Dentists 4 Children

PATIENT INFORMATION

TODAYS DATE: _____

NAME (FIRST, MIDDLE, LAST): _____ DOB: _____

PREFERRED NAME: _____ SEX: ☐FEMALE ☐MALE

ADDRESS, CITY, STATE, ZIP: _____

APPT REMINDER TEXT#: _____ APPT REMINDER EMAIL: _____

PARENT OR GUARDIAN INFORMATION

MOTHER'S NAME (FIRST, MIDDLE, LAST) _____ DOB: _____

ADDRESS, CITY, STATE, ZIP: _____ SS#: _____

HOME#: _____ CELL#: _____

EMAIL: _____ EMPLOYER/WORK#: _____

EMERGENCY NAME AND PHONE#: _____

FATHER'S NAME (FIRST, MIDDLE, LAST): _____ DOB: _____

ADDRESS, CITY, STATE, ZIP: _____ SS#: _____

HOME#: _____ CELL#: _____

EMAIL: _____ EMPLOYER/WORK#: _____

EMERGENCY NAME AND PHONE#: _____

PREVIOUS DENTIST, CITY, STATE, ZIP, PHONE#: _____ ALLOW RECORDS RELEASE: **YES**

HIPAA NOTICE OFFERED ON WEBSITE: **YES** ALLOW VOICE, EMAIL, TEXT REMINDER MESSAGE: **YES** ALLOW PATIENT PORTAL: **YES**

PRIMARY DENTAL INSURANCE INFORMATION: ☐ N/A

SUBSCRIBER NAME: _____ SUBSCRIBER DOB: _____

SUBSCRIBER EMPLOYER: _____ DENTAL INSURANCE COMPANY: _____

DENTAL CLAIMS ADDRESS: _____ DENTAL CLAIMS PHONE#: _____

PLAN NAME/ GROUP#: _____ CONTRACT/POLICY# OR SS#: _____

SECONDARY DENTAL INSURANCE INFORMATION: ☐ N/A

SUBSCRIBER NAME: _____ SUBSCRIBER DOB: _____

SUBSCRIBER EMPLOYER: _____ DENTAL INSURANCE COMPANY: _____

DENTAL CLAIMS ADDRESS: _____ DENTAL CLAIMS PHONE#: _____

PLAN NAME/ GROUP#: _____ CONTRACT/POLICY# OR SS#: _____

Dentists 4 Children

Date: _____

Patient Name: _____ **Patient Date of Birth:** _____

Name of Person Updating: _____ **Relationship:** _____

Due to HIPAA Laws, Is Patient Over 16 Years of Age? ☐Yes ☐No

Is the Patient Pregnant? ☐YES ☐NO ☐OVER 16 YRS OF AGE ☐MALE

Allergic to Food or Medications? ☐YES ☐NO ☐NONE KNOWN

If Yes, Please List: _____

Any Dairy Allergies? (for MI Paste) ☐YES ☐NO

If Yes, Which Allergies? ☐Casein (milk protein) allergy ☐Paraben allergy ☐Whey allergy
☐Undergoing dialysis ☐Salicylates allergy ☐Titanium dioxide allergy
☐Xylitol allergy ☐Diagnosis of Phenylketonuria (PKU) ☐None

Any Fluoride Varnish Allergy? (Peanut or Tree Sap) ☐YES ☐NO

If yes, Which One? ☐Peanuts or Nuts in general ☐Pine Tree Sap ☐None

MEDICAL HISTORY: ☐ADD/ADHD ☐Anemia ☐Asthma ☐Autism/Mental Challenges or Delays
☐Cancer or Tumor ☐Cerebral Palsy ☐Chronis Sinus
☐Cystic Fibrosis ☐Depression/Anxiety ☐Excessive Bleeding ☐Hemophilia
☐Von Willebrand Disease ☐Idiopathic Thrombosis ☐Fainting Spells
☐HIV/AIDS ☐Kidney or Bladder ☐Language Delays ☐Liver or Hepatitis
☐Mastoid ☐Physical Challenges ☐Sickle Cell or Trait ☐Thyroid
☐Tuberculosis ☐(MTHFR) methylenetetrahydrofolate reductase
☐NONE ☐Notes: _____

If Yes, List Diagnosis Date, Physician, Phone#: _____

Currently Taking Medications for ADD/ADHD? ☐Yes ☐No **NAME/DOSE:** _____

Any Other Medications? ☐YES ☐NO **If Yes, Medications & Dosage Info:** _____

Ever Had HEART ISSUES (Even at Birth)? Ex: Murmur, Valves, Surgeries, etc? ☐YES ☐NO

If Yes, Cardiologist Name? _____ **Phone #?** _____

SBE Needed for Heart Coverage? ☐YES ☐NO ☐N/A

Ever Had Chicken Pox, Measles, Mononucleosis, Mumps, Rheumatic Fever? ☐YES ☐NO

If Yes, When? _____

Patient's Pediatrician, City, State, Zip and Phone#: _____

Excessive Bleeding When Cut? ☐Yes ☐No ☐Unsure

If Yes, Please Explain: _____

Ever Been Hospitalized? ☐Yes ☐No

If Yes, List When and Why: _____

Any Surgeries? ☐Yes ☐No

If YES, list why and when: _____

Complained of Dental Problems? ☐Yes ☐No

If Yes, Please Explain: _____

Is Fluoride Given in Home? (water, toothpaste, etc) ☐Yes ☐No ☐Unsure

Source? _____

Please list any other medical treatment, injuries, physical or emotional needs that we need to be aware of:

I, the undersigned parent, or guardian of the above patient, am hereby disclosing my child's health history information, including current medications, allergies, reactions to medicine, diseases/chronic illness, and past procedures. I have updated all registration history including address, phone number, financial and insurance information and/or changes with Dentists 4 Children, LLC.

I understand that my insurance claims will be filed as a courtesy and that all co-pays and deductibles will be paid at time services are rendered. I understand that my payment at time of service is only an estimate until all claims have been received from my insurance company. At which time a statement will be sent for any remaining balance. I understand that I will be financially responsible for any treatment I choose that is not covered by my insurance plan. I understand that I am agreeing to this patient's treatment, therefore, I am the responsible party regardless of who carries the dental insurance as well as custody/divorce decrees. I agree to all financial responsibility including any collection fees associated with past due accounts.

I understand that I have a right to Dentists 4 Children, LLC HIPAA policies and all questions and concerns have been asked and answered concerning all new OSHA and COVID19 safety protocols.

I have reviewed and verified this information to be true. I agree to notify Dentists 4 Children, LLC with all changes that may occur in the future. I understand that with holding this information may affect the outcome of the procedure(s) or course(s) of treatment and/or future treatment.

I am a native speaker of English or have brought a qualified translator who has explained the information in my native tongue.

_____ _____

Print Parent or Guardian's Name **Relationship to Patient**

X _____ _____

Parent of Guardian's Signature **Date**

DENTISTS 4 CHILDREN NOTICE OF CONSENT

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g., my insurance company)
- The day-to-day healthcare operations of your practice.

I have been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information. and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice f.om time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However. any use or disclosure that occurred prior to the date I revoke this consent is not affected.

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

- I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for the delivery of proper dentalcare.
- I authorize release of any information concerning my (or my child's) healthcare, for the advice and treatment provided for purpose of evaluation and administering claims for insurance benefits.
- I authorize release of any information concerning my (or my child's) healthcare, for the advice and treatment to another dentist, or another healthcare professional and their staff.

FINANCIAL RESPONSIBILITY

- I hereby authorize payment of insurance benefits directly to the dentist, otherwise payable to me.
- I understand that my dentist and staff will estimate insurance benefits as close as possible. I understand that I am responsible for payment of the account, and providing correct insurance information.
- I understand that if insurance is not applicable when dental services are rendered, then full payment is due at the time of service.

DO WE HAVE PERMISSION FOR THE FOLLOWING?

- Allow Voice Mail Message, SMS Text Message, Email Message Y / N
- Allow Health Information Exchange Between Doctors Y / N
- Speak to other members of your household regarding your appointment? Y / N
- Leave a message at your place of employment? Y / N

PLEASE LIST NAMES OTHER THAN PARENTS THAT MAY BRING / CONSENT FOR TREATMENT ON YOUR BEHALF

_____

_____

Signature: _____ Date: _____

7015 Halcyon Park Drive Montgomery, AL 36117 334-284-1100 Fax- 334-281-12485 Email- Office@DentistS4children.com

Dentists 4 Children

Patient(s) Name: _____

Behavioral techniques endorsed by the AAPD can make for a more pleasant visit. The most common are "the gas" & mouth props' However' if passive restraint (papoose) is needed, your signature will be attained first.	INITIAL _____
Estimated copays due at appt Remaining balance after ins pays, will be mailed or texted to you. Please contact ins if you need exact copay amounts on services such as white fillings, seals, or nitrous oxide (the gas)	INITIAL _____
Local anesthetics (numbing) is given by an RDH (hyg) with a local infiltration certificate rare side effects include but not limited to dizziness, twitching, metallic taste, seizure, low bp, slowed hr, allergic reactions.	INITIAL _____
I authorize Dentists 4 Children llc,/staff to perform the best techniques including but not limited to: radiographs, study models, photos, diagnostic aids or materials. anesthetics/nitrous oxide, compulsory life-saving procedures/medication	SIGNATURE: _____
I understand that written authorization must be given for anyone to act on behalf of the legal parent or guardian. Dentists 4 Children llc has addressed all my concerns and the above is true.	SIGNATURE: _____ Date: _____

7015 Halcyon Park Dr. Montgomery, AL 36117 334-284-1100 Fax-334-281-1245 Email-Office@DentistS4children.com

DENTISTS 4 CHILDREN-CONSENT INFORMATION

Dentists 4 Children, LLC complies with all safety measures required by the State of Alabama, CDC, OSHA, HIPAA and follows guidelines provided by the American Dental Association. If at any time you would like a 2nd copy of our policies, please ask our front desk staff.

Our reminder system will email and text you several times to remind and confirm your scheduled appointment. Please keep all emails and cell phone numbers updated so that our system can reach you. Please reply YES so, the system will confirm the appointment. Please be aware that if you have more than one child scheduled or you have back-to-back appointments on hygiene and treatment, you may receive multiple reminders showing different appointment times. Please use the earliest appointment time. This will ensure that we have plenty of time to perform all procedures necessary. If you need to cancel, please reply No then you must call at least 24 hours in advance or leave a message on our voicemail system.

We do have a patient portal where appointments can be verified, messages can be sent to the staff, and forms can be completed. Please notify us if you need a new invite or instructions on how to.

As your child's dental office, we want to provide you with your choice of dental services while keeping you informed of the best dental techniques available. Certain services offered may not be covered by your insurance and each child's insurance policy varies. Please check with your insurance on the frequencies and limitations of your policy. Our policy is to do routine x-rays and fluoride treatments EVERY 6 months. If you do not wish to have routine x-rays or fluoride, we must have this in writing before each appointment. We can give you our best estimate, but for an exact amount you will need to contact your insurance company directly.

Estimated co pays are due at the time of service. Once insurance payments are received, statement info is mailed/texted for any remaining balance. Please call us to make payments over the phone or to make a payment plan. We will gladly file insurance claims for you but please understand that regardless of insurance subscriber/carrier or divorce decree, Dentists 4 Children, LLC will assign responsibility to the parent or guardian responsible for bringing the child to our office. If you are sending your child with someone on your behalf, please send the co pay on that date of service. If needed, Dentists 4 Children, LLC will gladly supply receipts or itemized statements for any reimbursement.

Due to young age, many children cannot receive proper treatment without behavior management techniques. The most commonly used includes nitrous oxide/oxygen (the gas) and mouth props. It is our experience that these procedures help to make it a more pleasant experience for your child. These techniques are endorsed by the American Academy of Pediatric Dentistry. I understand that my signature below, is authorizing Dentists 4 Children, LLC and their staff the discretion to choose if these techniques should be used. I understand that in the event the use of passive (papoose) restraint is necessary to complete the dental treatment, I will be notified by the dental team. I will be asked for my consent and signature before this technique is used.

Your signature below shows an understanding of this statement. "I authorize and request my insurance to pay directly to Dentists 4 Children, LLC. This office may not participate with my insurance company so I will be responsible if a lesser amount is paid or if any part of my claim is denied for any reason. If another parent or guardian has insurance on my child, I understand that I am ultimately responsible for supplying the insurance information to Dentists 4 Children. If for some reason, my insurance pays directly to the subscriber, I understand that I am responsible for the balance".

My signature below confirms that I have read the above information and agree to all terms. I understand that as a courtesy to me, my insurance claims will be processed for me, but I will be responsible for deductibles and co pays at the time services are rendered. I authorize responsible for all fees including co pays and denial of claims. I understand that finance charges may be applied to past due balances and additional fees may be added for missed appointments without a 24-hour notice. I am accepting the fee charges as a lawful debt and promise to pay said fee including the cost of collection, attorney fees, and court costs is such be necessary, waiving now and forever the right to claim exemption under the constitution and laws of the state of Alabama.

All questions and concerns up to this point have been addressed by the dental team of Dentists 4 Children, LLC. I understand that I may discuss treatment or concerns as they arise, and they will be handled accordingly.

_____

Signature of Parent or Guardian ***Date***

DENTISTS 4 CHILDREN-PARENT INFORMATION

If a child's mouth is to develop and grow properly, the first (primary) teeth must be healthy. Please realize that x-rays enable the dentist to thoroughly examine and condition a patient for treatment. Moreover, this is an easier introduction to dentistry rather than rushing into the mouth with instruments.

At the first visit the teeth are cleaned, painted with fluoride varnish, and x-rays will be taken. Your child will be instructed on the care of his or her teeth. This will include tooth brushing instruction as well as diet control. If the child is suffering from a toothache, emergency treatment will be made on that tooth only. No fillings will be done on a first visit. We do prefer to see our smaller children (6 years and under), special needs patients, and/or uncooperative patients during our morning appointments.

On completion of these procedures, your child will be examined by Dr. Vann, Thornton, or Dr. Jenkins, and the condition of your child's mouth will then be related to you. If you prefer a specific provider or hygienist, please inform the assistant who calls your child back to the treatment room otherwise, either or all doctors may examine your child. **We find generally, that children enjoy being the center of attention. As a result of this desire, they cooperate better if the parent does not accompany them into the treatment room. Let your child enjoy "His or Her Day". The doctors, hygienists, and assistants will discuss your child's dental health with you at the proper time.**

It is essential that you discuss dentistry at home so that your child understands why he or she is being brought to the dental office. Please use positive phrases and refrain from saying "the doctor will not hurt you." Instead, say "the doctor will be gentle while working". We will treat your child as we would our own children while rendering dental care to them. We want them to have a fun experience, but the important thing is to do the dentistry and do it correctly. Children's dentistry is not a game or a plaything but a health service. We do offer special techniques such as nitrous oxide and mouth props to help make the treatment visit as pleasant as possible. Papoose procedures and other behavior management techniques will require your signature and will be discussed before these techniques are used. Please do not be upset if your child cries. Crying is a normal reaction to fear. Children are sometimes afraid of things new or strange. We will explain procedures and spend as much time as is needed in order to make them feel as comfortable as possible!

It is our intention never to keep a patient waiting past his or her appointment time. For this reason, we ask that you be prompt for all appointment. However, please realize that a child may require more attention than was expected and may run into your allotted time. Please understand that we will give your child the exact attention that he or she needs when it is their turn. If an appointment needs to be canceled or rescheduled, please notify us at least 24 hours in advance to avoid broken appointment fees.

Our appointment reminder system will email and text you several times to remind and confirm your scheduled appointment. Please keep all emails and cell phone numbers updated so that our system can reach you. Please reply YES so, the system will confirm the appointment. Please be aware that if you have more than one child scheduled or you have back to back appointments on hygiene and treatment, you may receive multiple reminders showing different appointment times. Please use the earliest appointment time. This will ensure that we have plenty of time to perform all procedures necessary. If you need to cancel, please reply no and you must call at least 24 hours in advance or leave a message on our voicemail system. We do have a patient portal where appointments can be verified, messages can be sent to the staff, and forms can be completed. Please notify us if you need a new invite or instructions on how to use our patient portal.

If you ever need to discuss your child's dental health, please feel free to call our office. Thank you for allowing us to be a part of your child's "SMILE".

_____

Signature of Parent or Guardian ***Date***