CHILD PATIENT & GUARDIAN INFORMATION

THE FOLLOWING IS NECESSARY FOR US TO UNDERSTAND AND ADEQUATELY TREAT YOUR CHILD. PLEASE COMPLETE IN FULL. IF YOU HAVE ANY QUESTIONS OR NEED ASSISTANCE, PLEASE ASK.

PATIENT

Patient's Full Name: _____ Preferred Name: _____
Age: _____ Date of Birth: _____ Sex: _____SSN: _____
Address: _____
City: _____ State: _____ Zip: _____
Dental Insurance if not through a parent: _____ ID: _____Group: _____
Who can we thank for referring you to the practice? _____

GUARDIANS

Guardian 1: _____
SSN: _____
Date of Birth: _____
Email: _____
Address if different from patient: _____
_____
Cell:_____Other: _____
Empoyer: _____
Dental Insurance: _____
Group #: _____ Contract #: _____

Guardian 2: _____
SSN: _____
Date of Birth: _____
Email: _____
Address if different from patient: _____
_____
Cell:_____ Other: _____
Employerr: _____
Dental Insurance: _____
Group #: _____ Contract #:_____

*** PLEASE PROVIDE DRIVER'S LICENSE AND INSURANCE CARD OF PRIMARY POLICY HOLDER**

If parents are divorced or not living together, who has custody of the child? _____
Nearest relative not living with you: _____ Phone: _____

PLEASE LIST ANY STEP PARENTS OR ADDITIONAL LEGAL GUARDIANS BELOW:

Guardian Name	Relationship to Patient	Phone

AUTHORIZATION FOR ADULT <u>OTHER THAN PARENT OR GUARDIAN</u> TO CONSENT TO TREATMENT FOR A MINOR CHILD

I authorize the following adult(s) to consent to any dental cleaning, dental examination, x-ray examination, fluoride, local anesthetic, nitrous oxide, and all other dental treatment needs that may be needed for my child. These services are to be performed by Whitesburg Pediatric Dentistry. I also consent to the following adult(s) to call our office to obtain medical information, appointment information, or treatment records for my child.

Adults authorized to bring my child to Whitesburg Pediatric Dentistry:

If my children are 16 years or older and listed below, this authorizes them to bring both themselves and their siblings to dental appointments and consent to their treatment.

Date	Name of Authorized Adult	Relationship to child	Date & Sign if removing authorization

I am the patient's (Circle one): Mother Father Legal Guardian/Foster Parent

_____ _____ _____ _____
Signature Print Name Date WPD

CHILD PATIENT AND PARENT AGREEMENTS AND ACKNOWLEDGEMENTS

1. Patient's Rights: The patient or representative has the right to inquire about the patient's rights.
2. HIPAA Agreement: The Health Insurance Portability and Accountability Acto f 1996 (HIPAA) requres that health providers keep patient's medical and dental information private. The HIPAA Privacy Rule states that health providers must also post in a clear and prominent location and provide patients with a written Notice of Privacy Policy upon request. The privacy practices desrived are currently in effect. We reserve the right to change our privacy practices and the terms of this notice at any time, procided such changes are permitted by law. If changes are made, a new Ntice of Privacy Policy Will be displayed in our office and provided to patients. You may request a copy of our notice at any time.
3. Assignment of Financial Responsibility:
    - I hereby authorize Whitesburg Pediatric Dentistry (WPD) and any other provider rendering services to collect for all charges not covered by insurance. I understand that WPD will file insurance claims as a courtesy however, payment is due at the time services are rendered. This includes copays, estimates, and deductibles. We accept cash, checks, credit and debit cards.
    - I understand that WPD allows 45 dyas for payment from my insurance company after which I am responsible for the account balance.
    - I acknowledge that my insurance is a contract between myself, my employer, and the insurance company. WPD is not a party to that contract. Not all services are covered benefits in all contracts and some insurance companies arvitarily select certain services they will not cover.
    - I authorize parment for all collection costs, securing, or attempting to collect or secure, including reasonable attorney fees or collection agency fees, whether a lawsuit is necessary or otherwise.
    - I agree that WPD and/or associated agents may contact me by phone, text, and/or email using any phone numbers or addresses associated with my account.
    - I understand that all patients who are considered legal adults are financially responsible for all services rendered. If my child is a minor, I will be financially responsible for his/ her services.
    - WPD may release health information to insurance companies and other professionals providing services. Health information may be released to insurance companies should the need arise, especially in the case of accidents.
    - I am aware that WPD will not become a party to divorce situations.
4. Appointment Agreement: Out of respect to our team at WPD and to our other patients, we kindly request advanced notice if your child will not be able to attend his/her appointment. I acknowledge that any missed appointment or an appointment that is cancelled with less than 48 hour notice will result in a $50 fee per child charged to my account. Likewise, if my child arrives more than 15 minutes late for his/her appointment, this will be considered a missed appointment, and the appointment will need to be rescheduled.

THE SIGNATURE BELOW APPLIES TO ITEMS # 1-4 INDICATED ABOVE. I HAVE READ AND UNDERTAND THE ABOVE STATEMENTS, ALL OF MY QUESTIONS HAVE BEEN ANSWERED, AND I HAVE WILLINGLY SIGNED THIS DOCUMENT.

I am the patient's (Circle one): Mother Father Legal Guardian/Foster Parent

Signature	Print Name	Date	WPD

***CHILDREN UNDER THE AGE OF 16 MUST HAVE A PARENT OR GUARDIAN PRESENT ON OFFICE PREMISES AT ALL TIMES. ***

IN THE STATE OF ALABAMA, PATIENTS 14 YEARS AND OLDER CAN LEGALLY MAKE THEIR OWN MEDICAL DECISIONS. IF THE PARENT/GUARDIAN WOULD LIKE TO BE PRESENT FOR JOINT DECISION MAKING, THE PARENT/GUARDIAN MUST REMAIN ON OFFICE PREMISES DURING THE CHILD'S APPOINTMENT. OTHERWISE, THE PATIENT HAS THE RIGHT TO CONSENT TO HIS/HER OWN TREATMENT.

Signature	Print Name	Date	WPD

CONSENT FOR DENTAL, MEDICAL, AND EMERGENCY TREATMENT

I hereby authorize WPD to render usual and customary dental, medical, and emergency treatment. This includes diagnostic and radiological procedures, minor surgical procedures, administration of local anesthetics as necessary, and other treatment considered advisable or necessary by the dental care provider.

CONSENT FOR X-RAYS, FLUORIDE, AND NITROUS OXIDE

We practice conservative dentistry. When posible, we like to obtain cavity detecting bitewing x-rays once a year, a panoramic x-ray ever three years, and we place fluoride varnish every 6 months. In addition, nitrous oxide is routinely used for treatment appointments. Do we have your permission to perform these services when necessary?

☐ No (Elaborate if so):_____

☐ Yes

If no is chosen, the parent MUST stay on premesis while treatment is being rendered so that permission may be obtained when necessary.

CONSENT FOR PREFERRED METHOD OF CONTACT

☐ Email ☐Text ☐CelL ☐Other Phone(Please Specify):_____

☐I authorize WPD to leave a detailed voicemail regarding my child's dental care.

PHOTO CONSENT

I hereby give consent to Whitesburg Pediatric Dentistry to maintain any photographs and/or videos of my child as a record of his/her care. The content may also be used for advertising purposes including website publications and social media. I further understand that if the photographs or videos used in any publication or as part of a demonstration, my identifying information (first name only) could be used unless stated differently below. I do not expect compensation, financial or otherwise, for use of these photographs. If I wish to revoke consent, I will do so in writing.

☐Yes ☐No Photographs or videos of my child may be used for communication with other healthcare professionals, in educational publications, and in educational lectures.

☐Yes ☐No Photographs or videos of my child may be used for advertising purposes including website publications and social media.

I HAVE READ AND WILLINGLY COMPLETED ALL OF THE ABOVE INFORMATION REGARDING CONSENT FOR MY CHILD. ALL MY QUESTIONS HAVE BEEN ANSWERED.

I am the patient's (Circle one): Mother Father Legal Guardian/Foster Parent

Signature	Print Name	Date	WPD
Signature of patient 14 or older	Print Name	Date	WPD

CHILD PATIENT MEDICAL HISTORY

PHYSICIAN & PHARMACY

Child's Physician: _____ Physician Phone: _____ Last Exam: _____
Physician Address: _____

Is your child under the care of any medical specialists? (Ex.: Psychiatrist, Allergist, Cardiologist?) ☐Yes ☐No
If so, please list name and phone number: _____

Preferred Pharmacy: _____ Phone: _____
Pharmacy Address: _____

Are your child's immunizations up to date? ☐Yes ☐No
May we request the release of your child's medical records for our reference? ☐Yes ☐No

MEDICATIONS

Is your child any daily medications? (Including vitamins, over-the-counter medications, and inhalers?) ☐Yes ☐No
If yes, please list medication(s), dose, and frequency below (use back of page if necessary).

Medication	Dose	Frequency

Has a physician recommended your child take antibiotic premedication prior to dental treatment? ☐Yes ☐No
If yes, please list prescribing physician and medication: _____

ALLERGIES

Is your child allergic to any medications? ☐Yes ☐No
If yes, please list medication(s) & reaction(s): _____
Does your child have any other allergies? ☐Yes ☐No
If yes, please list allergies and reaction(s): _____

SURGICAL & HOSPITALIZATION HISTORY

Has your child ever been hospitalized? ☐Yes ☐No
If yes, please list reason(s) and date(s): _____
Has your child ever undergone a surgical procedure? ☐Yes ☐No
If yes, please list reason(s) and date(s): _____

MEDICAL, PHYSICAL, BEHAVIORAL, AND EMOTIONAL DIAGNOSES

ADHD	☐Yes ☐No	Cleft Lip/Palate	☐Yes ☐No	Liver Conditions	☐Yes ☐No
AIDS/HIV	☐Yes ☐No	Developmental Delay	☐Yes ☐No	Physical Handicap	☐Yes ☐No
Anemia	☐Yes ☐No	Diabetes	☐Yes ☐No	Sickle Cell Anemia	☐Yes ☐No
Asthma	☐Yes ☐No	Down's Syndrome	☐Yes ☐No	Sleep Apnea	☐Yes ☐No
Autism	☐Yes ☐No	Epilepsy/Seizures	☐Yes ☐No	Speech Delay	☐Yes ☐No
Anxiety or Depression	☐Yes ☐No	Hearing Impairment	☐Yes ☐No	Stomach Conditions	☐Yes ☐No
Bleeding Disorders	☐Yes ☐No	Heart Condition	☐Yes ☐No	Thyroid Condition	☐Yes ☐No
Cancer	☐Yes ☐No	Hepatitis	☐Yes ☐No	Vision Impairment	☐Yes ☐No
Cerebral Palsy	☐Yes ☐No	Kidney Conditions	☐Yes ☐No	Other	☐Yes ☐No

If other, please explain: _____
Has any other member of your immediate family had problems with any of the above? _____

CHILD PATIENT DENTAL HISTORY

Briefly explain the reason or chief concern for today's visit: _____

Is today your child's first visit to the dentist? ☐Yes ☐No
If no: Previous Dentist's Name: _____Phone Number: _____City/State:_____
Date of last visit: _____Services provided: _____

Has your child ever had dental x-rays? ☐Yes ☐No
If yes, please list type (if known) and date: _____

Has your child ever experienced a dental injury? ☐Yes ☐No
If yes, please describe and list date: _____

Does your child have a toothache today? ☐Yes ☐No
If yes, Where is the toothache? _____When did it begin? _____
What makes the tooth hurt? _____What makes it feel better? _____

Has your child ever had a traumatic experience in a dental office? ☐Yes ☐No
If yes, please describe: _____

Do you have any behavioral concerns for your child regarding today's visit?
If yes, please describe: _____

Please list some of your child's interests: _____

DIET & ORAL HYGIENE

Does your child brush his/her own teeth? ☐Yes ☐No How often?_____	Is your water supply fluoridated? ☐Yes ☐No
Does your child use dental floss? ☐Yes ☐No How often? _____	Does your child breastfeed or use a bottle? ☐Yes ☐No
Does your child use toothpaste with Fluoride? ☐Yes ☐No	What does your child eat for snacks daily? _____
Has your child ever had any oral habits? ☐Yes ☐No Circle all that apply: Thumb Sucking / Finger Sucking / Pacifier Use Is the habit still active? ☐Yes ☐No	What does your child drink daily? Circle any that apply. Juice / Tea / Lemonade / Soda / Sports Drinks Milk / Water # of beverages other than water per day: _____

I HAVE COMPLETED ALL OF THE ABOVE INFORMATION REGARDING MY CHILD'S COMPLETE HISTORY

I am the patient's (Circle one): Mother Father Legal Guardian/Foster Parent

_____	_____	_____	_____
Signature	Print Name	Date	WPD
_____	_____	_____	_____
Signature of Patient 14 or Older	Print Name	Date	WPD

Broken Appointment Policy

No Charge: Cancellation or rescheduling of an appointment with **48 hours or more notice.**

$50.00: Cancellation or rescheduling of an appointment less than **48 hours** prior to the appointment.

Definition of a broken appointment: A broken appointment is when you cancel or reschedule an appointment with less than sufficient notice or do not show up for the appointment.

Our patient's dental health is our number one concern. We strive to keep the cost of dental services as economical as possible. The appointment you schedule for treatment is reserved specifically for you and your recommended treatment only. When you fail to keep your appointment without providing adequate notice, this adds to the overall cost for us to provide care to all patients.

We appreciate your understanding and consideration regarding our appointment policy and if you have any questions or concerns, please do not hesitate to ask.

I have read and understand the above-mentioned policy.

I am the patient's (Circle one): Mother Father Legal Guardian/Foster Parent

Signature	Print Name	Date	WPD
Signature of Patient 14 or Older	Print Name	Date	WPD