# *Update Patient Information*

Patient Name: ____________________________________________________ Date of Birth:________________________

Change in Address:____________________________________________________________________________________

Change In: ☐ Mobile Phone: _____________________________ ☐ Home Phone: ________________________________

☐ Email address: _____________________________________________________________________________

Change in Dental Insurance: ________________________________________________________________________

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

☐ Requires Pre-Medication for treatment:___________________ (due to medical condition) ☐ ADHD

| | | | |
|---|---|---|---|
| ☐ Allergy: Aspirin | ☐ Allergy: Codeine | ☐ Allergy: Erythromycin | ☐ Allergy: Latex |
| ☐ Allergy: Other | ☐ Allergy: Amoxicillin | ☐ Allergy: Sulfa | ☐ Allergy: Metal |
| ☐ Allergy: Penicillin | ☐ Allergy: Seasonal | ☐ Anemia | ☐ Artificial Joints |
| ☐ Asthma | ☐ Autism | ☐ Blood Disease | ☐ Cancer |
| ☐ Cerebral Palsy | ☐ Chemotherapy | ☐ Cleft Lip | ☐ Cleft Palate |
| ☐ Congenital Condition | ☐ Developmental Delay | ☐ Diabetes | ☐ Drug/Alcohol Abuse |
| ☐ Excessive Bleeding | ☐ Fainting | ☐ GERD/Reflux | ☐ Head Injury |
| ☐ Hearing Problem | ☐ Heart Disease | ☐ Heart Murmur | ☐ Hepatitis |
| ☐ High Blood Pressure | ☐ HIV/AIDS | ☐ Immunocompromised | ☐ Kidney Disease |
| ☐ Language Delay | ☐ Liver Disease | ☐ Malignant Hyperthermia | ☐ Mental Disorder |
| ☐ MRSA Positive | ☐ Nervous Disorder | ☐ Other | ☐ Pregnancy |
| ☐ Radiation Treatment | ☐ Respiratory Problems | ☐ Seizure Disorder | ☐ Sensory Disorder |
| ☐ Severe Headaches | ☐ Sickle Cell Disease | ☐ Sight Problem | ☐ Sinus Problems |
| ☐ Sleep Apnea | ☐ STD | ☐ Stomach Problems | ☐ Stroke |
| ☐ Thyroid Disease | ☐ Tuberculosis | ☐ Tumors | ☐ Ulcers |

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

_____________________________________________________________________________________________

_____________________________________________________________________________________________

**Immunization History**

☐ All Immunizations up-to-date
☐ Immunizations are not up-to-date
☐ Conscientious objection to immunization
☐ 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 |
|---|---|---|
| ______________________ | ____________ | ______________________ |
| ______________________ | ____________ | ______________________ |
| ______________________ | ____________ | ______________________ |
| ______________________ | ____________ | ______________________ |

## *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

## *Appointment Policy Reminder*

Our practice requires a minimum of **2 Business Days'** notice for any cancellations or changes to an appointment.
We strive to provide excellent dental care to all of our patients and reserve time on Dr. Coffman's schedule specifically for your child. To be fair to all patients wanting to be seen here, we require advanced notice of changes so unused appointment time can be offered to another patient. In the event that we are not given 2 Business Days' notice for a cancellation, we may not be able to reschedule your child or your family at our office in the future.

Initial ________________
*Indicates you have been informed of our policy

## *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.

## *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.

## *Consent for Electronic Communication*

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.

**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 |