HAMILTON CO. PEDIATRIC DENTISTRY

Patient Information

Patient Name: _____ Preferred Name: _____

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

Address: _____ Gender: Male Female
(street)

_____ Preferred Pronouns: He/Him
(city) (state) (zip) She/Her
They/Them

Sibling(s): _____ Hobbies: _____

Guardian Information

Guardian Name: _____ Mom / Dad / Other: _____

Address: *Check here if same as patient ( )* DOB: ____ / ____ / _____

_____ SSN: _____ - _____ - _____
(street)

_____
(city) (state) (zip)

Primary Phone Number: _____ Home ( ) Work ( ) Cell ( )

Place of Employment: _____ Occupation: _____

Guardian Information

Guardian Name: _____ Mom / Dad / Other: _____

Address: *Check here if same as patient ( )* DOB: ____ / ____ / _____

_____ SSN: _____ - _____ - _____
(street)

_____
(city) (state) (zip)

Primary Phone Number: _____ Home ( ) Work ( ) Cell ( )

Place of Employment: _____ Occupation: _____

HAMILTON CO. PEDIATRIC DENTISTRY

Insurance Information and Financial Policy

Primary Insurance:	_____
Subscriber Name:	_____
Subscriber DOB:	_____/_____/_____
Subscriber ID Number:	_____
Group Number:	_____
Employer:	_____
Insurance Co. Phone #	(_____) _____-_____

Secondary Insurance:	_____
Subscriber Name:	_____
Subscriber DOB:	_____/_____/_____
Subscriber ID Number:	_____
Group Number:	_____
Employer:	_____
Insurance Co. Phone #	(_____) _____-_____

Insurance and Financial Policy

Please read and initial the following:

_____ HCPD is an in-network provider for Delta Dental Premier and Aetna PPO with Extended plans only.
_____ HCPD will submit insurance claims for all patients regardless of network status.
_____ Out-of-network coverage varies greatly by plans, and patients are responsible for understanding benefits.
_____ Co-payments are required at the time of service (including full payment for self-pay patients).
_____ Insurance estimations are *never* a guarantee of payment.
_____ Patients are financially responsible for all charges not paid by insurance.
_____ 24 hours advanced notice is needed for appointment cancellations in order to avoid a $50/patient fee.
_____ A $35 fee will be applied to all returned checks.
_____ Sedation / hospital fees must be paid in advance to schedule and hold a date.
_____ Accounts must be in good standing (paid in full) prior to any regularly scheduled six-month cleaning appts.
_____ Payments can be made by check, cash, or credit card (Visa, MC, American Express, Discover).
_____ Online payments are available at www.hcpdent.com.
_____ Balances over 90 days will be turned over to an external collection agency or IN State Clerk of Courts, and all charges incurred in the pursuit of the debt will be the financial responsibility of the account holder.

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Use and Disclosure of Health Information (HIPAA)

Protected health information is used to carry out treatment/payments, bill insurance, and make referrals.
A copy of our Notice of Privacy Practices is available in person at the office or electronically by request.

Please check the appointment items below that can be addressed via voicemail on your primary number.

( ) Scheduling ( ) Exam Findings ( ) Referrals
( ) Treatment Needs ( ) Billing Information ( ) Test Results

Please Note: HCPD will not discuss or disclose protected health information to a non-guardian family member without your written consent. This includes siblings, nannies, and/or grandparents. You may designate a non-guardian family member to escort your child to appointments and discuss protected health information by writing the name below. HCPD cannot be held liable for any inaccuracies in the transfer of information when a legal guardian is not present.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Appointment Policies

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

Please read and initial the following:

_____ A legal guardian is required at all first-appointment visits.
_____ Before/after school appointments are in high demand, we recommend scheduling six months in advance.
_____ Short-notice cancellations typically result in re-appointment during school hours.
_____ Filling and extraction appointments are scheduled at 10:30 AM and 1:30 PM only.
_____ Parents are encouraged to come back with their kids during appointments (exception: sedation appts).
_____ Please make accommodations for other children/siblings if you wish to be back during visits.
_____ Children/siblings cannot be left unattended in the waiting room.
_____ If you are more than 15 minutes late, we reserve the right to reschedule (resulting in fee).

Consent

By signing below, I certify the information provided within this new patient packet is accurate. I have read, understand, and agree to all of the insurance and financial policies, and I give permission to HCPD to bill my insurance company. I assume financial responsibility for my child's account and agree to pay any remaining balance. I have been offered a copy of the Notice of Privacy Practices, and I give consent for HCPD to use and disclose protected health information to carry out treatment, billing, and healthcare referrals. I have read, understand and agree to all of the appointment policies. I give consent for Dr. Laura Juntgen and the HCPD team to treat my child.

Signature of Guardian: _____ Date: _____

Print Name: _____

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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

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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

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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? _____