Welcome

You may fill this form out on-screen and print if desired

Welcome to our practice! We strive to make each of your child's visits pleasant and comfortable. Our goal is to teach your child oral habits which will help keep their smile beautiful for their lifetime.

Today's Date:

YOUR CHILD:

Child's Legal Name: Nickname: ☐ Male ☐ Female

Birth Date: Age: School: Grade:

Child's Home Address:

City: State: Zip: Phone:

☐ MOTHER

☐ STEPMOTHER ◯ GUARDIAN ?

Name:

Phone:

Email:

Cell Phone:

Employer:

Occupation:

☐ FATHER

☐ STEPFATHER ◯ GUARDIAN ?

Name:

Phone:

Email:

Cell Phone:

Employer:

Occupation:

PERSON BRINGING CHILD

Name:

Relationship:

Phone Number:

What Doctor's Office Referred You?:

PARENT'S MARITAL STATUS

☐ Single ◯ Divorced ◯ Married ◯ Widowed ◯ Separated

PRIMARY DENTAL INSURANCE

Insured's Name: D.O.B. Social Security #:

Relationship to child: Insured address (if different fromchild):

Employer: Occupation:

Insurance Company: Group #: SSN / ID#:

Insurance Company Address:

COMMENTS

DENTISTRY 4 CHILDREN & TEENS 2

FLEMING ISLAND
1530 Business Center Drive, Suite 1
Orange Park, Florida 32003
Phone: (904) 215-4221
Fax: (904) 215-9887

OAKLEAF TOWN CENTER LOCATION
9640 Crosshill Boulevard, Suite 101
Jacksonville, Florida 32222
(904) 404-4444
Fax: (904) 404-4440

Health History

Has your child ever had any of the following?

- ☐ Asthma
- ☐ Cancer
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Hemophilia
- ☐ Diabetes
- ☐ Speech Impairments
- ☐ Abnormal Bleeding
- ☐ Hearing Loss
- ☐ Previous Surgery ☐ MTHFR mutation_____
- ☐ Behavioral/Learning Problems/Autism/Aspergers Syndrome _____
- ☐ Handicaps/Disabilities
- ☐ Heart Murmur.

Requires Pre-med? ☐ Yes ◯ No What Medication?

- ☐ Congenital Heart Defect.

Requires Pre-med? ☐ Yes ◯ No What Medication?

- ☐ Convulsions/Epilepsy.

Requires Pre-med? ☐ Yes ◯ No What Medication?

Previous Dental Hx

How long since your last dental visit?

Reason for that visit?

Were any x-rays taken at the last visit? ☐ Yes ◯ No

Previous Dentist:

Child's Physician:

Phone Number:

Has your child had difficulty with previous visits? ☐ Yes ◯ No

If yes, explain:

Allergy to medications:

Any Medical problems:

Child currently taking any medications:

How did you hear about us? ☐ Google Ad ☐ Facebook ☐ Internet search ☐ Insurance company ☐ Doctor's Office

☐ Event: ☐ Patient we have seen (who can we thank?):

☐ Other:

AUTHORIZATION AND RELEASE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise paybale to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of parent or guardian: Date:

General Consent for Pediatric Dental Treatment

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Patient name: _____ DOB _____

We invite all parents to accompany their child to the back office for their dental needs, however we ask that only one parent and no siblings come back. It is very important for the dentist, dental assistant and patient to develop a relationship for their dental care. We are highly experienced in helping children overcome fear and anxiety. As with any dental procedures, it is necessary for the dentist and the dental assistant to focus 100% on your child. In return, it is necessary for your child to focus 100% on our instructions for the procedure. We ask that if you are present to please remain at the end of the dental chair or in the doorway to allow the communication between our team and the patient.

Pain and fear are two common feelings associated with dental visits. We attempt to alleviate these feelings by making the child feel comfortable with the office environment designed for them and with the dental team. In most cases, we develop a positive relationship with the child leaving him/her wanting to return for their next visit. We use several behavior techniques and pain control such as:

- Explaining the procedure to the child in simple terms
- Topical and local anesthetic (Lidocaine, etc.)
- Nitrous Oxide to relax your child (you will be informed before the use)
- Sedation (in extreme cases).

CELLULAR PHONES MUST BE TURNED OFF WHEN IN THE TREATMENT AREA

We **REQUIRE 24 hour notice to cancel your appointment for 1-2 children. We REQUIRE 48 hours notice to cancel your appointment for 3 or more children scheduled.** FEE for broken appointment with no notification is $50.00 per CHILD.

Notice of Privacy Practices for Dentistry 4 Children Fleming Island & Oakleaf Town Center locations

I have been made aware of the Notice of Privacy Practices of Dentistry 4 Children & Teens 2 offices. I hereby authorize, as indicated by my signature below, to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the patient consent form.

Print Parent/Guardian Name _____ Date _____

Relationship to Child _____ Signature of Parent/Guardian _____

Please list ALL authorized persons with whom we may discuss your child's protected health information with, who may be bringing the child to appointments and who make decisions regarding the child's dental needs.

1. _____ Relationship: _____
2. _____ Relationship: _____
3. _____ Relationship: _____
4. _____ Relationship: _____
5. _____ Relationship: _____

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Assignment of Benefits

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PLEASE READ AND INITIAL EACH SECTION BELOW

☐ I hereby authorize payment directly to Dentistry 4 Children & Teens 2, of any and all dental benefits applicable and otherwise payable to me. I understand that I am financially responsible to Dentistry 4 Children & Teens 2 for all charges not covered by this assignment.

RELEASE OF INFORMATION

☐ I hereby authorize Dentistry 4 Children & Teens 2, to furnish my insurance company with any and all information that may be contained in my child's medical and dental records that relates to procedures performed in the office of Dentistry 4 Children & Teens 2.

☐ I understand that AS A COURTESY, Dentistry 4 Children & Teens 2 will submit a pre-treatment estimate to my dental insurance company if my treatment exceeds $600.00. This service is available upon my request.

FINANCIAL POLICY

☐ Dental insurance is a contract between you, your employer and your insurance carrier. We are NOT part of that contract, however we are a preferred provider for several insurances, please check with our team for our current status with your plan. AS A COURTESY – we verify your coverage, breakdown of benefits, file your dental claim and accept assignment of benefits directly from your insurance. However, the information that YOUR INSURANCE CO. provides us may not be accurate or current on the date the services are actually performed. The benefits we verify are not an authorization, nor a guarantee of eligibility, benefits or payment. Most insurance companies pay the out-of-network-providers their "usual and customary allowable fees". Our practice is a "specialty" pediatric dental office and our fees do not match their usual and customary fees. Therefore, you are responsible for the difference not covered.

☐ At each visit we will estimate the portion that your insurance may cover. At the time the service is provided, you will be responsible for the balance not covered by insurance. You will also be responsible for any additional balance left after the insurance company pays.

☐ SEPERATED/DIVORCED PARENTS: It is the policy of this office to bill the parent that brings the children in for their dental treatment. Please make arrangements for the payment from an ex-spouse before the dental treatment is rendered. We can provide a treatment cost estimate before your scheduled appointment.

☐ Payment is due at the time service is provided. We accept cash, checks, money orders, cashier's checks, Visa, Mastercard, Discover, American Express and Care Credit. RETURNED CHECK FEE IS $40.00

☐ If we do not receive payment from your insurance company within 35 days of the submission date, you will be expected to pay in full for all dental services rendered. We will assist you in every possible way to clarify the terms of your insurance coverage. Balances over 30 days are subject to finance charges equal to 18% annually. Balances over sixty (60) days are subject to collection fees, which are 40% of the total balance. Balances over 90 days will be sent to a collection agency.

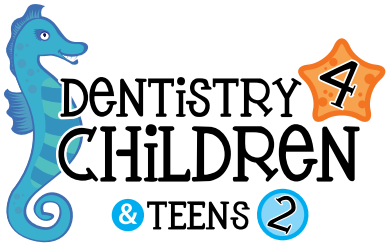
I have read, understand and give my permission to Dentistry 4 Children to provide routine care & dental treatment to my child as the Doctors deems necessary and appropriate. Please present any questions or concerns you may have to the assistant before your child is seated.

Print Parent/Guardian Name

Date

Relationship to Child

Signature of Parent/Guardian



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