Potomac Pediatric Dentistry

We are pleased to welcome you to our practice. Please take a few minutes to completely fill out this form.
If you have any questions, we'll be happy to help.
We look forward to working with you to maintain your child's dental health.

1. Tell Us About Your Child

Child's Name_____
Last First MI

Nickname _____ ☐Male ☐Female

Child's Birthdate_____/_____/_____ Child's Age _____

Child's Home # (_____)_____

Child's Home Address_____

_____

Referred by_____

Guardian Marital Status: ☐Single ☐Married ☐Separated

☐ Widowed ☐Divorced ☐Domestic Partners

2. Mother's Information

Name _____

Birthdate _____/_____/_____ ☐Stepmother ☐Guardian

Employer_____

Work # (_____)_____

Home # (_____)_____

Cell # (_____)_____

SS #_____

E-mail Address:_____

Is mother active duty military at this time? ☐Yes ☐No

3. Father's Information

Name _____

Birthdate _____/_____/_____ ☐Stepfather ☐Guardian

Employer_____

Work # (_____)_____

Home # (_____)_____

Cell # (_____)_____

SS #_____

E-mail Address_____

Is father active duty military at this time? ☐Yes ☐No

4. Person Responsible for Account

Name_____

5. Primary Dental Insurance

Insurance Co. Name_____

Insurance Co. Phone # (_____)_____

Policy #_____ Group #_____

Policy Owner's Name_____

Relationship to patient_____

Policy Owner's Birth date _____/_____/_____

Social Security # _____

Policy's Owner's Employer _____

6. Secondary Dental Insurance (if applicable)

Insurance Co. Name_____

Insurance Co. Phone # (_____)_____

Policy #_____ Group #_____

Policy Owner's Name_____

Relationship to patient_____

Policy Owner's Birth date _____/_____/_____

Social Security # _____

Policy's Owner's Employer _____

7. Health History

Child's Physician_____

Phone (_____)_____

Is the child under the care of a physician? ☐Yes ☐No

Ever been hospitalized / surgery? ☐Yes ☐No

Does your child have any allergies? ☐Yes ☐No

If so, please list_____

_____

Is your child allergic to: ☐Latex ☐ Penicillin

☐Amoxicillin ☐Tetracycline ☐ Dental Anesthesia

☐Aspirin ☐Other(s): _____

_____

Please list all medications and dosage the child is currently taking:_____

_____

Does your child require pre medication before dental treatment? ____ Yes ____No

Has the child ever had any of the following problems?

Please check all that apply:

- ☐Tonsillitis
- ☐Asthma
- ☐Leukemia/Anemia
- ☐Hemophilia
- ☐High/Low Blood Pressure
- ☐Liver/Kidney Problems
- ☐HIV/AIDS/ARC
- ☐Respiratory Problems
- ☐Blood Transfusion(s)
- ☐Diabetes/Hypoglycemia
- ☐Abnormal Bleeding
- ☐Hepatitis
- ☐Cancer/Tumors
- ☐Tuberculosis TB
- ☐Psychiatric Problems
- ☐Fainting/Seizures
- ☐Heart Murmur
- ☐Congenital Heart Defect
- ☐Scarlet Fever
- ☐Hyper Active/ADD
- ☐Cerebral Palsy
- ☐Rheumatic Fever
- ☐Artificial Heart Valves
- ☐Cleft lip/Palate

Please relate any other significant medical problems the child has: _____

_____

***Dental History:**

- Is this your child's 1st time to the dentist? ☐Yes ☐No

- Has your child ever had complications following dental treatment? ☐Yes ☐No
  If yes, please explain: _____

- Doe the patient have any oral habits?
  ☐ Thumb Sucking ☐Pacifier ☐Clenching ☐Chewing on objects ☐Grinding

- Does your child use a bottle or Sippy cup?
  ☐Yes* ☐No

*If yes, when is the usage of a bottle or Sippy cup occuring?

☐With meals only ☐Throughout the day ☐During bedtime/naptime

10. I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I am the parent, guardian, or personal representation of the child listed above and there are no court orders in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered. I certify that my dependent is covered by the insurance listed above and assign directly to Potomac Pediatric Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Potomac Pediatric Dentistry may use my child's health care information and may disclose such information to the above named insurance company and their agents for the purpose of obtaining payment for services and determining benefits or the benefits payable for related services.

11. In the event that I am unable to bring my child in for an appointment, the following individuals have my permission to accompany my child, as well as make any necessary decisions for my child's care. This includes consenting to any necessary treatment. IMPORTANT: The legal guardian must accompany their child/children for the first appointment.

NAME:	CONTACT NUMBER:
_____	_____
_____	_____
_____	_____

12. **Overdue Balance**

You are ultimately responsible for any balance on your account. If you have not paid your balance within 60 days of receipt of an invoice, a $5 billing charge will be added each month until resolved. Any balance remaining unpaid for 90 days or more will receive a final notice letter before being sent to collections. In the event that your account is sent to collections, you will be responsible for any and all costs incurred in the collection of this debt. This includes: an interest rate of 1.5% of the unpaid balance from the last date of service, attorney fees and court costs.
I have read, understood and agree to abide by this financial policy.

Parent/Guardian Signature_____ Date_____

Consent for Use or Disclosure of Patient's Protected Health Information

**This form must be completed by the individual whose protected health information is to be disclosed or by a parent or guardian if the person is a minor under state law.*

NAME: _____

DATE OF BIRTH :_____(for identification purposes)

I hereby authorize **Potomac Pediatric Dentistry** to release the following personal health information for:

(Check all that apply)

☐ Dental service claims information

☐ Prescription, diagnostic, treatment, and/or care management services

☐ Reviews required by HHS or HIPAA-compliant health care operations

☐ Other (specify) _____

The above information may be released by:

☐ Phone ☐ Fax ☐ Mail ☐ E-mail ☐ Friend or Relative

My Consent

Effective: Today's Date _____

I want this consent to:

☐ Continue Indefinitely ☐ Effective Only Until _____(date)

I understand that consent may be revoked by me at any time. I understand why I have been asked to disclose this information and am aware that my patient rights are identified in the practice's Notice of Privacy Practices.

Signature of Patient _____ Date _____

Or, Guardian/Personal Representative _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.
You may refuse to sign this acknowledgement

Patient's Name: _____

I, _____ being the parent or legal guardian of the above named patient(s), acknowledge that I have either reviewed a copy or have been provided with a copy of Potomac Pediatric Dentistry's Notice of Privacy Practice. I understand the office's Notice of Privacy.

_____
Parent Printed Name

_____
Date of Signature

_____
Parent Signature

OR

If completed by a patient's personal representative, please print and sign your name in the space below

_____
Personal Representative's Printed Name

_____
Personal Representative's Signature

Relationship: ☐ Guardian ☐ Power of Attorney
☐ Other: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify): _____

_____

_____

Office No- Show and Late Policies

Dental exams, cleanings and consultation time slots are precious and very much in demand. In effort to serve you better, we ask for proper notice for any cancellations. Patients failing to provide at least **48 Hour Notice** will be charged **$25** for any missed appointments. Dental treatment will need a **72 Hour Cancellation Notice** before noon or the appointment will be rescheduled and pushed back to a later date and time and there will be a charge of **$75** for any missed appointments. **That Includes Same Day Cancellations.**

We make every effort to be on time for all appointments. Unfortunately, when even one patient arrives late, it can throw off the entire schedule for that session. In addition, **Rushing** or **"Squeezing**" in an appointment shortchanges the patient and contributes to decreased quality of care. In light of this, Patients arriving more than **10 minutes** after their appointment time will be asked to reschedule. We apologize for any inconvenience this might cause.

Any Child requiring **emergency** care will be seen as soon as possible.

The Doctors and Staff of Potomac Pediatric Dentistry

_____ _____

Signature Date