Pediatric Dental Associates

Welcome

Please Tell Us About Your Child

Albany (541) 928-1509

Tell Us About Your Child

Today's Date ____/____/____ ☐ Male ☐ Female

Name _____

Preferred Name _____

Birth Date ____/____/____ Age _____

Grade _____ Weight _____

Home Phone _____

Home Address _____

City _____ State ____ Zip _____

Names of other children in your family seen by us

_____

Referred By _____

RESPONSIBLE PARTY INFO (Parent or Guardian)

Mother _____

Home Phone _____ Cell Phone _____

Home Address _____

City _____ State ____ Zip _____

Employer _____

Work Phone _____

Birth Date ____/____/____ Age _____

Father _____

Home Phone _____ Cell Phone _____

Home Address _____

City _____ State ____ Zip _____

Employer _____

Work Phone _____

Birth Date ____/____/____ Age _____

EMAIL ADDRESS: _____

Emergency Contact

Name _____

Home Phone _____ Cell Phone _____

Relationship to Patient _____

PRIMARY INSURANCE

Insurance Co. Name _____

Insurance Co. Phone # _____

Group/ID # _____

Subscriber's Name _____

Subscriber's SS # _____

Subscriber's Employer _____

Relationship to Patient _____

SECONDARY INSURANCE

Insurance Co. Name _____

Insurance Co. Phone # _____

Group/ID # _____

Subscriber's Name _____

Subscriber's SS # _____

Subscriber's Employer _____

Relationship to Patient _____

DENTAL HISTORY

What are your primary dental concerns for your child?

_____

_____

Is this your child's first dental visit? ☐ Yes ☐ No

Is your child taking fluoride? ☐ Yes ☐ No

If yes: ☐ Tablets ☐ Drops

Prescribed By _____

Name of Previous Dentist _____

Date of last dental exam _____

Please use other side if additional space is needed.

Has your child ever injured their teeth or jaws?
☐ Yes ☐ No If yes when: _____

Does your child have a history of the following:

Nursing/Bottle Habits	☐ Past	☐ Present
Thumb/Finger Sucking	☐ Past	☐ Present
Pacifier	☐ Past	☐ Present
Teeth grinding/Clenching	☐ Past	☐ Present

Has your child ever had an unfavorable medical/dental experience? Please Explain: _____

_____

How do you think your child will act at the dentist office?

_____

_____

Medical History

Who is your child's primary care physician?

Name: _____ Phone: _____

Is your child currently under their care for a medical problem? ☐ Yes ☐ No If yes, please explain: _____

_____

Is your child currently taking any prescription or over-the-counter medications? ☐ Yes ☐ No If yes, please explain: _____

_____

Has your child ever been hospitalized or had surgery?
☐ Yes ☐ No If yes, please explain: _____

_____

Is your child allergic/sensitive to latex, acrylics or metals?
☐ Yes ☐ No If yes, please explain: _____

_____

Is your child allergic to any medications/foods?
☐ Yes ☐ No If yes, please explain: _____

_____

_____

Has anyone in your family had a negative reaction to any local or general anesthetic?
☐ Yes ☐ No If yes, please explain: _____

_____

Are you interested in orthodontics if your child would benefit from braces? ☐ Yes ☐ No

Has your child had any of the following medical problems:

Anemia	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Asthma (Severity: _____)	☐ Yes	☐ No
Autism/Sensory Disorder	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No
Bone/Joint Problems	☐ Yes	☐ No
Bruise Easily	☐ Yes	☐ No
Cancer, Malignancy, Chemotherapy or Radiation Please Explain: _____	☐ Yes	☐ No
Cerebral Palsy	☐ Yes	☐ No
Chronic Adenoid/Tonsil Issues	☐ Yes	☐ No
Chronic Ear Infections	☐ Yes	☐ No
Cleft Lip/Palate	☐ Yes	☐ No
Congenital Heart Defect	☐ Yes	☐ No
Developmentally Delayed	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Epilepsy/Seizures	☐ Yes	☐ No
Fainting/Dizziness	☐ Yes	☐ No
Growth/Development Problems	☐ Yes	☐ No
Heart Surgery/Murmur/Defects	☐ Yes	☐ No
Hearing/Speech Problems	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No
Hyperactivity/ADD	☐ Yes	☐ No
Neurological Disorder	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No
Seasonal Allergies	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No

Is there anything else that we should know about your child? _____

_____

I authorize Pediatric Dental Associates of Albany to administer necessary medications and perform such diagnostic, photographic, preventive, therapeutic, and restorative procedures a may be necessary for proper dental health and care. I understand that no treatment will be started until such recommended treatment, time involved, and financial investment has been discussed with me by either one of the Doctors or one of their staff members. The information on this page and the dental/medical history is correct to the best of my knowledge. I grant Pediatric Dental Associates of Albany the right to release my child's dental/medical histories and other information about my child's dental treatment to third party payers and/or other health professionals I attest that I have answered this dental/medical history to the best of my knowledge and have disclosed my child's complete health history on this document.

Parent/Guardian Signature: _____ Today's Date: _____

Dentist Signature: _____ Today's Date: _____

Reviewed On: _____ Reviewed On: _____ Reviewed On: _____ Reviewed On: _____

Pediatric Dental Associates of Albany
Payment Options

In order to make payment for services as convenient as possible while, at the same time, maintaining operation of our office in the highest standard of comprehensive care, we offer four payment options. We will do our best to give you an accurate estimate of your total fees at the onset of your child's treatment, however, in some cases, the required treatment may be more or less extensive than quoted once treatment begins.

Payment in Full:
Payment in full at the time of service. We accept cash, check, Visa, MasterCard and Discover. A 5% courtesy discount will be given with cash or check.

Installments:
Dental fees may be paid in installments. A down payment is required at the time of service and balance payable in monthly installments. Arrangement for payment of balance with credit or debit card must be made prior to treatment. Late payments will result in a $2.00 service fee.

Outside Financing:
For smaller monthly payments over an extended period of time, we will be happy to assist you by providing applications for outside financing.

Insurance Assignments:
We will gladly file your insurance claim and accept assignment of benefits. Benefits are estimates only. The actual claim benefits are determined when your insurance carrier receives the claim. The insurance carrier bases their benefits on their "usual and customary" charges and those may not reflect our charges. You are financially responsible at the time of services rendered for any patient portion, co-payments, deductible or non-covered procedures, as determined by your insurance carrier.

CANCELLATION POLICY:
Please notify us as soon as possible if needing to reschedule or cancel an appointment.

Signature of Parent/Guardian _____ Date _____/_____/_____

Privacy Practices Consent Form

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 ad Accountability Act of 1996 (HIPPA). 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 operation of your practice.

I have also been informed of, and given the rights 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 HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and 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 then 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 to prior to the date I revoke this consent is not affected.

Date Signed: _____/_____/_____

Print Patient Name: _____

Signature of Parent/Legal Guardian: _____

Printed Name of Parent/Legal Guardian: _____

Pediatric Dental Associates of Albany

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