Shaenfield
PEDIATRIC DENTISTRY

# Patient Information

Child's Name_____
*Last Name* *First Name* *Middle Initial*

☐ Male
☐ Female Age____ Birthday__/__/__ Nickname_____ Hobbies_____

Child's Name_____
*Last Name* *First Name* *Middle Initial*

☐ Male
☐ Female Age____ Birthday__/__/__ Nickname_____ Hobbies_____

Child's Name_____
*Last Name* *First Name* *Middle Initial*

☐ Male
☐ Female Age____ Birthday__/__/__ Nickname_____ Hobbies_____

Home Address_____
*Street* *Apt #* *City* *State* *Zip Code*

Mailing Address_____
*Street* *Apt #* *City* *State* *Zip Code*

Home Phone #_____ Mom Cell#_____ Dad Cell#_____

How did you hear about us?_____

Email Address:_____

*We remind you about appointments via email, text message and phone calls.*

## PARENT'S INFORMATION

Circle One:
Father Stepfather Guardian

Name_____

Date of Birth:__/__/__

Address (if different from patient)

_____

Home Phone_____
*(if different from above)*

Work Phone_____
*(if different from above)*

Employer_____

Do you have dental insurance coverage for minor/child? YES NO

Circle One:
Mother Stepmother Guardian

Name_____

Date of Birth:__/__/__

Address (if different from patient)

_____

Home Phone_____
*(if different from above)*

Work Phone_____
*(if different from above)*

Employer_____

Do you have dental insurance coverage for a a minor/child? YES NO

## PRIMARY INSURANCE

Subscriber Name:_____
Subscriber SSN#:_____
Subscriber Date of Birth:__/__/_____
Insurance Co._____
Group #_____
Policy/I.D. #_____

## SECONDARY INSURANCE

Subscriber Name:_____
Subscriber SSN#:_____
Subscriber Date of Birth:_____/__/_____
Insurance Co. _____
Group #_____
Policy/I.D. #_____

## EMERGENCY CONTACT

In the event of an emergency, whom should we contact?_____
Name_____Relationship_____Phone#_____
Name_____Relationship_____Phone#_____

## PHOTO CONSENT

I _____, give consent for Shaenfield Pediatric Dentistry to capture a photographic imagery of my child _____, for their records only. I understand that for Shaenfield Pediatric Dentistry staff will have access to their photo in the dental record.

**Patient/Guardian Signature**_____ **Date**_____

## SOCIAL MEDIA CONSENT

I _____, give consent for Shaenfield Pediatric Dentistry to post imagery of my child/children, for social media. I understand that for Shaenfield Pediatric Dentistry staff will utilize the image for social media purposes only.

**Patient/Guardian Signature**_____ **Date**_____

## CONSENT FOR TREATMENT

The information that I have given is correct and complete 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.

I authorize Associate Dentist/Staff to perform the necessary dental procedures: complete dental examination (check-up), prophylaxis (cleaning), fluoride treatment, radiographs (x-rays), sealants, study models, and other diagnostic/preventive aids deemed necessary by the Dentist and the staff to make a thorough diagnosis of my child's dental needs.

I authorize the Dentist and Staff to provide any information to other Doctors (physicians, dentist, etc.) for the purpose of consultation. I understand that prior to providing any treatment I will be advised about such treatment, that I may ask questions concerning the treatment, and that I may revoke this BEFORE treatment is provided. As the parent/legal guardian of the patient, I do hereby grant the dentist and the staff permission to perform any needed treatment(s).

**Patient/Guardian Signature**_____ **Date**_____

## APPOINTMENT AUTHORIZATIONS

For future appointments, if you are planning to send your child with someone other than a parent/legal guardian, please provide the following information (must be 18yrs or older): Name of authorized person(s) to accompany my child for future treatment visits:

1. **NAME:**_____**Relationship to Child:**_____
2. **NAME:**_____**Relationship to Child:**_____

# FINANCIAL AGREEMENT

- **Your insurance is a contract between you, your employer, and the insurance company; our relationship is with you, NOT the insurance company. We file your insurance claim as a courtesy to you.**
- ALL charges incurred are charged directly to YOU and you are personally responsible for payment. Deductibles and co-payments are due at the time of treatment. We ESTIMATE your co-payments according to your policy. We DO NOT in any way guarantee that your insurance will pay this amount.
- **If the insurance company doesn't pay within a 60 days, it is required that you pay the balance due.**
- I hereby authorize payment directly to for Shaenfield Pediatric Dentistry, the insurance benefits otherwise payable to me, and authorize release of any information required to process insurance claims.

**Patient/Guardian Signature**_____ **Date**_____

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY

I, _____ have reviewed a copy of for Shaenfield Pediatric Dentistry
(Parent or Legal Guardian's Name) Notice of Privacy Practices regarding my children.

**Patient/Guardian Signature**_____ **Date**_____
OFFICE USE ONLY: __Patient Refused to Sign __Emergency Situation __Language Barrier __Other

# Appointment Policy

We reserve time in our schedule especially for your child, and in consideration of others we request at least **48 hours notice prior to cancellation of appointments.** We do understand that there are circumstances that may prevent you from keeping your child's appointment, however, with providing us as much notice as possible we may be able to contact another family who would like that appointment time. Afternoon appointments fill quickly, and canceling with less than 48 hours notice does not allow us enough time to schedule another patient in need of treatment. **After the second missed appointment, you will be asked to pre-pay for your child's appointment before we will reserve time on our schedule.** Patients that are running late are asked to call the office as soon as possible to check with the staff if they will still be able to keep their appointment. Also, cancellations are not accepted if left on the answering service and the appointment will not be considered cancelled unless you call during regular business hours and speak with one of our scheduling coordinators.

**Appointments cancelled with less than 48 hours notice on a school holiday, an after school time, or Saturday will not be rescheduled on another school holiday, Saturday or after school appointment time, as they are our most popular appointments.**

We greatly appreciate your cooperation in helping us provide you with excellent care for your family. Please sign below that you have read, and acknowledge the above information provided to you. We will provide a copy for your records.

**Patient/Guardian Signature**_____ **Date**_____

**Patient Name:** _____ **Date of Birth:** _____ **Date:** _____

# CHILD'S MEDICAL HISTORY

Child's Physician_____City/State_____Phone_____
Date of last physical exam_____Child's Vaccinations Updated YES NO
Current Medical Conditions_____
Any other specialist your child is currently seeing:_____

| MEDICATIONS | Type: | Reason: | How often: |
|---|---|---|---|
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |

List of ALLERGIES (*LATEX, MEDICINES, FOODS, ETC*): _____

| | YES | NO | |
|---|---|---|---|
| Does your child have Congenital Heart Disease? | ___ | ___ | Is SBE prophylaxis required?_____ |
| Is child receiving any medication or drugs? | ___ | ___ | List Medications_____ |
| Has child ever been hospitalized? | ___ | ___ | Is so, why?_____ |
| Has child ever had surgery? | ___ | ___ | List surgeries_____ |
| Is there excessive bleeding when cut? | ___ | ___ | Handicaps/Disabilities?_____ |

**Does your child have, ever had or been diagnosed with any of the following (please check all that apply):**

## General
__Complications during pregnancy/birth
__Prematurity
__Cleft Lip/Palate
__Inherited Disorders
__Syndrome:_____
__Problems of growth or stature
__Currently Pregnant

## Head, ears, eyes, nose, throat
__Chronic adenoid/tonsil infections
__Chronic ear infections
__Ear Problems
__Hearing Impairments
__Eye Problems
__Visual Impairments
__Sinusitis
__Speech impairments
__Apena/Snoring
__Mouth Breathing

## Cardiovascular
__Heart Problem/Surgery
__Rheumatic Fever/Rheumatic heart disease
__High/Low Blood Pressure
__Heart Murmur

## Respiratory
__Asthma
Medications_____
Last Attack_____
Hospitalizations_____
__Frequent colds/coughs
__Reactive Airway Disease
__Tuberculosis
__RSV
__Breathing Problems
__Cystic Fibrosis
__Smoking

## Endocrine
__Diabetes
__Growth Delays
__Hormonal Problems
__Precocious Puberty
__Thyroid Problems

## Integumentary
__Fever blisters
__Eczema
__Rash/Hives
__Dermatologic Conditions
__Cold/Sores

## Gastrointestinal
__Eating Disorders
__Ulcer
__Excessive Gagging
__Gastroesophageal/acid reflux disease
__Hepatitis A, B or C
__Jaundice
__Liver Disease
__Intestinal Problems
__Prolonged diarrhea
__Unintentional weight loss
__Lactose Intolerance
__Dietary Restrictions

## Genitourinary
__Bladder Infections
__Kidney Infections
__Systemic Birth Control
__Sexual Transmitted Disease

## Musculoskeletal
__Arthritis
__Scoliosis
__Bone/Joint Problems
__TMJ problems-popping/clicking/locking
__Problems opening mouth or chewing

## Neurologic
__Fainting
__Dizziness
__Autism
__Developmental Disorders
__Learning Problems/Delay
__Mental Disabilities
__Brain Injury
__Cerebral Palsy
__Convulsions/Seizures/Epilepsy
__Hydrocephaly/Shunts

## Psychiatric
__Emotional Disturbance
__Hyperactivity/ADHD/ADD
__Psychiatric problems/treatment
__Alcohol and chemical dependency

## Hematologic/lymphatic/immunologic
__Anemia
__Blood Disorders
__Blood Transfusions
__Excessive Bleeding
__Bruising easily
__Hemophilia
__Sickle Cell Disease/Trait
__Cancer-Type:_____
__Immune disorder
__Chemotherapy
__Radiation Therapy
__Bone Marrow Transplant

## Infectious Disease
__Measles
__Mumps
__Rubella
__Varicella (Chickenpox)
__Mononucleosis
__Cytomegalovirus (CMV)
__Whooping Cough
__Scarlet Fever
__HIV/AIDS

## Family History
__Genetic Disorders
__Problems with General Anesthesia
__Serious Medical Conditions/Illness

## Social Concerns
__Passive Smoke Exposure
__Recreational Drug Use
__Religious or Philosophical objections to treatment

## Other
_____
_____

I understand the information I have provided is correct to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in my child's medical status.

**Parent/Legal Guardian Signature:**_____**Relationship to Child:**_____**Date:**_____

shaenfield
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# OFFICE FACEBOOK PHOTO CONSENT

____ I give Shaenfield Pediatric Dentistry permission to display my child's picture in the office/facebook

____ I give Shaenfield Pediatric Dentistry permission to display my child's picture ONLY in the office/facebook

____ I do NOT give permission for my child's picture to be displayed in the office/facebook

Patient's Name: _____ DOB: _____

Parent/Legal Guardian Name: _____

Signature: _____ Date: _____