ABOUT OUR OFFICE

APPOINTMENT TIMES

Our office makes every attempt to make scheduling your child's appointment as easy as possible. We have implemented a few guidelines in order to accommodate the majority of our patients.

Cleaning Appointments:
All children 6 years old and under will always be seen in the morning. This includes all children in kindergarten and preschool. This will allows us to see older patients in the afternoon time when it is more important not to miss school.

Filling Appointments:
Generally, children 8 years old and younger will be seen in the morning for filling appointments. The purpose for this is, children of this age tend to be too tired for late day appointments and do not handle the treatment as well. Also the office tends to be a bit slower in the morning which allows extra time for children that might be fearful.

Promptness:
Please schedule times that you are able keep. Many of our parents schedule after school appointments in which they wait for their child to get home from the bus or do not factor after school traffic. This often results in our patients arriving 10 to15 minutes late. The result is our schedule not running as assigned which is unfair to patients who arrive on time. Please take the appropriate measures to see that your child arrives on time to their visit. As a general rule patients that arrive more than 10 minutes late may not be seen.

DENTAL X-RAYS

We follow the guidelines established by the American Academy of Pediatric Dentistry for all treatment. We do not take dental x-rays every year just for the sake of it. Each child is treated as an individual, if your child has a dental decay history we tend to take them every year. If your child has no dental decay than we tend to take x-rays every 18 months to 24 months.

If you are present with your child we will always ask before we take dental x-rays. If you are not present with your child (a grand parent, family member or older sibling brings your child) we will update your child's x-rays if they are deemed necessary.

PAYMENT AND INSURANCE

Payment is expected at the time of treatment. Payments may be made by cash, check or credit card. If you are covered by a insurance plan any portion not covered by your insurance is expected at the time of treatment including deductibles and/or patient portions. Any account balance 60 days old will be subject to a finance charge of 1.5 % per month (18% per year) on the unpaid balance.

Pediatric Dental Associates is not responsible for the determination of benefits provided by your insurance company. Currently we estimate that we accept approximately one thousand insurance plans. Our office will make every effort to help you with your benefits. If your insurance carrier does not allow for the payment of a particular treatment than you will be responsible for the payment. If your company only recognizes a percentage of our fee you will be responsible for the difference.

NOTICE OF PRIVACY PRACTICES

Our office follows all HIPAA regulations concerning the confidentiality of patient records and information.
I have received a copy of this office's Notice of Privacy Practices, and give consent for the use and disclosure of health information to carry out treatment, payment activities and healthcare operations.

I the under signed have read and understand the policies and practices of Pediatric Dental Associates

_____

Your signature **Date**

PEDIATRIC DENTAL ASSOCIATES

General Parent Information

The child lives with ( ) both parents ( ) parent 1 ( ) Parent 2 ( ) Other

PARENT/GUARDIAN 1
( ) Father
( ) Mother
( ) Other
_____

NAME_____
SSN_____ DOB_____
STREET_____
CITY_____STATE_____ZIP_____
Home Phone:_____CELL:_____
Occupation:_____
Employer:_____
Business Address:_____
Business Phone:_____

PARENT/GUARDIAN 2
( ) Father
( ) Mother
( ) Other
_____

NAME_____
SSN_____ DOB_____
STREET_____
CITY_____STATE_____ZIP_____
Home Phone:_____CELL:_____
Occupation:_____
Employer:_____
Business Address:_____
Business Phone:_____

DENTAL INSURANCE INFORMATION

Primary Insurance _____
Employer_____Employee_____
Group Number_____Subscriber Number_____
Secondary Insurance_____
Group Number_____Subscriber Number_____

MEDICAL INSURANCE INFORMATION
Insurance Company_____
Employer_____Employee_____
Group Number_____Subscriber Number_____

IN ORDER TO COMPLY WITH MOST INSURANCE COMPANIES, WE ASK THAT YOU SIGN BELOW SO THAT WE MAY KEEP YOUR SIGNATURE ON FILE. I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM AND HEREBY AUTHORIZE PAYMENT DIRECTLY TO PEDIATRIC DENTAL ASSOCIATES.

Signature_____Date_____

Pediatric Dental Associates Health Form

Child's Name: _____ Nickname: _____ Gender: ☐ M ☐ F ☐ Nonbinary
Age:_____ Birth Date: _____ Pronouns: _____ Hobbies/Interests/Pets: _____
Mailing Address: _____ City:_____ State: ___ Zip: _____
Home Telephone: _____ Cell Phone: _____ Email: _____
Whom may we thank for referring you? _____

Child's Physician/Pediatrician: _____ Phone: _____
Address: _____ Child's Previous Dentist: _____

Do you have any concerns about your child's teeth? _____

Medical History

Were there any difficulties during the pregnancy, delivery (e.g. prematurity) or 1st year of your child's life? ☐ Yes ☐ No
If yes, describe. _____
Was your child bottle fed? ☐ Yes ☐ No If yes, until what age? _____ Any difficulty with bottle feeding? ☐ Yes ☐ No
Was your child breast fed? ☐ Yes ☐ No If yes, until what age? _____ Any difficulty latching? ☐ Yes ☐ No
Has your child had any frenectomies? ☐ Yes ☐ No If yes, date and provider: _____

Does your child have any history of the following? (*Check all that apply.)*

☐ ADHD	☐ Anemia	☐ Anxiety/Nervousness	☐ Arthritis/Bone/Joint Issues	☐ Asthma/Reactive Airway
☐ Autism	☐ Behavior Issues	☐ Bladder/Kidney Issues	☐ Bleeding (prolonged)	☐ Blood Transfusion
☐ Brain Injury/Stroke	☐ Cancer _____	☐ Cerebral Palsy	☐ Cleft Lip/Palate	☐ Communication Issues
☐ COVID-19/RSV	☐ Cystic Fibrosis	☐ Developmental Delay	☐ Diabetes	☐ Ear Infections/Ear Tubes
☐ Emotional Disability	☐ Feeding Problems	☐ Gastrointestinal Disorders (Celiac/Crohn's, GERD)		☐ Growth Problems
☐ Headaches/Migraines	☐ Hearing Loss	☐ Heart Disease	☐ Heart Murmur	☐ Hemophilia
☐ Hepatitis/Jaundice	☐ HIV/AIDS	☐ Learning Disability	☐ Neuromuscular Defects	☐ Orthopedic Problems
☐ Psychiatric Disorder	☐ Rheumatic Fever	☐ Scarlet Fever:	☐ Seizures/Epilepsy	☐ Sensory Integration
☐ Sickle Cell Disease/Trait	☐ Sinus/Adenoids/Tonsils	☐ Skin (Eczema/Rash/Hives)	☐ Sleep Apnea	☐ Sleep Problems/Snoring
☐ Speech Problems	☐ Spina Bifida	☐ Thyroid disorder	☐ Tobacco/Vaping/Drug use	☐ Tuberculosis
☐ Syndrome: _____		☐ Other: _____		☐ Abuse (physical/sexual)

If any boxes are checked, please describe further: _____
_____
_____

Is your child CURRENTLY taking any medications? ☐ Yes ☐ No

Drug	*Dose*	*Frequency*	*Reason*

Has your child had any allergic reactions to: Medications? ☐ Yes ☐ No _____ Latex? ☐ Yes ☐ No
Foods? ☐ Yes ☐ No _____ Other? _____

Development/Special Needs:
Can your child speak and understand at his/her age level? ☐ Yes ☐ No
Does your child attend a special class or school? _____ ☐ Yes ☐ No
Are your child's immunizations current? ☐ Yes ☐ No

Does your child need to take antibiotics before dental treatment? ☐ Yes ☐ No

Has your child ever been hospitalized? ☐ Yes ☐ No
When? _____ Where? _____ Reason? _____

Has your child had any surgery? ☐ Yes ☐ No
When? _____ Why? _____ Was general anesthesia used? ☐ Yes ☐ No
Any complications? _____

Dental History

Why is your child here today? _____

If your child has been to a dentist: Date of last visit _____ Have X-rays been taken? ☐ Yes ☐ No ☐ Unsure
How did your child react? _____

How would you describe your child's oral health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Is there a family history of cavities? ☐ Yes ☐ No If yes, indicate all that apply: ☐ Mother ☐ Father ☐ Sibling

Is fluoride taken in any of the following forms?
Fluoride tablets, drops, or multivitamins ☐ Yes ☐ No Drinking water ☐ Yes ☐ No
Toothpaste ☐ Yes ☐ No Fluoride rinse ☐ Yes ☐ No

How often do your child's teeth get brushed? # of times/day _____ Does someone help your child brush? ☐ Yes ☐ No
When does your child brush? ☐ AM ☐ PM ☐ After meals
How often do your child's teeth get flossed? # of times/day _____ Does someone help your child floss? ☐ Yes ☐ No
What kind of toothbrush does your child use? ☐ Manual ☐ Battery-powered/Electric
What toothpaste does your child use? _____
Does your child swallow toothpaste? ☐ Yes ☐ No ☐ Unsure

Does your child regularly eat 3 meals each day? ☐ Yes ☐ No
Does your child snack frequently? ☐ Yes ☐ No # of times/day _____
What does your child typically snack on? _____
Is your child on a special or restricted diet? ☐ Yes ☐ No Describe: _____
Is your child a picky eater? ☐ Yes ☐ No
Is your child a slow eater? ☐ Yes ☐ No
Does your child drink juice? ☐ Yes ☐ No How much? _____
Does your child drink soda? ☐ Yes ☐ No How much? _____
Does your child drink seltzer or flavored water? ☐ Yes ☐ No How much? _____
Does your child drink sports drinks? ☐ Yes ☐ No How much? _____
Does your child drink energy drinks or coffee? ☐ Yes ☐ No How much? _____
Does your child chew gum? ☐ Yes ☐ No Is it sugar free? ☐ Yes ☐ No ☐ Unsure

Have your child's teeth ever been injured? ☐ Yes ☐ No When (age)? _____
Which teeth? _____ Injury? _____
Treatment? _____

Does your child have any of the following habits? (Please check all that apply)
☐ Pacifier ☐ Thumb Sucking ☐ Finger Sucking ☐ Grinding ☐ Snoring
☐ Mouth Breathing ☐ Tongue Thrust ☐ Lip Sucking ☐ Open Mouth Posturing ☐ Nail Biting
☐ Excessive Gagging ☐ Holding Food in Mouth ☐ Bottle to Sleep or Nap ☐ Walking Around with a Sippy Cup or Bottle

Has your child had any unhappy dental experiences? ☐ Yes ☐ No Please explain. _____
_____

Is there anything else you'd like to tell us? _____
_____

Parent Signature: _____ Relationship to Patient: _____ Date: _____

Reviewed by:_____

Privacy Policy/HIPAA Compliance

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand that medical information about you and your health is personal "Protected Health Information" ("PHI") and we are committed to protecting your medical information. PHI includes individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for such health care.

We use and disclose PHI about you for treatment, payment, and health care operations.

Treatment:

We may disclose PHI to your insurance provider, our dentist(s), and other dental care providers for treatment purposes. For example, your dentist may wish to provide a dental service to you but first seeks information from your insurance provider as to whether the service has been previously provided.

Payment:

We disclose your PHI in order to fulfill our duty to check your coverage, determine your benefits, and secure payment for services provided to you. For example, we use your PHI in order to request process of your claims by your insurance provider.

Health Care Operations:

We disclose your PHI as a part of certain operations, such as quality improvement. For example, we may use your PHI to evaluate the quality of dental services that were performed.

We may be asked by the sponsor of your health plan to provide your PHI to the sponsor. If we are asked to do so, we intend to honor such requests unless we are prohibited by law.

We may use or disclose your PHI without your authorization for several other reasons. Subject to certain requirements, we may give out PHI without your authorization for public health purposes, auditing purposes, research studies, and emergencies. We provide PHI when otherwise required by law, such as for law enforcement in specific circumstances, or for judicial or administrative proceedings. In any other situation, we will ask for your written authorization before using or disclosing your PHI. If you choose to sign an authorization to allow disclosure of your PHI, you can later revoke that

authorization to stop any future uses and disclosures (other than for treatment, payment, and health care operations).

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and send the new notice to you. You can also request a copy of our notice at any time.

Individual Rights

In most cases, you have the right to view or get a copy of your PHI. You also have the right to receive a list of instances where we have disclosed your PHI without your written authorization for reasons other than treatment, payment, or health care operations. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. You may request in writing that we not use or disclose your PHI for treatment, payment, and health care operations except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request but are not legally required to accept it. You also have the right to receive confidential communications of PHI by alternative means or at alternative locations, if you clearly state that disclosure of all or part of your PHI could endanger you.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we have made about access to your records, you may contact the address listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. Customer Service can provide you with the appropriate address upon request.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice. If you wish to inspect your records, receive a listing of disclosures, or correct or add to the information in your record, or if you have any questions, complaints, or concerns, please contact our office.