PATIENT'S CONFIDENTIAL INFORMATION

PATIENT INFORMATION

Child's Full Name: _____ Nickname: _____
Date of Birth: _____ Age: _____ SS#:_____ Sex: ☐M ☐F
Address: _____ City: _____State: _____ Zip: _____
How did you hear about our office? _____

PARENT/GUARDIAN INFORMATION

Father/Guardian Name: _____Date of Birth:_____ SS#_____
Address: Same as patient? ☐Yes ☐ No
If not, please list: _____City: _____ State: _____ Zip: _____
Contact Information: Preferred Phone#_____ Text: ☐Yes ☐No
Alternate Phone #_____ Email: _____
Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Mother/Guardian Name: _____Date of Birth:_____ SS#_____
Address: Same as patient? ☐Yes ☐No
If not, please list: _____City: _____ State: _____ Zip: _____
Contact Information: Preferred Phone#_____ Text: ☐Yes ☐No
Alternate Phone #_____ Email: _____
Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Who has legal custody of this patient? _____

INSURANCE INFORMATION

Please fill out the following information if you have insurance benefits that you would like applied to your account.

PRIMARY INSURANCE:	**SECONDARY INSURANCE:**
Policy Holder:_____	Policy Holder:_____
Soc. Sec. #: _____	Soc. Sec. #: _____
Occupation: _____	Occupation: _____
Employer:_____	Employer:_____
Insurance Carrier: _____	Insurance Carrier: _____
Member ID#: _____Group #: _____	Member ID#: _____Group #: _____
Relationship to Patient: _____	Relationship to Patient: _____

MEDICAL HISTORY

Child's Physician: _____ Preferred Pharmacy:_____

Do you consider your child to be in good health? ☐Yes ☐No
(Explain):_____
Has your child ever had a health problem? ☐Yes ☐No (List):
_____
Has your child ever been hospitalized or had any surgical procedures? (Reasons & Dates): _____
_____
ALLERGIES: Is your child **allergic** to any medications/latex/foods? ☐Yes ☐No (List):

Is your child taking any **medications**? ☐Yes ☐No (List):

Were there any problems at birth? _____

Please check if your child has a history of any of the following:

☐Asthma/Reactive Airway	☐Autism/PPD	☐ADA/ADHD
☐Cancer/Tumors	☐Cleft Lip/Palate	☐Epilepsy, seizures, fainting
☐Ear Infections/Tubes	☐Diabetes	☐Developmental Delay
☐Heart disease or murmur	☐HIV/AIDS	☐Speech Delay
☐Liver Disease/Hepatitis	☐Kidney Disease	☐Genetic Disorder/Syndrome
☐Hearing or Vision Problems	☐Chemical Dependency	☐Motor or muscle disorder
☐Blood disorder/transfusions	☐Sleep Apnea/Snoring	☐Premature birth (weeks? _____)

Females Only: Is there any possibility of pregnancy? ☐Yes ☐No Taking birth control? ☐Yes ☐No

Is your child adopted? ☐Yes ☐No Does he/she know? ☐Yes ☐No

Does your child have any other medical issues or special needs? ☐Yes ☐No (Please List):

DENTAL HISTORY

On a scale from 1-10, with 10 being the highest:

- How important is your child's dental health to you? 1 2 3 4 5 6 7 8 9 10
- Where would you rate your child's current dental health? 1 2 3 4 5 6 7 8 9 10

What sources of fluoride does your child receive?	**How often does your child consume the following liquids (Please circle):**
☐Toothpaste ☐Home water supply ☐Over-the-counter rinse ☐Prescription rinse ☐Prescription drops/tablets/vitamins ☐Fluoride treatment by pediatrician/ other practitioner	**Milk:** Never 1x/month 1x/week Daily **Juice:** Never 1x/month 1x/week Daily **Soda:** Never 1x/month 1x/week Daily **Coffee/Tea:** Never 1x/month 1x/week Daily **Sport Drinks:** Never 1x/month 1x/week Daily

Does your child have a history of sucking on a **finger** or **pacifier**? ☐Yes ☐No

If yes, have they stopped? ☐Yes (At what age? _____) ☐No

Is your child currently being **breast fed**? ☐Yes ☐No … **formula fed**? ☐Yes ☐No

If no, at what age was it discontinued? _____

Does your child currently use a **sippy cup**? ☐Yes ☐No

If yes, what is placed in the cup: _____

Who performs brushing and flossing: ☐Child ☐Parent/Guardian

Frequency: Brushing _____ # per day / week Flossing _____ # per day/ week

Please check if your child is having problems with any of the following:

☐Cavities	☐Bad breath	☐Orthodontics/Crowding Issues	☐Bleeding gums
☐Toothache/Pain	☐Jaw Joint Problems	☐Sensitive Teeth (hot, cold, sweet)	☐Teeth or fillings breaking

Please share the following information and dates if applicable:

Name of Previous Dentist: _____ Your child's last cleaning _____/_____ or N/A

City: _____ State: _____ Your child's last oral cancer screening _____/_____

Phone #: _____ Your child's last complete x-rays _____/_____

Why did you leave your previous dentist? _____

What is the most important thing to you about your child's future smile and dental health? _____

Has your child had any unfavorable experience with previous dental care? ☐ Yes ☐No(Please explain):

Reviewed by Doctor: _____

CONSENT FOR DENTAL CARE AUTHORIZATION FOR NON-PARENT/GUARDIAN

I give my permission for the following adults to accompany my child to future dental appointments and make treatment decisions concerning my child when I am not present:

Name: _____Relationship: _____

(This consent shall be effective from date of signature until revoked by parent or legal guardian.)

PARENT/GUARDIAN Signature: _____ Date: _____

WEBSITE AND SOCIAL MEDIA RELEASE FORM

(Patient Name) _____ has my permission to have his/her dental work and/or photographs posted within our dental practice and/or on our website, social media accounts, videos or slide show presentations, print ads and all other marketing or advertising efforts that promote our dental practice.

PARENT/GUARDIAN Signature: _____ Date: _____

PATIENT SIGNATURE if 18 years or older: _____ Date: _____

OFFICE POLICIES & MATERIALS FACT SHEET

The following agreements and policies are in place to ensure that we can provide the best, most positive dental experience for your child. Please feel free to ask anyone in the office if you have a question or questions. Thank you for allowing us the opportunity to provide dental care for your child.

I have received and reviewed copies of Palm Tree Pediatric Dentistry's:

- Notice of Privacy Practices*
- Parental Agreement & Guidelines
- Dental Materials Fact Sheet

***Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Patient name: _____

I (PLEASE PRINT),_____, agree to follow the above policies and agreement.

PARENT/GUARDIAN Signature: _____ Date: _____

CONSENT FOR DENTAL TREATMENT AND FINANCIAL POLICY

I request and authorize Dr. Dani and her staff at Palm Tree Pediatric Dentistry to examine, clean, and provide dental treatment on my child's teeth. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Dani to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or child's teeth for diagnostic and educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr. Dani and her staff will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tones. As a condition of treatment by this office, I understand that I will be responsible for the payment of all fees at the time of service unless other arrangements have been made. Payment may be by cash, check, Visa, MasterCard, Discover, or American Express. For patients with insurance, I understand that the estimated portion of the treatment amount is due at the time of service and that any amount left unpaid by insurance is my responsibility to pay within 60 days. I hereby authorize payment of dental insurance benefits, if any to be made directly to Dr. Danielle Gilbert. We understand that emergencies happen, but for cancelled cleaning appointments with less than 24 hours notice, there will be a $25.00 charge. For any Nitrous Oxide, Oral Sedation, General Anesthesia or Operative appointment cancellation with less than 24 hours notice, there will be a $50.00 charge. (Certain circumstances do not apply to cancellation fees). For Oral Sedation or General Anesthesia appointments, there will be a $100.00 deposit for the appointment. It will be collected at time of scheduling the appointment and will be used towards the charges on the day of treatment. In consideration of the professional services rendered to my child, I agree to accept responsibility for the payment of such services, and I agree to pay all collection fees, court costs and reasonable attorney fees incurred by my failure to remit for services rendered. Returned checks will have a $15.00 charge added and balance over 90 days may be subject to interest charges of 1.5% per month. I grant my permission to you, or your assigns, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions of treatment and agree to its content.

PARENT/GUARDIAN Signature _____ Date _____