PLEASE PRINT

Patient Information

Child's Name: _____ ☐ Male ☐Female
Last First Middle

Nickname: _____ School: _____ Grade: _____

Siblings Names and Ages:_____

Address: _____
Street City State Zip

Home Phone: _____ Birth date: ____/___/_____ Age: _____ Child's Social Security #: _____

Name of child's pediatrician: _____ Phone #: _____

Name of child's previous dentist: _____ Phone #: _____

Date of last dental visit: _____

Parents' or guardians' name: _____

How did you hear about our office? _____

If a friend referred you, what is their name? _____

Child's Hobbies/Sports: _____

Parent/Legal Guardian Information

Who is responsible for account? _____ Parent's Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other

☐ **Father** ☐ Stepfather ☐ Legal Guardian

Name: _____

Birth date: ____/___/_____

Mailing Address: (If different than Child's)

_____
Street City State Zip

Home Phone: _____

Cell Phone: _____

May We Text You: ☐ Yes ☐ No

Work Phone: _____

Employer: _____

Email Address: _____

Social Security #: _____

Driver License # and State: _____

☐ **Mother** ☐ Stepmother ☐ Legal Guardian

Name: _____

Birth date: ____/___/_____

Mailing Address: (If different than Child's)

_____
Street City State Zip

Home Phone: _____

Cell Phone: _____

May We Text You: ☐ Yes ☐ No

Work Phone: _____

Employer: _____

Email Address: _____

Social Security #: _____

Driver License # and State: _____

Insurance Information

Primary Insurance Information:

Subscriber's Name: _____ Subscriber's Birth date: ____/___/_____

Subscriber's Social Security #: _____ Subscriber's ID#: _____

Subscriber's Employer: _____ Group/Plan #: _____

Insurance Company Name: _____ Insurance Company Phone #: _____

Insurance Company Address: _____

Street City State Zip

Do you have secondary insurance coverage? Yes No

Secondary Insurance Information:

Subscriber's Name: _____ Subscriber's Birth date: ____/___/_____

Subscriber's Social Security #: _____ Subscriber's ID#: _____

Subscriber's Employer: _____ Group/Plan #: _____

Insurance Company Name: _____ Insurance Company Phone #: _____

Insurance Company Address: _____

Street City State Zip

Emergency Contact Information

Relative or friend not living with you:

Name: _____ Phone #: _____

Address: _____

Street City State Zip

Relationship to child: _____

Authorization

I hereby authorize this office to release all information necessary to secure the payment of benefits, and I assign directly to this office all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover, including services that were previously considered to be covered.

I understand that where appropriate, credit bureau reports may be obtained.

I certify that the information I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence and that it is my responsibility to inform this office of any changes to my account.

I will be informed of any treatment my child may need prior to services rendered. I authorize the dental staff to perform all necessary dental services that pertain to the dental care of my child.

Signature of Parent or Legal Guardian: _____ Date: _____

Printed Name of Parent or Legal Guardian: _____ Relationship to Patient:_____

Health History Information

				Doctor's Notes
1.	Does your child have previous dental experience? ----------	☐Yes	☐No	
2.	If yes, was it pleasant? ----------	☐Yes	☐No	
3.	Has your physician ever told you that your child needs an antibiotic before having any dental work?	☐Yes	☐No	
4.	Is the child under a physician's care? ----------	☐Yes	☐No	
5.	When was the child's last physical exam? _____			
6.	Is the child taking any medications or substances? ----------	☐Yes	☐No	
	If yes, please list. _____			
7.	Is the child allergic to any medication or substances? ----------			
	If yes, please list. _____	☐Yes	☐No	
8.	Does the child have any problems with ☐ penicillin, ☐ antibiotics, ☐ local anesthetics (Novocaine)	☐Yes	☐No	
	or ☐ other types or medications? List others: _____			
9.	Is the child sensitive to any ☐ metals or ☐ latex? ----------	☐Yes	☐No	
	If yes, what types? _____			
10.	Has the child ever been treated for heart disease? ----------	☐Yes	☐No	
11.	Does the child have a heart murmur? ----------	☐Yes	☐No	
12.	Does the child have a ☐ pacemaker or an ☐ artificial heart valve implant? ----------	☐Yes	☐No	
13.	Has the child ever had rheumatic fever? ----------	☐Yes	☐No	
14.	Is the child ☐ pregnant or ☐ suspect that the child is pregnant? ----------	☐Yes	☐No	
15.	Does the child take birth control medications? ----------	☐Yes	☐No	
16.	Does the child have high blood pressure? ----------	☐Yes	☐No	
17.	Has the child ever had a ☐ serious illness or ☐ surgery? ----------	☐Yes	☐No	
	If yes, what? _____			
18.	Has the child ever had ☐ radiation treatment or ☐ chemotherapy? ----------	☐Yes	☐No	
19.	Does the child have ☐ soreness, ☐ clicking, or ☐ popping in the jaw joint? ----------	☐Yes	☐No	
20.	Does the child have any blood disorders, such as ☐ anemia, ☐ leukemia, ☐ hemophilia, etc? --------	☐Yes	☐No	
21.	Does the child have any artificial joints/prosthesis? ----------	☐Yes	☐No	
22.	Has the child ever bled excessively after being cut or injured? ----------	☐Yes	☐No	
23.	Has the child ever received a blood transfusion? ----------	☐Yes	☐No	
24.	Does the child have any ☐ kidney, ☐ stomach, or ☐ liver problems? ----------	☐Yes	☐No	
25.	Does the child have ☐ autism or ☐ any type of syndrome? ----------	☐Yes	☐No	
	If any other syndrome, what type? _____			
26.	Is the child developmentally delayed? ----------	☐Yes	☐No	
27.	Is the child diabetic? ----------	☐Yes	☐No	
28.	Does the child have asthma? ----------	☐Yes	☐No	
29.	Is the child ☐ HIV positive or have ☐ AIDS? ----------	☐Yes	☐No	
30.	Does the child have ☐ epilepsy or ☐ seizure disorders? ----------	☐Yes	☐No	
31.	Has the child had or tested positive for hepatitis? ----------	☐Yes	☐No	
32.	Did you read this question? ----------	☐Yes	☐No	
33.	Does the child or has the child ever had tuberculosis? ----------	☐Yes	☐No	
34.	Does the child smoke, use any form of tobacco, or live with someone who smokes? ----------	☐Yes	☐No	
35.	Does the child consume alcoholic beverages or use controlled substances? ----------	☐Yes	☐No	
36.	Is there anything else we should know about the health of the child not yet covered? ----------	☐Yes	☐No	
	If yes, what? _____			

I certify that I have read and understand the foregoing questions, and hereby certify that the information I have given is correct to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes in my child's medical status.

Signature of Parent or Legal Guardian: _____ Date: _____

Printed Name of Parent or Legal Guardian: _____

Patients Name: _____

LEGAL CONSENT TO MAKE DECISIONS

Patient's Name: _____

As a convenience, we would like to offer you a chance to provide us with a list of individuals that may accompany your child to subsequent visits. Listing an individual will automatically provide them with your legal consent to make both treatment and financial decisions on your behalf.

With this list, a family member, step-parent, or good friend would have the authority to accompany your child to a dental appointment and make decisions without the need of any additional written or oral consents. If not listed, patients must always present with a parent or legal guardian. Please only provide the names of those individuals that you trust to make such decisions as treatment changes, to make payments, and to discuss medical and financial information. Please remember, individuals that are permitted to make treatment decisions will also be responsible for any incurred payment changes.

We, as a HIPAA compliant healthcare facility, will use our best discretion to maintain all personal information and will only provide the individuals listed below with information needed to make a specific decision on your behalf. Information will only be provided on a need-to-know basis and we will not allow these individuals to have or copy your child's dental chart. We simply want to make treating your child in our facility as convenient as possible for you.

Please identify such individuals and initial your decision to allow them to provide consent to treatment decisions, to make financial arrangements, or both. Please also remember any individuals accompanying your child to an appointment will also be responsible for additional charges incurred during that particular visit.

CONSENT TO MAKE DECISIONS

Individual's Name	Treatment	Financial

As the parent or legal guardian of the patient noted above, I do hereby provide the individuals listed beneath the chart entitled "Consent to Make Decisions," the legal authority to make decisions in my absence. I also understand that these decisions may change or alter previous treatment recommendations or charges that I have already agreed to and that I, as this child's parent or legal guardian, am ultimately responsible for any new charges incurred as a result of treatment decisions made by any individuals listed above.

Parent or Legal Guardian: _____ Date: _____

Printed Name of Parent or Legal Guardian: _____

CANCELLATION POLICY

Due to the high patient no-show rate in our office, we must attempt to maintain an efficient patient flow to accommodate our large patient population. To best accomplish this, we have implemented office policies to help regulate appointment scheduling, including no-show appointments.

Our office policies are as follows:

- Our office will confirm all appointments with you twice; the first time will be one week prior to your child's appointment and the second will be the day before the appointment. If we are unable to reach you, we ask that you call back and confirm that you are keeping your appointment. **Should we not be able to confirm these appointments with you, we will be forced to forfeit the appointment to another child on our waiting list.** You are responsible for informing our office of changes in your contact information.

- It may be necessary for our office to dismiss patients that fail to keep appointments without notifying our office staff at least 48 hours prior to their scheduled appointment.

- After five missed appointments patients will be dismissed.

- A **$25 cancellation fee** will be assessed for each patient that no-shows or cancels an appointment without notifying our office staff at least 48 hours prior to their scheduled appointment.

Thank you for assisting us in making appointments accessible to all children.

I have read the preceding information.

Signature of Parent or Legal Guardian: _____ Date: _____

Printed Name of Parent or Legal Guardian: _____

PRIVACY PRACTICES CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change it's *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the above address to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Parent or Legal Guardian Signature: _____ Date: _____
Printed Name of Parent or Legal Guardian: _____

FINANCIAL POLICY

We are dedicated to providing our patients with the best treatment available and base our treatment recommendation on what will be best for your child and not what your insurance company does or does not pay for. As a courtesy, our office will be happy to submit any insurance claims for your child. Your dental insurance is a contract between you, your employer and your insurance company; therefore, you are ultimately responsible for your insurance coverage. Any co-pays, deductibles, or known percentages for your child's dental care must be paid the day services are rendered. However, please remember that in **most** cases these figures are only estimates. We cannot guarantee what your insurance will pay. You will be responsible for any services not covered or paid by your insurance carrier.

Prior to completing any treatment, we will provide you with a cost estimate indicating our total fee, what we expect your insurance coverage to be, and your estimated out-of-pocket portion. This is only an estimate based upon generalized information provided by your dental insurance. We will be happy to submit for a pre-treatment estimate to your insurance company for any treatment. Please request one from our staff.

We ask that you contact us immediately after making any changes to your dental coverage, so that we may keep accurate and current records of your account and to expedite reimbursement of your dental benefits.

We allow a maximum of 60 days for your insurance company to clear account balances. After 60 days, any unpaid portions will be due in full by you.

For your convenience, we accept cash, Visa, Mastercard, and Healthcare Credit Line.

After attempts to collect outstanding funds and a grace period of 90 days from the day of service, the parent or legal guardian responsible for the account will be sent to a collection agency to settle the financial obligation. There will be an additional charge of 33% added to your account plus a $500.00 processing fee if your account gets sent to collections. I agree to pay all finance charges, collection costs, attorney fees, and all other costs associated with collection of my outstanding accounts as allowed by law.

I acknowledge that I have read, understand, and am willing to comply with the above financial policy.

Signature of Parent or Legal Guardian: _____ Date: _____

Please Print Name of Parent or Guardian: _____

Divorce Policy for Divorced or Separated Parents

The providers and staff of Desert Sun Pediatric Dentistry are here to take care of your children. Our focus is on the overall oral health of your child. – NOT legal issues involving divorce, separation or custody agreements. That is why we ask that you read the following:

1. Either parent or legal guardian can schedule an appointment for the child, they may be present for the dental visit, and/or obtain a copy of the visit summary. ***Unless there is a written court order in the child's record that restricts a parent's right, please do not ask us to limit the other parent's involvement in your child's care.***

2. Payment (co-pays, deductibles, etc.) are due at the time of service regardless of which parent is responsible for dental coverage. We are not a party to your divorce agreement. **The parent/guardian who brings child to their visit is responsible for payment**. If the divorce decree requires the other parent to pay for all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

3. Both parents/legal guardians can sign a "Consent to Treatment" form. This means other persons (like grandparents, nannies, etc.) are authorized to bring your child to our practice, and can consent for treatment during the visit. **We will not be involved in any disputes regarding named individuals on your child's consent to treat form.** Both parents/legal guardians can see who is named on each other's forms; however, we will not comply with request to eliminate names on the other's form, unless instructed by the court, Please refer these request to your attorney.

4. Additionally, we will **not:**

- Call the other parent for consent prior to treatment or inform the other parent whenever visits are scheduled.
- Restrict either parent/legal guardians involvement in your child's care, unless authorized by law.
- Tolerate appointment scheduling/cancelling patterns of behavior between parents.

5. It is the responsibility of both parents to communicate with each other about the patients care, office appointments and any other important information relevant to the care of the child. Please do not ask our providers to call the non-attending parent following the child's visit.

6. Should the issues that come between parents become disruptive to our practice or impede the care of your child, we reserve the right to discharge your family from our practice.

Signature of Parent or Legal Guardian: _____ Date: _____

Printed Name of Parent or Legal Guardian: _____ Relationship to Patient:_____

Cell Phone and Photo/Video Policy

Cell Phone Use: In consideration of others, cell phone conversation is prohibited in the office. You are more than welcome to step outside to complete a call if necessary while you child is being treated.

Photo/Video: Photos and/or video are prohibited in the treatment area. We will be happy to take a photo of your child with the Dr. or a staff member if desired. Outside of the treatment area you may take a photo of your child in the office, however, we would ask that you respect others privacy in this.

Printed Name of Parent or Legal Guardian: _____ Relationship to Patient:_____

Signature of Parent or Legal Guardian: _____ Date: _____