HAMILTON CO. PEDIATRIC DENTISTRY

Patient and Family Information

Patient's Name: _____ Preferred Name: _____

Reason for Visit: _____ Date of Birth: ___/____/_____

Address: _____ Gender: Male Female
(street)

_____ Hobbies: _____
(city) (state) (zip)

A few words to describe your child: _____

Parent Name: _____ Legal Guardian? Yes No

Place of Employment & Occupation: _____

Email Address: _____

Primary Phone: (_____) _____ Home Work Cell

Secondary Phone: (_____) _____ Home Work Cell

Address: _____ Date of Birth: ___/___/_____
(street)

_____ Social Security # _____
(city) (state) (zip)

Parent Name: _____ Legal Guardian? Yes No

Place of Employment & Occupation: _____

Email Address: _____

Primary Phone: (_____) _____ Home Work Cell

Secondary Phone: (_____) _____ Home Work Cell

Address: _____ Date of Birth: ___/___/_____
(street)

_____ Social Security # _____
(city) (state) (zip)

HAMILTON CO. PEDIATRIC DENTISTRY

Treatment Policy and Consent

Patients under the age of 18 are minors and cannot consent to treatment. **All patients under the age of 18 must be accompanied by a legal guardian for their first dental visit**. For subsequent appointments, it is strongly recommended that a legal guardian be present. If a legal guardian cannot attend, the following is the responsibility of the guardian:

- You must contact our office before the scheduled appointment to inform us of your anticipated absence. This allows us an opportunity to gain treatment consent and review all necessary medical history updates.
- You must inform us if another adult will be accompanying your child, and this adult MUST be listed on the form below as a designated adult.
- You will be held responsible for any necessary same-day payments.
- You are responsible for scheduling an appointment review with the doctor during consultation hours (same-day consultations are not available).

Failure to inform the office of your absence and inability to reach a legal guardian by phone will result in appointment cancellation and a rescheduling fee ($50 per child).

Designated Adult (may bring child to appointments):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I have read and agree to the treatment policy outlined above. By signing, I am giving consent for my child (*or self if over the age of 18*) to receive care at Hamilton County Pediatric Dentistry by the dentist and dental team.

Signature: _____ Relationship: _____

Printed Name: _____ Date: _____

HAMILTON CO. PEDIATRIC DENTISTRY

Insurance and Financial Policy

Our primary goal is to assist in the treatment of all patients, regardless of treatment cost. We are happy to work with your family to assure all needed care.

Insurance:
We charge what is usual and customary for our area and specialty. We will assist you with your benefit eligibility before treatment to help you calculate costs and maximize insurance. We are happy to submit electronic claims and pre-estimates to see that you receive the full benefits of your coverage. However, **we cannot guarantee any estimated coverage, and you are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.** Please remember that your insurance policy is a contract between you and your insurance provider. It is your responsibility to provide us all necessary insurance identification, understand your eligibility and benefits, and notify us immediately of any changes. It is also your responsibility to ensure that our office is a participant with your insurance plan. We accept most insurance plans. However, we are only in-network providers with Delta Dental Premier and Aetna.

- Pre-estimates can be submitted on your behalf
  - **Please understand that pre-estimates are simply an *ESTIMATION* of patient cost and may vary based upon deductibles, maximum limits, unforeseen procedure changes, etc.**

Payment Options:
We make payments convenient as possible by accepting cash, check, Master Card, Visa, and American Express. Payments can be made online at www.hcpdent.com 24 hours a day.

- All services without insurance submission are due in full at the time of service
- We offer 10% discount on any bill paid in cash or check the day of service
- Internal financing is available with 15% interest
- A $35 fee will be applied to all returned checks
- Balances over 90 days will be turned over to an external collection company
- Accounts must be paid in full prior to any regularly scheduled 6-month cleaning/exam appointment
- Sedation and/or hospital fees must be paid in full prior to the date of service

I have read and agree to the insurance and financial policy outlined above. I understand and fully agree that I am responsible for my account balance. I agree that if turned over to a collection source, I will be responsible for all fees above and beyond my account which may include attorney fees associated with an external collection company. I understand that if my account becomes overdue or uncollected, it can result in cancelled appointments and/or dismissal from the practice. Lastly, if insurance is involved, I take full responsibility for any disputes that I may have with their payment schedule.

Signature: _____ Relationship: _____

Printed Name: _____ Date: _____

Do you have dental insurance that we may file on your behalf? **Yes** **No**

HAMILTON CO. PEDIATRIC DENTISTRY

Appointments and Cancellation Policy

The mission of Hamilton County Pediatric Dentistry is to create a fun, safe, and enthusiastic dental environment for our patients. We schedule longer-than-average appointment times so that our team can better interact with your child. In return, we ask parents to follow our appointment and cancellation policy to help maintain a certain level of predictability in our schedule.

Scheduling:

- You will receive a call, email, or text confirmation of your child's appointment at least 48 hours prior
- As a pediatric specialty office, before and after school appointments are in high demand, and we cannot guarantee that all appointments will be scheduled before or after school
    - If there is a certain day of the week or time that you require, we advise booking 6 months in advance to ensure the desired time slot
- Parents are allowed back in the treatment rooms (exception: sedation appointments)
- Other siblings/children cannot be left unattended in the waiting room
    - Please make accommodations for other children if you wish to be back during treatment
    - Please note, our treatment rooms cannot accommodate multiple guests

Late Appointments:

- If you are more than 10 minutes late, we cannot guarantee completion of treatment in a single visit
- If you are more than 15 minutes late, we reserve the right to reschedule your child's appointment
    - Rescheduling will result in a $50 per child fee
- Multiple late appointments will result in restricted scheduling:
    - Appointments between the hours of 10:00 AM and 2:00 PM only
    - Single child scheduling (no siblings on the same day)

Missed Appointments:

- We require 24 hours advanced notice of a cancellation
- Failure to notify our office in advance will result in a $50 per child rescheduling fee
- More than two missed appointments or short-notice cancellations (less than 24-hours notice) will result in dismissal from our office
- Failure to show for a first visit will result in dismissal from our office

Desensitization Appointments:

- Each child may complete 1-2 desensitization appointments per recall visit (free of charge)
    - Additional desensitization appointments require a $95 scheduling fee
    - Failure to show for a desensitization appointment and/or less than 24-hours notice of cancellation will result in the $95 desensitization fee
    - Failure to follow through with a regularly scheduled recall visit *after* completion of complementary desensitization visits will result in the $95 per visit charge

I have read and agree to the appointments and cancellation policy outlined above.

Signature: _____ Relationship: _____

Printed Name: _____ Date: _____

HAMILTON CO. PEDIATRIC DENTISTRY

Consent for Use and Disclosure of Health Information (HIPAA Consent)

Please read the following statements carefully:

- By signing this form, you consent to our use and disclosure of protected health information to carry out treatment, payment activities, and healthcare operations
- You have the right to read our Notice of Privacy Practices before you decide to sign this consent
- You may obtain a copy of our Notice of Privacy Practices at any time:
  - A hard copy request can be made in office at any appointment
  - A digital copy request can be made via email (patients@hcpdent.com)
  - A request by phone can be made at 317-846-5893
- We have the right to change privacy practices as described in our Notice of Privacy Practices
  - If we change our privacy practices, you will be informed and we will receive a revised Notice of Privacy Practices which will contain all changes
- You have the right to revoke this consent at any time by giving us written notice of your revocation

Please Note: We will not discuss protected health information with non-guardian family members (siblings, grandparents, step-parents, nannies) without your written consent. You may designate non-guardian family members to discuss your child's protected health information by providing their names below. However, HCPD cannot be held liable for any inaccuracies in the transfer of dental information when a legal guardian is not present. You are advised to contact the doctor during consultation hours to review the appointment summary and any treatment requirements and/or recommendations.

I give permission for HCPD to relay protected health information to the following adults (this includes but is not limited to appointment findings, treatment recommendations, future appointments, referrals):

_____ _____
Name Relationship

_____ _____
Name Relationship

I have read, understand, and agree to the contents of this HIPAA consent. I understand that by signing this consent form, I am giving permission for HCPD to use and disclose my protected health information.

Patient Name: _____ Patient DOB: _____

Signature: _____ Relationship: _____

Printed Name: _____ Date: _____

HAMILTON CO. PEDIATRIC DENTISTRY

Photo Consent

As part of your child's medical record, we take a face photograph for identification purposes at the first appointment and periodically thereafter. These photographs are placed in the patient record as protected health information and remain confidential.

I give my consent for Hamilton County Pediatric Dentistry to take photographs of my child for the medical record. I understand these photos are protected health information and will not be used for any marketing, educational, or promotional use.

Patient Name: _____ Patient DOB: _____

Signature: _____ Relationship: _____

Printed Name: _____ Date: _____

Occasionally we take photographs of patients and team members for marketing and/or social media purposes. We must have your written permission to use such photos for promotion, and you have the right to decline such photographs and their use. Pictures placed on our website and/or social media pages (Facebook, Instagram) are accessible to anyone with internet access. **Publication of such photos is completely voluntary**.

May we use your child's image on the internet (hcpdent.com, Facebook, Instagram)? Yes No

May we use or attach your child's first name to social media photos? Yes No

Signature: _____ Relationship: _____

Printed Name: _____ Date: _____

HAMILTON CO. PEDIATRIC DENTISTRY

Medical History

Child's Full Name: _____ DOB: _____
Gender: ☐ Male ☐ Female Race/Ethnicity: _____ Height: _____ Weight: _____
Name/Phone of Primary Physician: _____
Name/Phone of any Medical Specialist: _____

Is your child being treated by a physician at this time? If yes, describe reason:	☐ Yes	☐ No
Is your child taking any medications (prescription or over the counter)? If yes, list name/dosage/frequency/reason:	☐ Yes	☐ No
Has your child ever been hospitalized or undergone surgery? If yes, list dates and describe:	☐ Yes	☐ No
Has your child ever had a reaction to medication, foods, metals, latex, or dyes? If yes, list and describe reaction:	☐ Yes	☐ No
Is your child up to date on immunization?	☐ Yes	☐ No

Please CIRCLE condition and mark YES if your child has a history of the following:

Complications before or during birth, prematurity, birth defects, or syndromes	☐ Yes	☐ No
Problems with physical growth, development, or failure to thrive	☐ Yes	☐ No
Sinusitis, chronic tonsil infections, sleep apnea, or snoring	☐ Yes	☐ No
Congenital heart defect/disease, heart murmur, rheumatic fever or disease	☐ Yes	☐ No
Irregular heart beat, high or low blood pressure	☐ Yes	☐ No
Asthma, reactive airway disease, cystic fibrosis, or breathing problems	☐ Yes	☐ No
Frequent colds, coughs, or history of pneumonia	☐ Yes	☐ No
Jaundice, hepatitis, or liver problems	☐ Yes	☐ No
Gastroesophageal reflux disease (GERD), stomach ulcers, or intestinal problems	☐ Yes	☐ No
Lactose intolerance, food allergies, nutritional deficiencies, or dietary restrictions	☐ Yes	☐ No
Prolonged diarrhea, unintentional weight loss/gain, or eating disorder	☐ Yes	☐ No
Bladder or kidney problems	☐ Yes	☐ No
Arthritis, scoliosis, limited use of arms or legs, or muscle/bone/joint problems	☐ Yes	☐ No
Rash/hives, eczema, or skin problems	☐ Yes	☐ No
Impaired vision, hearing, or speech	☐ Yes	☐ No
Developmental disorders, learning problems/delays, or intellectual disability	☐ Yes	☐ No
Cerebral palsy, brain injury, epilepsy, or seizures	☐ Yes	☐ No
Autism or autism spectrum disorder	☐ Yes	☐ No
Recurrent or frequent headaches/migraines, fainting, or dizziness	☐ Yes	☐ No
Hydrocephaly or placement of a shunt (VP, VA, VV)	☐ Yes	☐ No
Attention deficit/hyperactivity disorder (ADD/ADHD)	☐ Yes	☐ No
Behavioral, emotional, communication, or psychiatric problems/treatment	☐ Yes	☐ No
Abuse (physical, emotional, psychological, or sexual) or neglect	☐ Yes	☐ No
Diabetes, hyperglycemia, or hypoglycemia	☐ Yes	☐ No
Precocious puberty or hormonal problems	☐ Yes	☐ No
Thyroid or pituitary problems	☐ Yes	☐ No
Anemia, sickle cell trait/disease, or blood disorder	☐ Yes	☐ No
Hemophilia, easy bruising, or excessive bleeding	☐ Yes	☐ No
Transfusions or receiving blood products	☐ Yes	☐ No
Cancer, tumor, other malignancy, chemotherapy, or radiation therapy	☐ Yes	☐ No
Bone marrow or organ transplant	☐ Yes	☐ No
Mononucleosis, tuberculosis, scarlet fever, or cytomegalovirus	☐ Yes	☐ No
MRSA, sexually transmitted disease, HIV/AIDS	☐ Yes	☐ No
Any other significant medical history we should be told?	☐ Yes	☐ No

HAMILTON CO. PEDIATRIC DENTISTRY

Dental History

What is your primary concern about your child's oral health? _____

How would you describe your child's oral health?	☐ Excellent	☐ Good	☐ Fair	☐ Poor
How would you describe *your* oral health?	☐ Excellent	☐ Good	☐ Fair	☐ Poor
How would you describe your family's oral health?	☐ Excellent	☐ Good	☐ Fair	☐ Poor
How will your child respond to dental treatment?	☐ Excellent	☐ Good	☐ Fair	☐ Poor
	☐ Unsure of my child's potential behavior			

Does your child have any of the following? If yes, please describe.

Inherited dental anomalies	☐ Yes	☐ No	_____
Mouth sores or fever blisters	☐ Yes	☐ No	_____
Bad breath	☐ Yes	☐ No	_____
Bleeding gums	☐ Yes	☐ No	_____
Cavities/tooth decay	☐ Yes	☐ No	_____
Toothache	☐ Yes	☐ No	_____
Injury to teeth or mouth	☐ Yes	☐ No	_____
Clenching or grinding	☐ Yes	☐ No	_____
Jaw joint problems (popping, pain, etc)	☐ Yes	☐ No	_____
Excessive gagging	☐ Yes	☐ No	_____
Sucking habit (fingers, pacifier, etc)	☐ Yes	☐ No	_____

Please answer the following questions concerning your child's oral hygiene.

How often does your child brush his/her teeth? _____ times per _____

Does someone help? ☐ Yes ☐ No

How often does your child floss his/her teeth? _____ time per _____

Does someone help? ☐ Yes ☐ No

What type of toothbrush does your child use? _____

What type of toothpaste does your child use? _____

What type of water does your child drink (city, well, bottled, filtered)? _____

Does your child use fluoride rinse, gel, drops, or tablets? ☐ Yes ☐ No

If yes, please describe: _____

Please answer the following questions concerning your child's diet.

Does your child regularly eat 3 meals a day?	☐ Yes	☐ No	
Is your child on a restricted diet?	☐ Yes	☐ No	Describe: _____
Is your child a picky eater?	☐ Yes	☐ No	Describe: _____
Does your child have a diet high in sugar?	☐ Yes	☐ No	Describe: _____
Does your child have a diet high in carbohydrates?	☐ Yes	☐ No	Describe: _____

How frequently does your child:

Eat candy, cookies, cake, or processed desserts?	☐ Never	☐ Rarely	☐ 1-2 times/day	☐ 3/+ times day
Drink soda, energy drinks, or carbonated drinks?	☐ Never	☐ Rarely	☐ 1-2 times/day	☐ 3/+ times day
Drink juice, fruit punch, or box drinks?	☐ Never	☐ Rarely	☐ 1-2 times/day	☐ 3/+ times day
Chew gum or mint?	☐ Never	☐ Rarely	☐ 1-2 times/day	☐ 3/+ times day
Snack between meals?	☐ Never	☐ Rarely	☐ 1-2 times/day	☐ 3/+ times day

Please answer the following questions:

Does your child participate in sports?.....	☐ Yes	☐ No	List: _____
Does your child wear a mouth guard?.....	☐ Yes	☐ No	Type: _____
Has your child been treated by another dentist?	☐ Yes	☐ No	Name: _____

If yes, date of last visit: _____ Reason for last visit: _____

Were x-rays taken? ☐ Yes ☐ No

Any difficulty with dental treatment? ☐ Yes ☐ No

HAMILTON CO. PEDIATRIC DENTISTRY

Infant History

How long has or was your child breast-feeding?	☐ N/A	☐ Less than 6 months	☐ 6 – 11 months	☐ 12 – 17 months	☐ 18 – 23 months	☐ 2 years or more
How long has or was your child bottle-feeding?	☐ N/A	☐ Less than 6 months	☐ 6 – 11 months	☐ 12 – 17 months	☐ 18 – 23 months	☐ 2 years or more

Does your child drink formula?..... ☐ Yes ☐ No If yes, type: _____
Does your child sleep with a bottle?..... ☐ Yes ☐ No If yes, contents: _____
Does your child use a sippy cup?..... ☐ Yes ☐ No If yes, when: _____

Child's age when first tooth appeared in mouth: _____

Has your child experienced teething problems? ☐ Yes ☐ No
If yes, please describe: _____

At what age did you begin brushing your child's teeth?	☐ N/A	☐ Less than 6 months	☐ 6 – 11 months	☐ 12 – 17 months	☐ 18 – 23 months	☐ 2 years or more
When did you begin using toothpaste? *(type:_____)*	☐ N/A	☐ Less than 6 months	☐ 6 – 11 months	☐ 12 – 17 months	☐ 18 – 23 months	☐ 2 years or more

Who is your child's primary care taker during the day? _____

Who is your child's primary care taker during the evening? _____