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Patient Information, Office and Privacy Policies, and Medical/Dental History Questionnaire

To provide the safest and most comprehensive dental care for your child, we ask for your cooperation in completing our detailed questionnaire.

Date: _____ Child's Name: _____ Nickname/Preferred Name: _____

Birthdate: Mo _____ Day _____ Year _____ Age: _____ SSN: _____

Gender: M F Preferred pronouns: _____ Cell phone: _____

Address: _____ City: _____ State: _____ Zip code: _____

Child primarily lives with: _____ Primary language spoken: _____

Who can we thank for referring you to our office? _____

Patient's Physician's Name: _____ Physician's Phone: _____

Are you child's immunizations up-to-date? Yes No

Is your child taking any medications? Yes No

List: _____

Has your child ever been hospitalized, sedated, or had surgery? Yes No

Explain: _____

Does your child have any allergies to medicines, latex, foods, or metals? Yes No

Explain: _____

Are antibiotics necessary for dental work because of a heart murmur, defect, prosthesis, shunt, organ transplant or other medical reason? Yes No

Explain: _____

Has any member of the family, including your child, had a problem with sedation or general anesthesia? Yes No

Explain: _____

Do any adults in your child's life use tobacco? Yes No

Medical History

If your child has or ever had any of the following conditions, please check "Yes" below.

Please explain any conditions to the doctor.

Yes	No	Condition
<input type="checkbox"/>	<input type="checkbox"/>	ADD/ADHD - Attention Deficit Disorder/Attention Hyperactivity Disorder
<input type="checkbox"/>	<input type="checkbox"/>	AIDS/HIV
<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Autism
<input type="checkbox"/>	<input type="checkbox"/>	Behavioral Problems
<input type="checkbox"/>	<input type="checkbox"/>	Birth Defects
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Gums
<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusions
<input type="checkbox"/>	<input type="checkbox"/>	Bone or Joint Problems
<input type="checkbox"/>	<input type="checkbox"/>	Brain Injury
<input type="checkbox"/>	<input type="checkbox"/>	Cerebral Palsy
<input type="checkbox"/>	<input type="checkbox"/>	Cancer/Tumor
<input type="checkbox"/>	<input type="checkbox"/>	Chemical Dependency
<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy/Radiation
<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox
<input type="checkbox"/>	<input type="checkbox"/>	Child Abuse
<input type="checkbox"/>	<input type="checkbox"/>	Cleft Palate/Lip
<input type="checkbox"/>	<input type="checkbox"/>	Cold Sores/Canker Sores
<input type="checkbox"/>	<input type="checkbox"/>	Developmentally Delayed (Age Level:_____)
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Earaches/Ear Infections
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizure Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Eye Conditions
<input type="checkbox"/>	<input type="checkbox"/>	Females: Are you pregnant?
<input type="checkbox"/>	<input type="checkbox"/>	Females: Are you taking birth control medication?

Yes	No	Condition
<input type="checkbox"/>	<input type="checkbox"/>	Hearing Impairment
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease
<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur
<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Liver Disease
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Injury To Front Teeth
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease
<input type="checkbox"/>	<input type="checkbox"/>	Mentally Handicapped
<input type="checkbox"/>	<input type="checkbox"/>	Metallic Implant, Shunts, Pins/Rods
<input type="checkbox"/>	<input type="checkbox"/>	Premature Birth
<input type="checkbox"/>	<input type="checkbox"/>	Prolonged Bleeding When Cut
<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease
<input type="checkbox"/>	<input type="checkbox"/>	Sore Throats
<input type="checkbox"/>	<input type="checkbox"/>	Speech Impairment
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease
<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Transplants, Organ (specify)
<input type="checkbox"/>	<input type="checkbox"/>	-----
<input type="checkbox"/>	<input type="checkbox"/>	Other (specify)
<input type="checkbox"/>	<input type="checkbox"/>	-----

Dental History

Is this your child's first dental visit? Yes No

Previous Dentist: _____ Date of last visit: _____

Date of last x-rays: _____

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

Explain: _____

How often does your child brush? _____

Is Fluoride Toothpaste used? Yes No Is dental floss used? Yes No

Is teeth brushing supervised? Yes No Does a parent do the brushing? Yes No

Does any member of the family have decay or fillings? Yes No

Explain: _____

Does your child receive (check all that apply):

Tap water Well water Bottled water Fluoride rinse Fluoride tablets/drops

Has there been any injuries to your child's teeth or jaws? Yes No

Explain: _____

History of (check all that currently apply):

Breast feeding Thumb sucking Bottle habits Pacifier Sippy cup Teeth grinding/clinching

Has your child had recent dental pain? Yes No

Explain: _____

Are you currently nursing? Yes No

How long did you nurse? _____

Does your child have a specific dental problem that needs attention? Yes No

Explain: _____

What does your child like to drink? _____

Explain: _____

What does your child eat for snacks?

Explain: _____

Auburn Pediatric Dentistry, P.C.

Financial Policy

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. 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 that you read and sign prior to any treatment. It is our hope that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choices related to your care.

INSURANCE:

Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services, including a pre-treatment estimate which we send to the insurance company at your request. It is physically impossible for us to have the knowledge and keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you. If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf.

Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion.

PAYMENT:

Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by the dentist.

FULL PAYMENT is due at the time of service. If insurance benefits apply, **ESTIMATED PATIENT CO-PAYMENTS** and **DEDUCTIBLES** are due at the time of service, unless other arrangements are made.

UNPAID BALANCE over 90 days old will be subject to a monthly interest of 1.0% (APR 12%). If payment is delinquent, the patient will be responsible for payment of collection, attorney's fees, and court costs associated with the recovery of the monies due on the account.

MISSED APPOINTMENTS: Unless we receive notice of cancellation 48 hours in advance, you will be charged \$75. Please help us maintain the highest quality of care by keeping scheduled appointments.

Financial Agreement: I have read, understand, and agree to the financial policy set forth by Auburn Pediatric Dentistry. I understand that this office has not contracted with any insurance company and will file my insurance as a courtesy. I understand that insurance benefits given at the time of service are only estimates and that I am responsible for the payment of this account. I understand that as soon as my insurance carrier issues a payment, or after 60 days, any unpaid portion of my claim will be due. I authorize my insurance carrier to issue benefits directly to this office and also the release of any information necessary to process the dental insurance. If the use of a third party becomes necessary to secure payment, I agree to be responsible for any and all collection charges incurred, which includes 35% of my outstanding balance and cost of collections, which include court costs and attorney fees.

Patient (guardian) _____ **Date** _____

Auburn Pediatric Dentistry, P.C.

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

You may refuse to sign this acknowledgement

I have received or been offered a copy of this office's Notice of Privacy Practices.

Please Print name

signature

date

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.
- communication barriers prohibited obtaining the acknowledgement.
- an emergency situation prevented us from obtaining acknowledgement.
- other (please specify)

Emergency Contact Information – other than parent

Name: _____ Relationship To Child: _____

Address: _____

Phone: _____ Cell Phone: _____ Work Phone: _____

Consent for Dental Treatment

The permission of a parent or legal guardian is necessary for dental treatment of a minor. As a minor child, it is necessary that signed permission be obtained from a parent or legal guardian before any dental care can begin. As the parent and/or legal guardian of the patient, I do hereby request and authorize Auburn Pediatric Dentistry and their staff to examine, clean, and provide dental, medical/surgical treatment as deemed necessary on my child. I further request and authorize the taking of dental x-rays as may be considered necessary to diagnose and/or treat my child's dental problem. Protective restraints are only used when a child might harm themselves or when certain procedures may jeopardize their health and welfare without such restraints. I also authorize the administration of anesthetics or analgesics that are advisable by Dr. Derrow, such as nitrous oxide (laughing gas). I understand that dental treatment for children includes efforts to guide their behavior by helping them understand the treatment in terms appropriate for their age. The usual and most frequent risks or complications occurring from dental operative treatment include but are not limited to, the possibility of pain or discomfort during the treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, temporary or permanent numbness, and allergic reactions.

I have given an accurate report of this patient's physical and mental health history. I have also reported any prior allergic or unusual reactions to medications, latex, foods, or metals, and any other disease or condition, including pregnancy.

I agree to inform Dr. Derrow and the staff of Auburn Pediatric Dentistry, P.C. of any changes in the medical history. This authorization is valid until revoked by me in writing.

SIGNATURE

RELATIONSHIP TO CHILD

DATE

Office Policies

NO SHOW / MISSED APPOINTMENTS POLICY

Missed appointments without 24-hour notification are considered "NO SHOW" appointments and will result in a \$75 fee. This fee must be paid before being scheduled again. After two "NO SHOW" appointments you will need to seek dental care elsewhere.

LATE ARRIVALS

Late arrivals for a scheduled appointment leads to inadequate time to accommodate the remaining patients on the schedule. As such, late arrivals of greater than 15 minutes may not be seen depending on the time available. In addition, those patients who are on the schedule and here at the assigned time will be seen first. We will try to accommodate late appointments if time permits.

TEXTING / EMAIL POLICY

Auburn Pediatric Dentistry, P.C. reserves the right to send text / email communications regarding practice updates, marketing promotions and feedback requests. I understand that by providing a cell phone number and an email address, I agree to receive texts or emails from Auburn Pediatric Dentistry, P.C. At any point, you may opt out. Message and data rates may apply.

SIGNATURE

RELATIONSHIP TO CHILD

DATE

Authorization for Verbal Communication

I _____ am giving consent to disclose any plan of care and/or changes in treatment/procedures, and financial information for my child/children that were provided or diagnosed by Auburn Pediatric Dentistry, P.C. :

Name: _____ Relationship: _____

Signature of Parent or Authorized Representative

Date

Signature of APD Representative

Date