Pediatric Dental
ASSOCIATES

To help us better serve you, please complete the following forms to the best of your ability.
If you have questions, do not hesitate to let us know. Thank you for choosing our office!

Child's Name: _____ **DOB (MM/DD/YY):** _____

Nickname: _____ **Age:** _____ **Social Security #:** _____

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Declined **Gender:** ☐ Male ☐ Female ☐ Other ☐ Undecided

Race: ☐ White ☐ Black/African American ☐ American Indian ☐ Asian ☐ Native Hawaiian ☐ Pacific Islander

☐ Other ☐ Declined

Home Address: _____

City, State, Zip: _____ **Phone Number:** _____

Who can we thank for referring you to us? (Please check all that apply.)

☐ Primary Care Doctor _____

☐ General Dentist _____

☐ Friend/Family _____

☐ School/Daycare _____

How have you heard about us? (Please check all that apply.)

☐ Social Media

☐ Google/Website

☐ Insurance Directory

☐ Drive-by/Signage

☐ Billboard

☐ Newspaper or magazine feature/ad

☐ School/Daycare

☐ Community Event/Festival

☐ Commercial or video

☐ Other _____

PARENT/FOSTER PARENT/LEGAL GUARDIAN INFORMATION (Mother/Guardian)

Name: _____ Relationship: _____

DOB: _____ Social Security #: _____ Email Address: _____

Home Address (if different than child): _____

City, State, Zip: _____ Phone Number: _____

PARENT/FOSTER PARENT/LEGAL GUARDIAN INFORMATION (Father/Guardian)

Name: _____ Relationship: _____

DOB: _____ Social Security #: _____ Email Address: _____

Home Address (if different than child): _____

City, State, Zip: _____ Phone Number: _____

PRIMARY DENTAL INSURANCE:

Insurance Company: _____ Insured's Name: _____

Relationship to Patient: _____ DOB: _____ Social Security #: _____

Employer: _____ Subscriber's ID: _____ Group #: _____

SECONDARY DENTAL INSURANCE:

Insurance Company: _____ Insured's Name: _____

Relationship to Patient: _____ DOB: _____ Social Security #: _____

Employer: _____ Subscriber's ID: _____ Group #: _____

FLUORIDE CONSENT

Most insurance companies cover fluoride treatment twice a year; however, some insurance companies only pay for a once-a-year application.

PLEASE CHOOSE ONE (1) OF THE FOLLOWING:

I, _____ give my consent to apply fluoride treatment TWICE a year. I agree that if my insurance company does not pay for the second application, that I am financially responsible for payment.

I, _____ give my consent to apply fluoride treatment only ONCE a year.

I, _____ do not wish fluoride treatment to be applied to my child at any time.

FINANCIAL ARRANGEMENTS/INSURANCE AGREEMENT

I authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my dependent's behalf. I agree to be responsible for all fees incurred in attempting to collect these fees.

Any unpaid balance due (as listed on a billing statement), not paid within 28 days of the monthly billing date, will be assessed a late charge of 1.5% each month. I realize that failure to keep this account current may result in my children being unable to receive additional dental services except for dental emergencies or when there is pre-payment for additional services. In the default on payment of this account (payment due over 60 days), I agree to pay additional collection cost (33% of the unpaid balance), postage, attorney and court fees incurred in attempting to collect on this amount or any future outstanding balances.

I hereby authorize the office to contact the designated phone numbers and/or email address listed in the patient's account. With this authorization, a message/communication may be left indicating appointment time and dates, reminders, balances due, and/or estimated co-pays for future visits.

Financially responsible person for account ☐ Self ☐ Other _____

_____

Signature of Parent or Legal Guardian **Date**

☐ Child in foster care- Children & Youth and Foster Parents will not sign Staff Initials _____

ACKNOWLEDGEMENT OF HIPAA PRIVACY PRACTICES

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY:

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protection health information to carry out treatment, payment activities, and healthcare operations. You also consent to having been provided with access to a copy of the company's Notice of Privacy Practices.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters regarding your protected health information and your patient rights under HIPAA. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice, at any time from the dental office, our website, or by contacting our Privacy Officer:

Contact: Jim DeFruscio

Telephone: 484-787-2943

Email: privacy@ChildrensDentalHealth.com

Address: 200 Willowbrook Lane, Suite 220, West Chester, PA 19382

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand the revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation and that we may decline to treat your child if you revoke this consent.

I have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

If this consent is signed by a personal representative on behalf of the patient complete the following:

Patient's Name: _____

Relationship to Patient: _____

Personal Representative's Name: _____

_____

Signature **Date**

YOU ARE ENTITLED TO A COPY OF YOUR PAPERWORK AFTER SIGNED.

MEDICAL HISTORY

Child's Physician: _____ **City:** _____ **Phone**_____**Date Last Seen:**_____

Is your child presently under the care of a physician for any medical issue? ☐ Yes ☐ No

If yes, please describe: _____

Is your child currently taking medication? ☐ Yes ☐ No

If yes, please describe: _____

Has your child ever been hospitalized for surgery? ☐ Yes ☐ No

If yes, please describe: _____

Does your child have allergies to any food or medication? ☐ Yes ☐ No

If yes, please describe: _____

Is your child pregnant? ☐ Yes ☐ No

Does your child have a history of:

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	Heart Murmurs	☐	☐	Diabetes	☐	☐	Hearing Impairment	☐	☐	Cancer/Tumors
☐	☐	Heart Trouble	☐	☐	Asthma	☐	☐	Speech Problem	☐	☐	Chemo/Radiation Therapy
☐	☐	Allergies	☐	☐	Epilepsy	☐	☐	Anemia	☐	☐	Leukemia
☐	☐	Allergy or Sensitivity to Anesthesia	☐	☐	Seizures/Convulsions	☐	☐	ADD/ADHD	☐	☐	Hepatitis
☐	☐	Drug Sensitivities	☐	☐	Recurrent Headaches	☐	☐	Autism/Asperger's	☐	☐	Bleeding Problems
☐	☐	High Temperature	☐	☐	Fractured Jaw	☐	☐	AIDS/ARC/HIV	☐	☐	Blood Disorders
☐	☐	Brain Injury/Concussion	☐	☐	Lung Problems	☐	☐	Kidney/Liver Involvement	☐	☐	High Blood Pressure
☐	☐	Vision Problems	☐	☐	Artificial Prosthesis	☐	☐	Nervous System Issues	☐	☐	History of Blood Transfusion
☐	☐	Premature Birth	☐	☐	Congenital Birth Defects				If yes, date of transfusion:		

Is there anything else regarding your child's physical, mental, or emotional health you feel we should know? ☐ Yes ☐ No

If yes, please describe: _____

DENTAL HISTORY

Is this your child's first visit to a dentist? ☐ Yes ☐ No

Previous Dentist: _____ **City:** _____ **Date Last Seen:** _____

Date Last X-rays: _____

Reason for today's visit: _____

Any injury to your child's teeth or jaws? (Falls, blows, chips, etc.) ☐ Yes ☐ No

Does your child have a history of: (Please check all that apply.)

☐ Thumb sucking ☐ Lip sucking ☐ Pacifier

☐ Finger sucking ☐ Nail biting

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

If yes, please describe: _____

How do you think your child will act towards the dentist? _____

Age of child when discontinued bottle or nursing: _____

Name of Family Dentist: _____ **City:** _____

PREVENTATIVE DENTAL HISTORY

How often does your child brush? _____ **Is toothbrushing supervised?** ☐ Yes ☐ No

If yes, by whom and when? _____

Is dental floss used? ☐ Yes ☐ No

Does your child receive: ☐ Fluoride in Vitamins ☐ Fluoride Tablets/Drops ☐ Fluoridated Water ☐ None

If yes, how often? _____

PERMISSION FOR OTHERS TO ESCORT CHILD TO DENTAL APPOINTMENTS

We understand there may be times when you are unable to attend your child's dental appointment. To help make your visit as prompt and pleasant as possible, please provide the following information:

I, _____hereby give the following individual(s) my permission to bring my child/children to the practice and, in effect, have access to private information about their treatment.. I recognize that during the course of the treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I hereby authorize e listed individual(s) to consent to the performance of any additional procedures that are deemed necessary or desirable to my child's oral health and well-being in the professional judgement of the dentists. I authorize the company and its employees to discuss all dental and medical information with the following individual(s) listed below.

Name of Individual _____ **Relationship to patient** _____

Name of Individual _____ **Relationship to patient** _____

Name of Individual _____ **Relationship to patient** _____

Signature **Printed Name** **Date**