for diagnostic or educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr. Amy C. Davidian will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone. I will be responsible for any charges incurred on this child for dental treatment.

Signature _____ **Date** _____

Financial Policy

Thank you for choosing Southpoint Pediatric Dentistry for your child's dental needs. We are committed to your child's successful treatment! Please understand that *payment of your bill is considered a part of your child's treatment.* Please be aware that the parent bringing the child to our office is *legally responsible for payment of all charges*. We cannot send statements to other persons.

As a courtesy to you, we will file your PRIMARY dental insurance claim for you if we have received all of your insurance information on the day of your appointment. We will also, as a courtesy, accept assignment of benefits. **We will file your insurance claim for you and you will be expected to pay your estimated uncovered portion at the time of service.** It is your responsibility to be familiar with your insurance benefits, as you will be responsible for what insurance does not cover. Once the insurance company reimburses our office, if there is still a balance, you will be billed for the remaining portion. If there is a credit, you will be sent a refund check. **Please be aware that our office does NOT file secondary insurance**. If you have secondary insurance, it is your responsibility to file with them.

Please understand that there is no direct relationship with your insurance company and our office. Your dental insurance is a contract between you and your insurance company. We are not responsible for how your insurance company handles its claims or for what benefits they pay on a claim. We can only assist you in estimating your portion of the cost and we will verify your benefits prior to treatment whenever possible. Please note that we only provide estimates, and only your insurance can determine exactly what they will pay on a claim once the claim is submitted. **In some cases**, insurance companies will only send payment to the patient, in which case you would be responsible for the entire account balance at the time of service and you should expect to receive a reimbursement check directly from your insurance carrier.

As payment is due at the time of service, we offer many different payment methods to accommodate you and your needs. For your convenience we accept **cash, Amex, Mastercard, Visa, and Discover only**. You, the legal guardian, are responsible for the entire account balance. If, for some reason, your insurance company does not pay on your claim, you will be expected to pay it in full within 30 days of the date of treatment. Also note, if we have not received payment or you have not contacted us within thirty (30) days, further action may be taken with a collection agency. We reserve the right to apply an interest rate of eighteen (18%) from the date of service. Thank you in advance for your understanding of our financial policy!

- I authorize the release of any information concerning my child's health care, advice and treatment provided for the purposes of evaluating and administering claims for insurance benefits.
- I authorize the release of any information concerning my child's health care, advice and treatment to another dentist.
- I authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.
- I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services.
- I understand that I am financially responsible for payments in full on all accounts.
- By signing this statement, I revoke all previous statements to the contrary and agree to be responsible for payment of services not paid, in full or in part by my dental insurance carrier.

Parent/Legal Guardian	Child's Name	Date

Appointment Policy

Scheduled appointments are reserved specifically for your child. Any change in this appointment may affect other patients. If a cancellation is unavoidable, please call the office **at least 48 hours** in advance so that we have sufficient time to schedule another child who needs our care. Our office attempts to schedule appointments at your convenience and when time is available.

- *All restorative (fillings, extractions, etc.) procedures are usually scheduled in the morning.* Children, as well as adults, are more prepared and typically do better in the morning for these types of procedures.

- *We strive to see all patients on time* for their scheduled appointment. There are times when our schedule is delayed in order to accommodate an injured child or an emergency. Please accept our apology in advance should this occur during your appointment. We will do the exact same if your child is in need of emergency treatment.

- *Please plan to arrive 15 minutes or more before your scheduled appointment*. This will allow time to complete any additional paperwork and allow us to see your child on time.

- *If you arrive 10-15 minutes late for your appointment, you may be asked to reschedule for the next available appointment time. Arriving 15 or more minutes late to a scheduled appointment does count as a no-show/cancelled appointment.*

- Again, *please call at least 48 hours in advance if a cancellation is unavoidable* so that we may provide our care to another patient. If we are not given proper notice for your child's new patient appointment, we reserve the right to not reschedule the appointment.

- *We reserve the right to charge a $25 cancellation fee* if you cancel without giving the proper 48 hour notice prior to your scheduled appointment.

- *Broken or missed appointments affect many people.* If two (2) broken/missed appointments occur or two (2) cancellations without 48-hour notice, our office reserves the right to NOT schedule any subsequent appointments.

If at any time you have questions, please feel free to ask our staff or call our office. We are here to help in any way we can. We appreciate you entrusting us with your child's dental health.

Parent/Legal Guardian	Child's Name	Date

Informed Consent for Pediatric Dental Treatment

Patient Name: _____

Please read this form *carefully*! If you do not understand something to your satisfaction, please ask questions. We will be pleased to explain it! Our goal is to prevent decay and have all of our patients "cavity-free"!

1. I request and authorize the taking of oral dental x-rays and the use of such anesthetics as may be considered necessary to treat the patient's dental problem(s).

2. The usual and most frequent risks or complications occurring from the planned treatment and procedures include, but are not limited to the following: the possibility of pain or discomfort during the treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of a temporomandibular joint disorder, temporary or permanent numbness, and allergic reactions.

3. **I understand** that during the course of the patient's dental treatment, something unexpected may arise that may necessitate procedures in addition to or different from those listed on the patient's Treatment Plan and that I will be consulted *prior to initiation of treatment procedures* not listed. I am aware that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the dental treatment that the patient receives in our office.

4. **I understand** that treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Behavior will be guided using praise, explanation and demonstration of procedures and instruments, using variable voice tone and loudness.

5. **I understand** that should the patient become uncooperative during dental procedures with movement of the head, arms and/or legs, dental treatment cannot be ***safely*** provided. During such disruptive behavior, it may be necessary for the assistant(s) to hold the patient's hands, stabilize the head and/or control leg movements.

6. I give my permission to take a picture of my child for identification at future appointments. We also give you a printed copy to remember their first dental visit.

7. **I understand** that I may revoke this consent to treatment at any time and that no further action based on this consent will be initiated except to the extent that treatment and procedures have already been performed or initiated.

8. **I confirm** that I have read and understand this form or it was read to me, and that all blanks were filled in and all inapplicable paragraphs, if any, were stricken before I signed below.

_____ _____

Signature of Legal Guardian Date

_____ _____

Witness Certification Date

SOUTHPOINT PEDIATRIC DENTISTRY

Acknowledgement of Receipt
Of
Notices of Privacy Practices

Patient Name: _____

Address: _____
Street City Zip

I have been allowed to read a copy of the Notice of Privacy Practices for the above named practice. I may obtain a copy by contacting the office manager.

_____ _____
Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❒ An emergency existed & a signature was not possible at the time
- ❒ The individual refused to sign
- ❒ A copy was mailed with a request for a signature by return mail
- ❒ Unable to communicate with the patient for the following reason:
  _____
- ❒ Other: _____

Prepared by: _____

Signature: _____

Date: _____