Pediatric Information and Health history Form

Child's Information **Today's date**:_____

Childs Name:_____ Nickname:_____ □ Male □ Female

Child's Date of Birth: _____ Child's SS# _____

Child's Home Address: _____
Street City State Zip

Name of Primary Dental Insurance Carrier:_____

Subscriber ID#:_____ Group #:_____

Name of Secondary Dental Insurance Carrier:_____

Subscriber ID#:_____ Group #:_____

Parent/Guardian Information

Name:_____

Circle one: Mother Stepmother Father Stepfather Legal Guardian □ yes □ no

Birthday:_____ SS# _____ Employer:_____

Home #_____ Cell # _____

Work #_____ Email Address:_____

Preferred Appointment Reminder Method: (Please Circle) Call Text Email

(Our office will send an E-mail the day appointment is made as well as Email/texts reminder one week and day before an appointment.)

Parent/Guardian Information

Name _____

Circle one: Mother Stepmother Father Stepfather Legal Guardian □ yes □ no

Birthday:_____ SS# _____ Employer:_____

Home # _____ Cell # _____

Work #_____ Email address:_____

Preferred Appointment Reminder Method: (Please Circle) Call Text Email

(Our office will send an E-mail the day appointment is made as well as Email/texts reminder one week and day before an appointment.)

Medical History

Child's Physician/Pediatrician _____ Phone # _____

□ yes □ no Is your child in good health? Date of last physical exam _____

□ yes □ no Has your child had any health problems? _____

□ yes □ no Is your child allergic to anything? If yes what? _____

□ yes □ no Is your child taking any medications? Please list:_____
_____

□ yes □ no Are your child's immunizations current?

□ yes □ no has your child ever been hospitalized, had general anesthesia, or emergency room visits?
Please explain _____

□ yes □ no Does your child have a history of chemical dependency?_____
Are they in recovery?_____If Yes, how long:_____.

Does your child have a history of being treated for or have difficulty with any of the following

Heart Disease	Speech/hearing/ear tubes	Anemia/bleeding problems	Cleft lip/palate
Congenital birth defects	mental/physical disability	Mental delays	Blood disorders
hepatitis	Frequent infections	Sickle cell	Rheumatic Fever
ADHD/ADD	Liver/ GI disease	Heart Murmur	Pregnant
Asthma/breathing	Tonsils/adenoid problems	Tuberculosis	Abuse
Diabetes	Cancer/tumors	Autism	Kidney Disease
Endocrine/growth	HIV/AIDS	HPV	Eyesight
Headaches	Seizures		

Dental History

What is the reason for your child's dental visit? _____

□ yes □ no Has your child ever been to the dentist? Date of last visit _____

□ yes □ no Has your child ever experienced any negative reaction to previous dental care?

□ yes □ no Does your child suck a finger, thumb or pacifier?

□ yes □ no Does your child go to bed with a bottle or sippy cup?

□ yes □ no Is your child drinking water fluoridated or do they take tablets?

□ yes □ no Has your child ever had any injury to the head, neck or jaw?

□ yes □ no Does your child brush their teeth daily? # of times a day

□ yes □ no Does your child floss their teeth daily? # of times a day

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

Cavities	Sensitive teeth	Trauma
Color of teeth	jaw sounds	Gum infections
Toothache	Mouth breathing	
Orthodontics	Grinding of teeth	

Consent for Dental Treatment

I am the parent, legal guardian, or personal representative of the patient and there are no court orders no in effect to prevent me from signing this consent. The information listed above is complete and accurate. I give consent to Williston Road Family Dental staff and Dental providers to perform a dental examination, dental prophylaxis, fluoride treatment and take necessary radiographs on my child.

I affirm that the information above is correct to the best of my knowledge. I understand it is my responsibility to inform Williston Road Family Dental of any changes to my child's medical status

Legal Guardian Signature _____ Date _____

Williston Road Family Dental

Parental/Legal Guardian Consent for Dental Treatment

A parent or legal guardian MUST accompany any child under the age of eighteen to all appointments. If a parent or legal guardian cannot accompany the child a "consent for dental treatment" form must be completed and sent along to the appointment

Parental/Legal Guardian Consent for Dental Treatment:
The "Consent for Dental Treatment" form gives a child's caregiver, who is not the parent/legal guardian permission to consent to dental treatment for your child(ren).
This form must be presented when anyone other than the parent or legal guardian will accompany your child(ren) to our practice or if the child is coming alone. We will kindly keep a copy on file if the same person will commonly accompany the child to the practice.

All information requested on our authorization form must be completed, or we may be unable to treat your child(ren)

Williston Road Family Dental

Parental/Legal Guardian Consent for Dental Treatment

_____ _____
Child's Name Date of Birth

_____ _____
Child's Name Date of Birth

_____ _____
Child's Name Date of Birth

_____ _____
Child's Name Date of Birth

_____ _____
Child's Name Date of Birth

_____ _____
Parent/legal guardian Phone number

_____ _____
Caregiver's name Home/Cell phone

The above named caregiver shall be authorized to consent for all dental treatment, for the above named child(ren), which may be required during my absence. I agree to pay for all the services provided to my child(ren) that the caregiver authorized.

If circumstances permit and WRFD needs to contact me, please contact with the following telephone number:
_____
This consent serves as permission for treatment for dental care for the above named child(ren).
This authorization shall be effective until one year from date signed

parent/guardian Initials _____

or
Until _____(list Month, Day, Year)

This authorization will remain in effect until the date stated above – unless I revoke this authorization in writing and submit it to WRFD prior to this date.

Signature

_____ _____
Parent/legal guardian Date

_____ _____
Witness Date

*****Note: consents are NOT required in emergency situations*****

Williston Road Family Dental

General Dental Treatment Consent Form

Patient Name: _____

Drugs, Medications and Local Anesthetics **Initials _____**

I understand the antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting and or anaphylactic shock (severe allergic reaction). I also understand there are risks of local anesthetic that may affect my body such as dizziness, nausea, vomiting, accelerated/slow heart rate or various types of allergic reactions. It may also cause injury to nerves that can result in pain, tingling or numbness that may persist for several weeks, months, or permanent. I have informed my dentist of my complete medical history, including any recent surgeries, changes in medical history and any known allergies.

Fillings **Initials_____**

I understand that I may experience hot and cold sensitivity, pain or discomfort following routine restorative procedures and that is usually temporary and should settle without further treatment. If in the event that my condition does not get any better, I understand that I may need further dental treatment, the most common being root canal therapy, resulting in additional costs.

Crown (caps) and Bridges **Initials_____**

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes to my new crown or bridge (including shape, fit, size, and color) will be before cementation. Once cemented, I understand that any changes to shape, fit, size or color will incur additional charge.

Changes in Treatment Plan **Initials_____**

I understand that during treatment, it may be necessary to change and or add procedures because of conditions found while working on the teeth that were not discovered during examination. Upon consent I will give permission to the dentist to make any/all changes and additions as necessary

Alternative treatment **Initials_____**

I understand that I have the right to choose, on the basis of adequate information, from alternate treatment plans that meet professional standards of care. The treatment plan chosen by me may/may not be the procedure that your providing dentist prefers.

Out of office referrals **Initials_____**

In the event we refer you for treatment not rendered in this office, i.e. Oral surgery, root canal therapy, periodontal therapy, orthodontics etc. I give permission for my necessary records to be e mailed to the referring doctor.

By signing below, I consent to the general dentist treatment and or proposed treatment agreed by my primary providing dentist and myself.

Patient/Guardian Signature: _____ Date: _____

Williston Road Family Dental

Financial Policy

Thank you for choosing us as your dental care provider. Our office is committed to providing you with the best possible care. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment. All patients must complete our Information and Insurance form before seeing the doctor.

Regarding Payment

We accept the following forms of payment: Cash, Check, Visa, MasterCard, Discover and care credit

Payment for services is due at the time service rendered unless prior arrangements have been made with the doctor and the billing receptionist.

If dentures, partial dentures, crown and bridge are to be fabricated by a dental laboratory, a 50% deposit will be required at the time of the first impression. The remaining balance is due at the time of prosthesis is cemented or inserted.

The parent that accompanies the minor child/children to the appointment is responded for any payment due. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized before the appointment date of previous arrangements have been made with the doctor or billing receptionist.

Checks that are returned to our office from the financial institution are subject to a $20.00 returned check fee. This fee covers the processing fees that charged to our office.

Regarding Insurance

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits and your insurance company has not paid your account in full within 60 days, the balance may be transferred to your account. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and customary under the terms of your insurance policy. Our practice is committed to providing the best treatment for our patients and we charge what is the usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Your complete insurance information must be presented at the time services are provided. Insurance claims cannot be backdated. Most benefits will be verified before your insurance company can be billed.

All insurance co pays, which would include deductible must be paid at the time of service.

We would be happy to discuss our charges and how they relate to your particular situation. We also realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy, I understand and agree to this Policy , and filled out the back of form as needed.

Signature of Patient or Responsible party:_____Date:_____

Williston Road Family Dental
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You May Refuse to Sign This Acknowledgement****

I _____have received a copy of this office's Notice of Privacy Practices.
Print Name: _____
Sign: _____
Date: _____

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding you covered under the Privacy Act to people other than yourself. I,_____ authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____
{Please Print Name} Relationship

{Please Print Name} Relationship

_____
{Please Print Name} Relationship

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

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)_____