



Child's Medical History

Within the past 6 months, have there been any changes to your child's general health? YES / NO

What is the approximate date of your child's last **medical** exam? _____

Child's Medical Physician: _____ Phone #: _____

May our office send your child's physician an updated dental history and/or communicate with your child's doctor if a medical consult is required for dental treatment? YES / NO

Please indicate if your child has experienced any of the following:

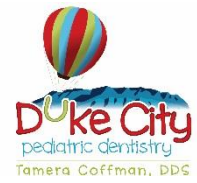
My child is healthy and has no current conditions nor history of conditions listed below

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Requires Pre-Medication for treatment: _____ (due to medical condition) | <input type="checkbox"/> ADHD | | |
| <input type="checkbox"/> Allergy: Aspirin | <input type="checkbox"/> Allergy: Codeine | <input type="checkbox"/> Allergy: Erythromycin | <input type="checkbox"/> Allergy: Latex |
| <input type="checkbox"/> Allergy: Other | <input type="checkbox"/> Allergy: Amoxicillin | <input type="checkbox"/> Allergy: Sulfa | <input type="checkbox"/> Allergy: Metal |
| <input type="checkbox"/> Allergy: Penicillin | <input type="checkbox"/> Allergy: Seasonal | <input type="checkbox"/> Anemia | <input type="checkbox"/> Artificial Joints |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Autism | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Cleft Lip | <input type="checkbox"/> Cleft Palate |
| <input type="checkbox"/> Congenital Condition | <input type="checkbox"/> Developmental Delay | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Drug/Alcohol Abuse |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Fainting | <input type="checkbox"/> GERD/Reflux | <input type="checkbox"/> Head Injury |
| <input type="checkbox"/> Hearing Problem | <input type="checkbox"/> Hear Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Immunocompromised | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Language Delay | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Malignant Hyperthermia | <input type="checkbox"/> Mental Disorder |
| <input type="checkbox"/> MRSA Positive | <input type="checkbox"/> Nervous Disorder | <input type="checkbox"/> Other | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> Sensory Disorder |
| <input type="checkbox"/> Severe Headaches | <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Sight Problem | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> STD | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Tumors | <input type="checkbox"/> Ulcers |

If any of the previous conditions were marked, please explain: _____

Immunization History

- | | |
|--|---|
| <input type="checkbox"/> All Immunizations up-to-date | <input type="checkbox"/> Immunizations are not up-to-date |
| <input type="checkbox"/> Conscientious objection to immunization | <input type="checkbox"/> Unknown |



Please let us know if your child:

- Had complications with or after dental treatment
- Is currently under the care of a physician due to a specific condition
- Has been seen by a cardiologist
- Has been admitted to a hospital in the last 5 years due to surgery or illness
- Has any other condition, disease, etc. not listed above

If any of the previous questions are marked, please explain: _____

Current Medications, including vitamins, herbs and OTC (over-the-counter) medicines:

*If list is extensive, please ask for an additional sheet or bring a list with you to child's appointment

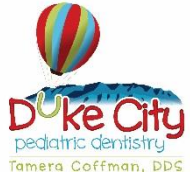
Drug/Medication	Dose	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

The information that I have given is correct and completed to the best of my knowledge. It will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I am the LEGAL GUARDIAN of the patient.

Parent/ Legal Guardian Signature

Relationship to Child

Date



Social History

School/daycare name: _____ Grade: _____

Please list patient's interests, activities, sports, hobbies, etc.: _____

How would you describe your child?

- Easy going or Flexible
- Difficult, Active or Feisty
- Slow to warm up or Cautious



Accompany Minor

The following individuals may accompany and/or authorize dental treatment for this minor patient, and act on my behalf as indicated below (persons must be over 18 years old).

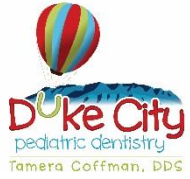
*Duke City Pediatric Dentistry reserves the right to postpone delivery of treatment in certain cases when the legal guardian is not present.

Name	Relationship to Patient

Parent/Legal Guardian Signature

Relationship to Child

Date



Financial Agreement

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the most comprehensive dental care using only the highest quality materials and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is an agreement between you, your employer, and the insurance company. Our practice is not a party to that agreement. If payment from your insurance company is not received within 60 days from date of service, you will be expected to pay the balance in full.

As a courtesy to you we will help you process all your insurance claims. You may direct your insurance company to pay your benefits directly to our practice by signing the authorization on the Assignment of Benefits Agreement. In order for our practice to file your insurance claim, you must bring a completed dental insurance form or proof of insurance at each appointment.

Your **estimated** copayment for treatment, which is the amount not covered by your insurance, is due at the time treatment is provided. Your **estimated** copayment may be adjusted after the time of treatment depending upon the final reconciliation of insurance payments. Our practice accepts cash, personal checks, MasterCard, Visa, and Discover. Third party, extended payment financing is available upon request and approval.

Returned checks and balances older than 60 days will be subject to collection fees and finance charges at the rate of 1.5% per month (18% annually).

Additionally, our practice requests a minimum of 2 business-days' notice for any cancellations or changes in the schedule. Please do not hesitate to ask if you have any questions regarding this financial agreement. We are committed to providing you with the ultimate experience in dental care.

Print Name of Parent/Legal Guardian

Parent/Legal Guardian Signature

Relationship to Child

Date



Consent for Services

The permission of a parent or legal guardian is necessary for dental treatment of a minor before any treatment can be started or completed by our office. While signing this form gives consent for us to treat your child, we encourage you to speak to any of our staff members, especially Dr. Coffman, if you have any questions regarding your child's specific needs or treatment being provided.

Our examination will include a hard and soft tissue examination. Dental X-rays may or may not be taken depending on your child's age, specific dental needs and their ability to cooperate. While not every patient gets dental X-rays every visit, diagnostic X-rays are necessary from time to time as your child grows. Photographs for diagnosis, treatment planning and teaching may also be taken.

Restorative and surgical treatments may be needed depending on your child's specific needs. You will be consulted in advance before any treatment is performed. The restorative materials may include composite (tooth-colored) resin fillings, dental sealants, silver amalgam fillings, or full coverage crowns (either tooth-colored or stainless steel). Restorative treatment may include nerve treatment (pulpotomy or pulp capping) when necessary due to deep dental decay. Surgical treatment may include but is not limited to tooth removal or minor gum or soft tissue surgery. Local anesthesia is routinely used if necessary for child's comfort. Your child's treatment needs, if any, will be reviewed with you at the end of the examination appointment and before any treatment is started.

No sedative drugs are used, including nitrous oxide (laughing gas) without prior consent by a parent/legal guardian. Physical restraint is not used without a parent's consent, except as needed to protect a child from accidental self-injury during treatment. An assistant may hold your child's hands if we are concerned your child will reach up while Dr. Coffman is working.

Self-induced soft tissue injury caused by lip and cheek biting is an unfortunate complication of local anesthetic used in the mouth and is usually self-limiting and heals without complications. To help avoid the possibility of soft tissue injury, patients and their parents or caregivers need to be especially watchful and not allow the patient to bite, suck or scratch on their lip, cheek or tongue, and do not allow them to chew food while the anesthesia (numbness) persists.

As a parent or legal guardian of the above patient, I acknowledge that the above information is correct and grant Dr. Coffman and Duke City Pediatric Dentistry permission to provide my child's dental and related medical/surgical treatment as deemed necessary. I have given an accurate report of this patient's physical and mental health history.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment of my insurance carrier to submit payment directly to the dentist or dental practice to be applied to my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance and I will be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on behalf of my children/dependents.

Parent/Legal Guardian Signature

Relationship to Child

Date



PLEASE BE ADVISED OF THE FOLLOWING

You may choose whether or not you accompany your child in the examination/treatment rooms. We do ask that you remain a silent observer. This allows our trained dental team to prepare your child for treatment avoiding giving incorrect or misleading information. It is BEST if your child maintains communication with the dental provider, and additional instructions from a parent or guardian can be confusing. The dentist or dental provider will let you know where you may sit if they feel your child will benefit from you being close. It is important to stay in the location requested to avoid accidental contamination of instruments or interference of treatment.

Sometimes children “act out” as a way to try and control a situation. In order to “short-circuit” this type of behavior, the dentist may request that you step out. If you are asked to leave, please do so immediately. You can continue to monitor your child through the window, out of their sight. You will be able to return as a reward to your child when their behavior improves. We will continue to support your child at all times, and we will not restrain your child in any way.

It is best if siblings and other children remain in the reception area so we can give our entire attention to the patient. If you must bring a child to the examination/treatment room, they may be asked to step out if they become disruptive or interfere with treatment. We also will ask you to take them out during injections (shot/sleepy juice) to avoid causing unnecessary dental fear through observation.

Please avoid words such as: “needles” “shots” “drill” “pull” “yank” “pain” or telling your child to “be brave”. These words imply there is something to fear and that is not the message we want to send.

Initial _____

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.
I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed.
I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.
I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

Parent/Legal Guardian Signature

Relationship to Child

Date



Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

Parent/Legal Guardian Signature

Relationship to Child

Date