Pediatric Dental
ASSOCIATES

Tell Us About Your Child:

Name: _____

Birth Date: _____ ☐ Male ☐ Female

Nickname: _____ Weight: _____

Responsible Party Information:

Mother/Guardian: _____

Cell Phone: _____ Texting Ok?: ☐ Yes ☐ No

Address: _____

Employer: _____ Birthdate: ___/___/_____

Email: _____

Father/Guardian: _____

Cell Phone: _____ Texting Ok?: ☐ Yes ☐ No

Address: _____

Employer: _____ Birthdate: ___/___/_____

Email: _____

Insurance Information:

Primary Insurance Company: _____

Insurance Co. Phone #: _____

Group #: _____ ID#: _____

Subscriber: _____

Subscriber's SS #: ____-____-_____

Secondary Insurance Company: _____

Insurance Co. Phone #: _____

Group #: _____ ID#: _____

Subscriber: _____

Subscriber's SS #: ____-____-_____

Accompany Members - Please list any adults (non-parent/guardians) who may be bringing your child to their appointments. Leave this space empty if not applicable.

Name: _____

Relationship to Patient: _____

Permissions (check any box below to allow that permission):

☐ Schedule Appointments ☐ Consent to Treatment

☐ Update Account Info. ☐ Access Financial Info.

Name: _____

Relationship to Patient: _____

Permissions (check any box below to allow that permission):

☐ Schedule Appointments ☐ Consent to Treatment

☐ Update Account Info. ☐ Access Financial Info.

Other Information:

Please list any other children in your family that we have seen before: _____

How did you hear about our office?: _____

What are your primary dental concerns for your child?: ____

_____

_____

Is this your child's first dental visit?: _____

Name of previous Dentist: _____

Date of last dental appointment: _____

Were X-rays taken? : _____

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: _____

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

155 NW Hickory • Albany, OR 97321

(p) 541 928-1509

Pediatric Dental Associates
Payment Options

In order to make payment for services as convenient as possible, while at the same time maintaining operations of our office in the highest standard of comprehensive care, we offer **three different payment options** (see below). 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 will be more or less expensive than was originally quoted. All estimates are based on insurance information provided by the parent/guardian, and estimated coverage is not a guarantee of payment from your insurance provider.

Payment Options

1. **Payment in Full:**
   Payment of your estimated patient share is expected at the time of service. We accept Cash, Check, Visa, Master Card, Discover, American Express, and Care Credit. A 10% discount will be credited for any accounts who do not have dental insurance.

2. **Installments/Payment Plan:**
   Our office understands that the cost of dental treatment can sometimes be unexpected. In order to help ease any financial burden, we offer in-house payment plans. Each plan is customized based on the cost of your child's treatment and the amount of months you would like to pay. There is no interest and no early termination fee if you wish to pay your account off early. **You will be required to keep a debit or credit card on file for automatic monthly payments.** If the account becomes delinquent due to three (3) missed payments, our office reserves the right to turn the account over to an outside collections agency. For additional information regarding this payment option, please ask a front office staff member.

3. **Insurance Assignments:**
   We will gladly file insurance claims and accept assignment of benefits in place of payment at the time of service. **You will still be responsible for any non-covered services, co-insurances, or co-payments at the time services are rendered.** Insurance payments are determined by your insurance company at the time they receive the dental claim based on their "usual and customary" fee schedule. Your insurance company's fee schedule may not align with our offices charges. You may be responsible for the difference in these amounts. You are financially responsible for any charges not covered by your insurance.

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Additional Payment Policies/Information:

- **Missed Appointments:** To best serve our patients, we kindly ask for your appointments to be kept, or to be notified 24 hours in advance of the cancellation of an appointment. We do understand emergencies happen, and calling before missing an appointment is not always possible. If two (2) appointments are missed within a six (6) month period, you will be responsible for a $30.00 missed appointment fee (per missed appointment).
- **Military/Emergency Response Personnel Discount:** To honor those who serve, a 15% discount will be applied to any out of pocket cost that is incurred in our office. A parent/guardian must be employed by the US Military, Fire Department, or Police/Sheriff Station to qualify.

Signature of Parent/Guardian: _____ Date: ____/____/____