Pediatric Dentistry
Orthodontics
TRUPKIN • WILENTZ • CHIZNER

Welcome to Our Practice, Patients < Age 12

Does your child have or have they had any of the following diseases or problems?

◯ None of the above ◯ Active Tuberculosis ◯ Persistent cough greater than three-week duration
◯ Fever within 48 hours ◯ Head lice within last month ◯ Covid-19 (Coronavirus) If yes, when? _____
◯ Traveled out of country in last 6 months. If yes, please list country and date of travel: _____
IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE, PLEASE STOP AND RETURN THE FORM TO THE RECEPTIONIST.

Patient's Health History

Today's Date: ___ /_____/_____

Patient's Name: _____ Birthdate: ___/____/____
Are you being treated by a physician at this time? ◯ Yes ◯ No
If yes, please indicate the reason why? _____

Primary Physician/Pediatrician Name: _____ Phone: _____
Address: _____City: _____ State: _____ Zip Code: _____
Medical Specialist Name: _____ Specialist: _____
Address/phone number: _____
Preferred Pharmacy: _____ Phone: _____

THE FOLLOWING IS MANDATORY:
Please mark yes/no if you have a history of the following conditions. For each "Yes" provide details below.

ADD/ADHD:	◯ Yes ◯ No	Anemia:	◯ Yes ◯ No
Artificial Bones:	◯ Yes ◯ No	Asthma:.....	◯ Yes ◯ No
Artificial Valves/Joints....	◯ Yes ◯ No	Bleeding Disorder:	◯ Yes ◯ No
Autism/Aspergers/PDD	◯ Yes ◯ No	Blood Transfusion:.....	◯ Yes ◯ No
Cancer:	◯ Yes ◯ No	Cerebral Palsy:.....	◯ Yes ◯ No
Chicken Pox (current):	◯ Yes ◯ No	Congenital Heart Defect:	◯ Yes ◯ No
Developmental Delay:....	◯ Yes ◯ No	Diabetes:.....	◯ Yes ◯ No
Dialysis:	◯ Yes ◯ No	Down Syndrome:	◯ Yes ◯ No
Ear Infections:	◯ Yes ◯ No	Eating Disorder:	◯ Yes ◯ No
Epilepsy/Seizures:.....	◯ Yes ◯ No	Genetic Disorder:	◯ Yes ◯ No
GI Disorder:.....	◯ Yes ◯ No	Growth Hormone Deficiency....	◯ Yes ◯ No
Handicapped/Disabilities:	◯ Yes ◯ No	Hearing loss.....	◯ Yes ◯ No
Heart Disease:	◯ Yes ◯ No	Heart Murmur:	◯ Yes ◯ No
Hemophilia:.....	◯ Yes ◯ No	Hepatitis:	◯ Yes ◯ No
HIV:.....	◯ Yes ◯ No	Hormone Deficiency:.....	◯ Yes ◯ No
Infectious Disease:.....	◯ Yes ◯ No	Intestinal Problems:.....	◯ Yes ◯ No
Kidney Problems:.....	◯ Yes ◯ No	Lung Problems:.....	◯ Yes ◯ No
Measles/Mumps:.....	◯ Yes ◯ No	Mental Illness:.....	◯ Yes ◯ No
Mononucleosis:.....	◯ Yes ◯ No	MTHFR gene:.....	◯ Yes ◯ No
Other:	◯ Yes ◯ No	Pregnancy (Current):.....	◯ Yes ◯ No
Reflux:	◯ Yes ◯ No	Rheumatic Fever:	◯ Yes ◯ No
Scoliosis:	◯ Yes ◯ No	Sensory Issues:	◯ Yes ◯ No
Sickle Cell Disease.....	◯ Yes ◯ No	Speech Impediment:	◯ Yes ◯ No
Spina Bifida:	◯ Yes ◯ No	Substance Abuse:.....	◯ Yes ◯ No
Thyroid Problems:	◯ Yes ◯ No	Transplant-Specify:.....	◯ Yes ◯ No
Tuberculosis.....	◯ Yes ◯ No	Vision loss/problems:	◯ Yes ◯ No

Does your child have any allergies? ◯ **Yes** ◯ **No**

Please explain/clarify any conditions or allergies selected above: Be specific:
Allergies/ Conditions: _____

Is your child taking any medication (prescription or over the counter) vitamins, or dietary supplements? ◯ Yes ◯ No
List name, dose and date started:_____
Has your child been hospitalized, had surgery, a significant injury, or been treated in an emergency department?
◯ Yes ◯ No If yes, list date and describe:_____

Has your child ever had a reaction or problem with an anesthetic? ◯ Yes ◯ No
If yes, describe: _____

Are your child's immunizations up to date: ◯ Yes ◯ No

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment: _____

Was your child born prematurely? ◯ Yes ◯ No If yes, at how many weeks? _____ Birth Weight: _____

Is there any other significant medical history pertaining to your child that would you'd like to discuss with the Doctor in private? ◯ Yes ◯ No

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I understand the information I have given is true and correct to the best of my knowledge, it will be held at the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.

X_____ Date: ___/____/____
Signature of parent or legal guardian

X_____
Print Name

X_____
Signature of witness (dental staff)

Tell us about your child

Today's Date: ___ /____/_____

This information is important to verify your child's identity at any time, and to fully access your insurance benefits.

Patient Name: _____Preferred Name: _____
Address: _____ City: _____State:_____ Zip Code: _____
Sex: ◯ Male ◯ Female Gender (What does your child identify as): ◯ Male ◯ Female ◯ Other
Birth Date: _____ SS#:_____ Best time to call: _____

Guardian 1 Name: _____ SS #: _____ Driver License: _____DOB: _____
Home Phone: _____ Mobile: _____ Work: _____ Email:_____

Guardian 2 Name: _____ SS #: _____ Driver License: _____ DOB:_____
Home Phone: _____ Mobile: _____ Work: _____ Email: _____
Marital status: ◯ Married ◯ Single ◯Divorced ◯Widowed
Child lives with: ◯ Both Parents ◯Mother ◯Father ◯ Legal Guardian ◯ Other: _____

Additional Person to contact in case of emergency: _____Relationship:_____
Phone Number: _____

Who is accompanying the child to their dental visit today?

Name: _____ Relationship: _____

Besides you, provide 2 alternate adults (over age 18) who are authorized to bring child to the dentist?**

1) Name:_____ Relationship to Patient: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Cell Phone: _____ Date of Birth: ____/_____/_____

2) Name:_____ Relationship to Patient: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Cell Phone: _____ Date of Birth: ____/_____/_____

PRIMARY DENTAL INSURANCE:
Name of Insured: _____ Date of Birth: _____Phone:_____
Insured's Address: _____City: _____ State: _____ Zip Code:_____
Patient's relationship to insured: ___Self ____Spouse ___Child ____Other
Insurance Plan Name: _____ Employer: _____
ID#: _____ Group# _____
Insurance Address: _____City: _____State: _____Zip Code:_____
Please note if you have a secondary insurance, we do not bill multiple insurances.
Insurance Authorization:
I authorize my insurance company to pay the dentist all insurance benefits rendered. I authorize the dentist to release all information necessary to secure the payment of my benefits. *I understand that I am financially responsible for all charges whether or not paid by my insurance.
Signature: X_____

Previous Dentist: _____ Last Visit: _____ X-rays taken: ◯Yes ◯No
Has your child had braces or are they under the supervision of an Orthodontist? ◯ Yes ◯ No
If yes, what is the name and phone number of the Orthodontist? _____ Phone#_____

We enjoy thanking those who referred you and your child our way!

Whom may we thank for referring you? _____

CONSENTS

HIPPA Acknowledgement & Release

I understand that information used or disclosed because of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing this authorization.

This authorization shall be enforced and in effect until revoked by the patient or representative signing the authorization.
I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as describe in this document by sending a written notification to PEDIATRIC DENTISTRY AND ORTHODONTICS. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

Name of Patient: (Please Print) _____
Name of Parent/Legal Guardian: (Please Print) _____
Relationship to child: ◯ **Self** ◯ **Mother** ◯ **Father** ◯ **Sibling** ◯ **Other:** _____

Pediatric Dentistry and Orthodontics is authorized to release protected information about the above named patient to the following listed entities:
Please select each situation giving Pediatric Dentistry and Orthodontics authorization to supply information to your entity:
◯ Release financial information ◯ Discuss dental treatment plan ◯ Other information as described below:

Patient/Legal Guardian Signature: _____ Date: ____/_____/_____

Consent for Internet Communications

I grant my permission to PEDIATRIC DENTISTRY AND ORTHODONTICS 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 that PEDIATRIC DENTISTRY AND ORTHODONTICS, and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that PEDIATRIC DENTISTRY AND ORTHODONTICS 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 PEDIATRIC DENTISTRY AND ORTHODONTICS 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 PEDIATRIC DENTISTRY AND ORTHODONTICS 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 PEDIATRIC DENTISTRY AND ORTHODONTICS 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 PEDIATRIC DENTISTRY AND ORTHODONTICS 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 PEDIATRIC DENTISTRY AND ORTHODONTICS 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 PEDIATRIC DENTISTRY AND ORTHODONTICS 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.

I authorize to receive communication via the following:
Check all that apply: ◯ Correspondence ◯ Email ◯ Text

I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant PEDIATRIC DENTISTRY AND ORTHODONTICS permission to securely upload my patient information to the web site.

Patient/Legal Guardian Signature: _____ Date: _____/_____/_____

Consent for Services and Financial Policy

As a condition of treatment by PEDIATRIC DENTISTRY AND ORTHODONTICS, financial arrangements must be made in advance. PEDIATRIC DENTISTRY AND ORTHODONTICS depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company, and the patient/guardian is ultimately responsible for their own insurance company.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination. Fees may change as procedures may change when the dentist/doctor is finishing treatment. The doctor/dentist will inform you if any change in treatment is recommended, and you may inquire at any time about change in cost or finances.

In consideration for the professional services rendered to me by PEDIATRIC DENTISTRY AND ORTHODONTICS, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended.

I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

At PDO, we take HIPAA and protecting your child's information seriously.
I authorize my doctor to provide personal information/communications regarding my child (if unable to speak in person at my child's appointment) by phone, email, text, and/or by other contact/communication provided by myself to the practice, if necessary.

Patient/ Legal Guardian Signature:_____ Date: ____/_____/_____

PHOTO RELEASE

We love your children just as much as you do. Thus, we love to share just how great our patients are at PEDIATRIC DENTISTRY AND ORTHODONTICS. By signing the below, you are consenting for us to post your child's photograph/picture online on social media (i.e. Facebook, Instagram, etc.) to show everyone just how great your child is! We, of course, strive to keep your privacy, so should you consent to this form, only first names will be posted with your child's picture. Should you decline signature of this page, this will in no way affect our treatment of your family during your visit.

Authorization for Use or Disclosure of Patient Photographic and/or Video Images
Authorization:
I authorize the use of disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by the practice listed below. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by HIPAA privacy regulations.

Purpose: the photographic/video images, and/or testimonial will be used for: Social Media and/or Advertising

Revocability:
I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice via registered mail. Revocation affects disclosure moving forward and is not retroactive. This authorization expires 99 years from date signed.

No treatment conditions:
I understand that the practice cannot condition treatment on whether or not I sign this authorization.

Please initial:
_____I **authorize** the use of disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by the practice listed above.
_____I **revoke** this authorization at this time for the use of disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by the practice listed above.

Name of child: ____

Patient/Legal Guardian Signature: ____ Date: ____/______/______