Warner Robins
PEDIATRIC DENTISTRY

Welcome to our office

Patient's Name _____ NickName _____ Age _____

Sex_____ D.O.B _____ School Attending_____

Parent/Guardian #1 _____ D.O.B_____ Social Security #_____

Home Phone_____ Cell Phone_____ Text Ok? _____

Street_____ City_____ State_____ Zip_____

Where Employed_____ Work Place_____

Employer's Address_____

Parent/Guardian #2 _____ D.O.B_____ Social Security #_____

Home Phone_____ Cell Phone_____ Text Ok? _____

Street_____ City_____ State_____ Zip_____

Where Employed_____ Work Place_____

Employer's Address_____

Insurance Information

Dental Insurance_____

Insurance Policy Number _____ Group number_____

Emergency contact information

Whom may we notify in case of an emergency? _____

Relationship to patient: _____

Best contact number: _____

Email Address: _____

How did you hear about us: _____

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MEDICAL HISTORY

Please answer the following questions so that we may provide optimum care for you...

Patient _____

Is your child currently under the care of a pediatrician, if yes who? _____

Is your child seeing any other doctors? If so why?: _____

_____

Is your child currently taking any prescription drugs? Please list: _____

Does your child have any allergies? Please list: _____

Does your child have any behavioral issues (ADHD, AUTISM, etc.)? _____

Has your child had any major surgeries in the last five years? _____ Please list date: _____

Does your child have pins, plates, screws, or artificial joints? _____

Have you ever been informed of your child having a heart murmur, condition, or had heart surgery? Please explain in detail:

_____

Has your child ever bled excessively? _____Has your child ever had complications with anesthesia? _____

Has a previous dentist ever used Nitrous Oxide (laughing gas) in dental treatment? _____

Please circle any of the following and provide a date if your child has had or currently has:

High/low blood pressure:	Rheumatic Fever:	Glaucoma (wide or narrow?):	X-ray or Cobalt Treatment:	
Tuberculosis:	Chemotherapy:	Mitrovalve Prolapse:	Liver Disease:	HIV:
AIDS:	Hepatitis A. B, or C:	Chest pain:	Yellow Jaundice:	Anemia:
Blood Transfusion:	Hemophilia:	Sickle cell Disease:	Kidney Trouble:	Stroke:
Congenital Heart Lesions:	Scarlet Fever:	Hay Fever:	Narcotic addiction:	Hives:
Sinus Trouble:	Asthma:	Ulcers: Cold Sores:	Arthritis:	Epilepsy:
Rheumatism:	Cortisone Meds:	Psychiatric Treatment:	Drug Addictions:	:
fainting:	Nervouness:	Eating Disorder:	Diabetes:	
Thyroid Disease:				

Is there anything that has not been covered on this form that you would like to share with us regarding your child's overall dental history? _____

'The information I have given today is true and correct to the best o/ my knowledge. I will inform the doctor/assistant/hygienist if there is any change in my child's medical or dental status,

_____

Parent or Guardian Signature: _____ Date: _____

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Dental History

Patient _____

Reason for today's visit: _____

How long has it been since your child's last visit? _____

Were dental Xrays taken within the past year? Y N

Previous dentist's name: _____

Was there any recommended dental treatment not completed? Y N

Does your child feel nervous about dental appointments? Y N

Has your child ever had an unpleasant experience at the dentist? Y N

Has your child ever had braces or orthodontic treatment? Y N

Does your child have any habits (thumb/finger sucking, pacifier)? Y N

Does your child brush daily? Y N How many times? _____

Does your child floss? Y N How often? _____

Do you help your child brush and/or floss? Y N

Does your child use a fluoride toothpaste or mouthrinse? Y N

How do you feel about your child's overall dental health?

Is there anything else you would like to share with us regarding your child's dental history? _____

_____

The information I have given is true and accurate to the of my knowledge. I will inform the doctor or dental team if there is any changes to my child's medical or dental status.

Signature of Parent/guardian _____ Date:_____

Warner Robins Pediatric Dentistry Privacy Notice

This notice describes how medical/dental information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

We understand that the privacy of your personal information is important to you. As your dental office, we believe your right to privacy is a fundamental part of your treatment; as such, we want you to understand our privacy practices and Should you have any questions regarding these policies please do not hesitate to call the office at (478) 449-4200

Information We Collect About You

We collect personal information you and your family as of our new patient process, during the course of your care. and from other health we entities you utilize such as, other dentists and specialists, imaging facilities, laboratories and your Insurance company. This personal information includes items such as your name. address, phone number, birth date, social security number, employer, health history, insurance policy and coverage information, and any information you provide. During the course of your child's treatment we will dental information diagnosis, treatment plans, and any test results or films.

How Your Information Is Used

The personal and health information may be used and disclosed with your general consent for purpose of treatment, payment. or routine healthcare operations. This means we may send your child's information to dentists or facilities involved in your treatment as well as to your insurance company or a collection agency to obtain payment. Any other uses of your information require a signed authorization by you, the patient or guardian and can revoked in at any time with a written request.

Warner Robins Pediatric Dentistry does not sell patient information to marketing or pharmaceutical companies. In certain cases of public health interest we may be required to disclose certain information to state or national health organizations or government agencies.

We may contact you to provide appointment reminders or information about treatment.

Safeguarding Your Personal and Health Information

We are by law to (1) make sure that medical identifies your child is kept (2) provide you with our privacy policy (3) follow the terms laid out in the privacy As a means of your privacy, we restrict access to your child's personal and health information to only those employees who require the information to complete their jobs and provide quality service to you.

Warner Robins Pediatric Dentistry maintains physical, electronic and procedural safeguards to comply with state and federal regulations that guard your child's personal and health information. If you feel your privacy has been violated you have the right to file a complaint with the Department of Health and Human Services. The complaint in no way influences your course of treatment with Big Top Dentistry for kids.

Changes to Our Privacy Policy

All new patients will review a copy of our privacy policy. Warner Robins Pediatric Dentistry occasionally reviews its privacy policy and reserves the right to amend it. Notification of changes will be available at the front desk prior to the effective date of any changes.

Your Right to Restrict Use of Information

You have to right to request restrictions to our uses or disclosures of your child's personal or health information, although we are not required to agree to those restrictions. Once your request has been processed it will remain in effect until you request a change.

Patient (or Parent/Guardian) Acknowledgement

I _____have reviewed Warner Robins Pediatric Dentistry's Privacy Policy

Parent/Guardian Signature_____ Date: _____

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PEDIATRIC DENTISTRY

INSURANCE AND PAYMENT POLICY

We are here to serve your family in a comfortable and professional environment. Our goal is to provide you with the very best quality of care.

Fees for service will be requested AT THE TIME OF YOUR VISIT. For treatment involving fees greater than $500, special financial arrangements may be discussed. For overdue balances, a 2% finance charge will be assessed monthly, and balances past 90 days will be sent to collections unless arrangements for payments are made.

For patients with dental insurance: We will file your claim for your primary insurance at no charge, however your deductibles and your estimated portions (usually 20-50%) are required as services are rendered. If you have questions about your insurance or fees, we request that you address those concerns prior to treatment, in order to avoid any issues in the future.

We will do our best to work with you and your insurance company to provide accurate financial information, but ANY AND ALL ACCOUNT BALANCES ARE ULTIMATELY YOUR RESPONSIBILITY. The parent who requests treatment for a child is responsible to us for all the fees incurred.

For your convenience, we do accept Visa, Discover, Mastercard and Care Credit as well as checks and cash.

I have read and understand the above information. I hereby authorize the Doctor to provide those diagnostic and treatment procedures, including local anesthesia and sedation deemed necessary. For insured patients, my signature below authorizes the assignment of insurance benefits to the Doctor and authorizes the release of dental records to my insurance company.

Patient _____

Parent/guardian signature _____ Date _____

Warner Robins
PEDIATRIC DENTISTRY

AUTHORIZATION TO TREAT A MINOR

I, as the Parent/Guardian of _____am legally able to make all medical/dental decisions for said child. I understand that by signing this form, all responsibility, for consenting to proposed and performed treatment is my decision, and I do not legally need to consult anyone else in order to authorize treatment of my child.

I am authorizing the following person(s) to consent to dental treatment in the event I cannot attend a dental appointment.

_____ _____
NAME OF AUTHORIZED PERSON RELATIONSHIP

_____ _____
NAME OF AUTHORIZED PERSON RELATIONSHIP

_____ _____
NAME OF AUTHORIZED PERSON RELATIONSHIP

_____ _____
PARENT/GUARDIAN SIGNATURE DATE

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EXAM, FLUORIDE, XRAYS AND CLEANING CONSENT

Patient _____

I consent to Dr. Brandon and his team to examine my child. _____ (initial)

I consent for my child to receive a dental cleaning. _____ (initial)

I consent to photographs of my child, both extraoral and intraoral, as necessary for diagnosis or for educational purposes.
_____ (initial)

I consent to a topical fluoride being placed on my child's teeth, following a dental cleaning. The team will do their best to inform me if insurance covers this treatment at each appointment, or the cost to me if my insurance does not cover it, but I may be responsible for the fee if my insurance does not cover the fluoride application.
_____(initial)

I consent to digital dental Xrays being taken on my child as needed for proper diagnosis. The office uses the ALARA (as low as reasonably achievable) principle for taking dental radiographs, however, I understand that Xrays may occasionally be necessary to obtain a proper diagnosis of a dental condition and/or to evaluate growth and development.
_____(initial)

I have read and understand each consent on this form. I understand that these consents will remain in effect while my child is a dental patient at Warner Robins Pediatric Dentistry, unless I request changes.

Parent/guardian signature _____ Date _____

Warner Robins
PEDIATRIC DENTISTRY

Appointment Agreement

We appreciate you giving us the opportunity to take care of your child. Our goal is to provide your child with the highest level individualized care. In order to accomplish this we have set aside a specific part of our schedule to do this. Our goal is to respect your time by seeing you and your child on time. We have found that following this agreement is the best way to respect everyone's time.

- **Please be on time for your child's appointment.** We have set aside a specific block of time for your child. When a child it is late it effects all the children being seen around that same time.
- If your child is more than **15 minutes late** then we will see them if possible. We may have to reschedule the patient. Even if we can see your child we may not be able to complete everything originally planned for the visit.
- If a patient misses their appointment two times in a twelve month period, they will be seen on a "work-in" basis and possibly dismissed from our practice.
- If necessary, parents may cancel or change their appointment **48 hours** before the appointment.
- It is your responsibility to personally confirm your child's appointment at least **48 hours** before your appointment.
- We will make multiple attempts to contact you via email, phone and text starting 6 days before your child's appointment.
- An unconfirmed appointment will be moved off of our schedule to allow another child to be seen by our office. If you show up for an unconfirmed appointment we cannot guarantee that we will be able to see you child. If we do see your child, we may not be able to complete all treatment in that visit.
- We are asking a lot from you and understand life doesn't always work on a perfect schedule. We will be happy to work with you but we need you to communicate with us. A phone call if you have any questions, concerns, or problems can help everyone work together to figure out a solution.
- We also commit to respect your time and will work hard to make sure we see you and your child at their scheduled time.

We ask that you acknowledge our appointment policy by signing below.

_____ _____

Signature Date