camas
pediatric dentistry

Date _____

Patient Information Form

The information provided on this form is important to your children's health. Please complete all of questions to the best of your ability. If there have been any changes in your health, please tell us. Questions are welcome and appreciated.

Patient Information

Patient Name 1: _____

Patient Name 2: _____

Patient Name 3: _____

How did you hear about us?: _____

Parent/Guardian Information

Parent/Guardian Name 1: _____ Relation to Patient: _____ Date of birth: _____

Home phone: _____ Work phone: _____

Cell phone: _____ Email: _____

Mailing Address: _____
STREET APT #

_____
CITY STATE ZIP

Employer: _____ Occupation: _____

Preferred way to contact: ☐ Home Phone ☐ Cell Phone ☐ Email ☐ Work Phone

Parent/Guardian Name 2: _____ Relation to Patient: _____ Date of birth: _____

Home phone: _____ Work phone: _____

Cell phone: _____ Email: _____

Mailing Address: _____
STREET APT #

_____
CITY STATE ZIP

Employer: _____ Occupation: _____

Preferred way to contact: ☐ Home Phone ☐ Cell Phone ☐ Email ☐ Work Phone

Emergency Contact:
(Please list contact other than parent/guardian):

Relation to Patient: _____ Home phone: _____

Patient Insurance Information

Primary Insurance Provider: _____ Subscriber: _____
(Bring copy of card to appointment) (Legal Name):

Date of birth: _____ Social Security Number: _____

Employer: _____ Relationship to Patient: _____

ID#: _____ Group#: _____ Effective Date: _____

Secondary Insurance Provider: _____ Subscriber: _____
(Bring copy of card to appointment) (Legal Name):

Date of birth: _____ Social Security Number: _____

Employer: _____ Relationship to Patient: _____

ID#: _____ Group#: _____ Effective Date: _____

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Medical History Form

Although dentistry deals with primarily teeth and its surrounding structures, oral cavity is a part of the entire body. Health problems that your child may have, or medications that your child may be taking could have an important interaction with dentistry your child may receive. Thank you for answering the following questions thoroughly.

Contact Information

Patient First Name: _____

Patient Middle Name: _____

Patient Last Name: _____

Date of Birth: _____ Age: _____ Male / Female

Medical History

Name of Child's Physician: _____

Child Physician's Phone Number: _____

Any problems/complications durning pregnancy/delivery? If yes, please explain: _____

Does your child have any health problems? If yes, please explain: _____

Has your child been diagnosed with any medical conditions? If yes, please explain: _____

Does your child have any allergies? If yes, please explain: _____

Has your child ever been hospitalized? If yes, please explain (For & When): _____

Has you child ever had surgery? If yes, please explain (For & When): _____

Is your child taking any medication? If yes, please list: _____

Are your child's immunizations up to date?: _____

Medical History

- ☐ AIDS/HIV Positive
- ☐ Diabetes
- ☐ Hepatitis A/B/C
- ☐ ADHD/ADD
- ☐ Down Syndrome
- ☐ Liver/Kidney Disease
- ☐ Arthritis
- ☐ Ear Infection
- ☐ Leukemia
- ☐ Asthma
- ☐ Emotional Problems
- ☐ Prolonged Bleeding
- ☐ Autism
- ☐ Endocrine Problems
- ☐ Rheumatic Fever
- ☐ Blood Problems
- ☐ Epilepsy Seizures
- ☐ Speech Problems
- ☐ Bronchitis
- ☐ Eye Problems
- ☐ Tonsillitis
- ☐ Cancer
- ☐ Hearing Problems
- ☐ Tuberculosis
- ☐ Cerebral Palsy
- ☐ Heart Problems
- ☐ Thyroid Disease

Main reason for today's visit: _____

How often are the child's teeth brushed? ☐ 1x/day ☐ 2x/day ☐ Every Other Day ☐ Not Regularly

How often are the child's teeth being flossed? ☐ 1x/day ☐ 2x/day ☐ Every Other Day ☐ Not Regularly

Who does the brushing and flossing? ☐ Parent ☐ Child ☐ Half/Half ☐ None

Fluoride Use? ☐ Rx by MD/DMD ☐ In H2O ☐ Toothpaste ☐ Rinse ☐ None

When was your child weaned off nursing/bottle? ☐ 6 Months ☐ 12 Months ☐ 24 Months ☐ Still Use

Does your child have any oral habits? ☐ Thumb/Finger ☐ Binky ☐ Mouth Breather ☐ Grinding

History of Dental Trauma? If yes, please explain: _____

How would you rate mother's oral health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ I don't know

How would you rate father's oral health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ I don't know

How would you rate your child's candy consumption? (candy, juice, etc) ☐ Low ☐ Average ☐ High

Is there any additional medical/dental information you may want the dentists to know? _____

_____

Signature: _____

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Understanding Your Dental Insurance

Dental insurance is designed to help pay part of the cost of dental treatment. Dental insurance is not designed to pay all of the cost of treatment; it is more like a benefit towards the total costs.

We do our best to retrieve your child's dental benefits prior to their scheduled appointments. The information that we receive is not a guarantee of payment from your insurance company. They will only consider payment when a claim is received. The benefit information that we receive from them is very basic, meaning that the information that we provide to you is only an estimate based on the information provided to us. Since there is no guarantee that we will receive full payment from your insurance company, it is important to understand that ultimately you are responsible for your child's bill.

Initial _____

Financial Consent

I acknowledge that I have read and agree with the office financial policy. I understand that any estimate of my insurance benefits is solely an estimate and not a guarantee of payment. I understand that this office bills my insurance as a courtesy and is not required to file my claims either legally or contractually. I am ultimately responsible for knowing the benefits and limitations of my plan. I understand that this office may place composite (tooth-colored) fillings and I may have a higher copay if my insurance only covers amalgam (silver) fillings for back teeth. I also understand other charges such as (but not limited to) nitrous oxide (laughing gas) and fluoride may not be covered by insurance and will be my financial responsibility.

Initial _____

I certify that I have given the correct insurance information to the office and will notify the office of any changes in insurance company coverage. I also understand that fees and treatment needs are subject to change and previous estimates are not to be considered a guarantee.

Initial _____

I acknowledge that payment in full is expected in cases of no insurance unless extended financing has been obtained.

Name of Parent/Guardian _____

Signature _____ Date _____

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General Consent

I request and authorize Harmony Pediatric Dentistry to perform examinations, cleanings, radiographs (x-rays), photographs, and fluoride for my child as necessary. I understand that any treatment needs will be explained to me prior to treatment and I give consent for Dr. Tee to do recommended treatment as needed.

I state that I am the child's legal guardian and that I have read and agree to follow all office policies stated on the website and available within the office. This consent will remain in effect unless cancelled in writing.

I agree to notify this office of any change in my child's health, including any allergies or current medications/supplements. As well as any changes in contact and insurance information.

I authorize Harmony Pediatric Dentistry to release any information necessary to any providers pertaining to my child's dental care and for processing of dental insurance claims and authorize direct payment from the insurance company to Harmony Pediatric Dentistry.

Name of Parent/Guardian _____

Signature _____ Date _____

Acknowledgment of Receipt of Notice of Privacy Practices. You may refuse to sign this acknowledgment.

I have reviewed a copy of Harmony Pediatric Dentistry notice of privacy practices.

Name of Parent/Guardian _____

Signature _____ Date _____

FOR OFFICE USE ONLY

We attempted to obtain Acknowledgment of Receipt of our notice of privacy practices, but Acknowledgment could not be obtained because:

☐ Individual refused to sign ☐ Communication barriers prohibited obtaining acknowledgment

☐ Other _____

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To make sure that every patient gets individual attention, we set aside dedicated time for each appointment. Our staff takes the time to prepare for each appointment by sterilizing, organizing, and setting up the room specifically to meet your child's needs prior to your arrival. This ensures that your child receives the highest quality of care that we pride ourselves in.

Running Late

Arriving more than 10 minutes late for an appointment will require rescheduling. We will do everything we can to accommodate you; however we schedule each appointment according to the time needed to provide quality care for your child. If you are late to your appointment it doesn't allow us to provide the quality of service that we strive for. Please call if you are going to be late. Our office makes every attempt to be on time, but we do run on "kid time". Some children require additional time, and understand that we will do the same for your child as needed.

Cancellations

Because appointed times are reserved exclusively for each patient we ask that you please notify our office 48 hours in advance if you are unable to keep your appointment. Another patient who needs our care can be scheduled if we have sufficient time to notify them. We realize that unexpected things can happen, but we ask for your cooperation.

No Shows

If no notice is given and your child no shows to a scheduled appointment, we may ask that your child be seen by another dental office for future appointments.

By signing this policy, I have read and understand the cancellation policy.

Name of Parent/Guardian _____

Signature _____ Date _____