Welcome, Tell Us About Your Child

dr. Palmer's PEDIATRIC DENTISTRY

Today's Date: _____

Child's Name: _____ Child's Nickname: _____ Child's Age: _____

○ Male ○ Female Child's Birthdate: _____

School: _____ Grade: _____ Hobbies: _____

Who does your child live with: _____ Is your child adopted? ○ Yes ○ No

Phone: _____ Email: _____

Child's Home Address: _____ Zip Code: _____

PARENTS INFORMATION

MOTHER

Name: _____ Mother's Nick Name: _____

Social Security#: _____ Drivers License #: _____

Birthday: _____ Home Phone: _____ Work Phone: _____

Employer/Occupation: _____ Length of Employment: _____

FATHER

Name: _____ Father's Nick Name: _____

Social Security#: _____ Drivers License #: _____

Birthday: _____ Home Phone: _____ Work Phone: _____

Employer/Occupation: _____ Length of Employment: _____

If not the natural parent(s), are you the child's legal guardian? ○ Yes ○ No

EMERGENCY INFORMATION

Name: _____ Relationship to Patient: _____

Phone #: _____ Alternate Phone #: _____ Alternate Phone #: _____

INSURANCE INFORMATION

PRIMARY INSURANCE Dental Coverage ○ Yes ○ No

Insurance Co. Name: _____ Phone #: _____ Group # (plan, local, or policy #): _____

Insurance Co. Address: _____

Insured's Name: _____ Relationship to Patient: _____

SECONDARY INSURANCE Dental Coverage ○ Yes ○ No

Insurance Co. Name: _____ Phone #: _____ Group # (plan, local, or policy #): _____

Insurance Co. Address: _____

HOW DID YOU HEAR ABOUT US?

Friend or Family (Please provide name): _____ ○ **Our Website** ○ **Phone Book** ○ **Facebook**

Referring Dentist (Please provide name): _____ **Other:** (specify) _____

Our Staff (Please provide name): _____

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What is the main reason for today's dental visit?: _____

Yes No Is your child currently ill? If yes, please explain _____

Yes No Does your child have any allergies? If yes, please explain _____

Yes No Does your child currently take any medications? Please list below all including over-the-counter medications and vitamins:

_____

Has your child ever had any of the following? **Comments:**

Yes **No**

- ○ ○ ADHD
- ○ ○ Asthma (Mild/Moderate Severe/Exercise induced)
- ○ ○ Autism
- ○ ○ Blood Disorders (eg. Anemia , Hemophilia, Sickle Cell Disease)
- ○ ○ Cancer
- ○ ○ Cystic Fibrosis or respiratory disease
- ○ ○ Endocrine Disease (eg. Diabetes, Thyroid, Glandular)
- ○ ○ Genetic Disorder/Syndrome (Please Circle)
- ○ ○ Heart Disease (Murmur, Surgery, Previous Endocarditis, Congenital Abnormality)
- ○ ○ Immunocompromise
- ○ ○ Kidney Disease
- ○ ○ Liver Disease (Including Hepatitis)
- ○ ○ Mental or emotional problems, or developmental delays
- ○ ○ Neurological Disease (eg. CP, seizures, TBI)
- ○ ○ STD or HIV
- ○ ○ Severe Headaches
- ○ ○ Sight, Hearing, or Speech Disorder
- ○ ○ Skin, Bone, Muscle, or Joint Disease
- ○ ○ Has the patient ever been to the hospital due to serious illness, injury, or surgery?
- ○ ○ Is your child MRSA positive?
- ○ ○ Was your child born prematurely or had complications during birth?
- ○ ○ Vaccinations/Immunizations current?
- ○ ○ Injury to face or teeth?
- ○ ○ Currently Seeing an Orthodontist? Dr._____
- ○ ○ Previous or Current Orthodontic treatment?
- ○ ○ Does your child get help or supervision w/ brushing?
- ○ ○ Is the child's water Fluorinated?
- ○ ○ Does your child have any oral habits?

Has your child been seen by any other specialty clinics? Does your child have any other condition that you did not mention above?

If Yes, please explain: _____

Anything else you'd like to discuss? Yes / No _____

Previous Dentist: _____ Last Visit Date: _____

Previous dental experience Good / Bad

Who is your child's Primary Physician or Physicians Group?

Name:_____ Phone Number:_____

Sometimes it's helpful to have other family members, friends, or caregivers bring in your child. Could you please list anyone else who is authorized to bring in your child for dental treatment? If none, that's ok.

Name:_____ Relation: _____

I affirm that the information I have provided above is correct and to the best of my knowledge.

_____

Parent/Guardian Signature Date Signature of Dentist (information has been personally reviewed with parent)

INFECTIOUS DISEASE SCREENING

TO BE COMPLETED BY ALL PATIENTS AND VISITORS UPON ENTRY TO THE FACILITY

1. Have you OR anyone you are in close contact with been in contact with anyone that has been diagnosed or is being monitored by the CDC for COVID-19 in the last 30 days? ☐ **No** ☐ **Yes**

2. Traveled via any method (i.e. plane, bus, train, ship, car) in or out of the US where positive COVID-19 cases have been identified in the last 30 days? ☐ **No** ☐ **Yes**

   If yes, what City / State / Country did you / they visit? _____

3. Are you OR anyone you are in close contact with currently experiencing ANY of the following symptoms?

Fever (greater than 38.0°C or 100.4°F)	☐ No	☐ Yes
Severe headache	☐ No	☐ Yes
Muscle pain	☐ No	☐ Yes
Weakness	☐ No	☐ Yes
Diarrhea/Vomiting/Abdominal Pain	☐ No	☐ Yes
Respiratory illness	☐ No	☐ Yes
Rash/skin irritation	☐ No	☐ Yes
Unexplained hemorrhage (bleeding or bruising)	☐ No	☐ Yes

4. Do you experience these symptoms every year (i.e., Seasonal allergies)? ☐ No ☐ Yes

_____ Patient Name

_____ Visitor Name

_____ Signature of Patient/Visitor

_____ Date/Time

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OFFICE POLICIES

EXPECTED PAYMENT

In order to keep our fees as low as possible we ask that co-payments be paid at the time of service. For your conveniene an estimate for dental care will be prepared prior to scheduled appointments to ensure you the opportunity to plan in advance for your child's dental care.

DENTAL INSURANCE

Please understand that our goal is to provide your child with the best dental care possible. The goal of your insurance company is to control costs. They are not in the business of determining what is optimal care. Your insurance is a contract between you and your insurance company. Please familiarize yourself with your insurance benefits and provide us the correct information to assist with the submittal of your child's claims. Not all services are a covered benefit in all contracts: therefore, you are ultimately responsible for the total amount due. Recommended dental care is indicated based on individual patient needs regardless of dental insurance benefits, deductibles, limitations, or maximums.

CANCELLATION NOTICE

If a reserved appointment cannot be kept we request you provide us with a 24-hour advance notice. Early notification ensures we can offer you a more convenient appointment and allows us sufficient time to accommodate the needs of another patient therefore filling the time previously reserved for your child. We realize emergencies do occur and we will be flexible under those circumstances. If a 24-hour notice is not given the following charges will be applied to your account.

*Basic exam appointment	$40.00
*Conscious oral sedation or treatment appointment	$65.00

DENTAL DIAGNOSIS AND TREATMENT

I hereby authorize Skyway Pediatric Dentistry and or designated staff to take x-rays and do prophylaxis and fluoride treatments deemed appropriate by doctor and is mutually agreed upon to make a through diagnosis of my child's dental needs.

My signature indicates that I understand the policies as outlined and my questions with regard to the office policies have been answered.

- _____ - _____

Signature of Responsible Party **Date**

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ACKNOWLEDGEMENT of NOTICE of PRIVACY PRACTICES

Patient Name: _____ Patient DOB: _____

Parent Name: _____ Contact Number: _____
and/or Guardian

Home Address : _____

_____

_____

I have been given an office copy to read of the Notice of Privacy Practices for Dr. Levi Palmer, and understand that i can obtain a copy for personal records by going to www.levipalmerdds.com

_____ _____
Parent/Guardian signature Date

FOR OFFICE USE ONLY

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ☐ An emergency existed and a signature was not possible at the time.
- ☐ The individual refused to sign.
- ☐ A copy was mailed with a request for signature by return mail.
- ☐ Unable to communicate with the patient for the following reason:

Request and Consent for Pediatric Dental Treatment

Levi S. Palmer DDS INC

Please read this form carefully! If you do not understand something to your satisfaction, please ask questions. We will be pleased to explain it!

1. I (legal guardian) request and authorize the treatment and procedures outlined on the Treatment Plan Form for:

Patient Name: _____

2. I further request and authorize for my dentist and clinical team the taking of oral dental x-rays, photos, or study models, cleaning of my child's teeth, fluoride treatment, and the use of such anesthetics as may be considered necessary to properly enable complete diagnosis and treatment of the patient's dental problem(s). If N_20, 0_2 (Nitrous Oxide, Oxygen) are required, Dr. Palmer is given permission for its use; the use of N_20, 0_2 having been explained.

3. I have had explained to me by Dr. Palmer or his associates and office staff, and have had sufficient opportunity to discuss the patient's dental condition/problem(s), the planned procedures and treatment, and the benefits to be reasonably expected from this treatment plan, compared with alternative approaches and/or no treatment.

4. The usual and most frequent risks or complications occurring from the planned treatment and procedures also have been explained to me. These risks include but are not limited to, the possibility of pain or discomfort during the treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of a temporomandibular joint disorder, temporary or permanent numbness, and allergic reactions.

5. I understand that during the course of the patient's dental treatment, something unexpected may arise that may necessitate procedures in addition to or different from those listed on the patient's Treatment Plan Form and that I will be consulted prior to initiation of treatment procedures not listed. I am aware that the practice of dentistry is not an exact science and acknowledge that no guarantees have been made to me concerning the results of the dental treatment that the patient receives at Levi S. Palmer Pediatric Dentistry.

6. I understand that treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Behavior will be guided using praise, explanation and demonstration of procedures and instruments, using variable voice tone and loudness.

7. I understand that should the patient become uncooperative during dental procedures with movement of the head, arms and/or legs, dental treatment cannot be **safely** provided. During such disruptive behavior, it may be necessary for the assistant(s) to hold the patient's hands, stabilize the head and/or control leg movements.

8. I further understand that should the patient become uncooperative during dental procedures with excessive body movements, the patient may need to be wrapped in a "hug blanket" or "papoose board" to prevent injury and enable Dr. Palmer to **safely** provide the necessary treatment.

9. For the purpose of advancing medical-dental education, I give permission for the use of clinical photographs of the patient for diagnostic, scientific, educational or research purposes.

10. All of my questions have been answered to my satisfaction and I consent to the treatment and procedures prescribed for the patient on the Treatment Plan Form.

11. I understand that I may revoke this consent to treatment at any time and that no further action based on this consent will be initiated except to the extent that treatment and procedures have already been performed or initiated.

12. I confirm that I have read and understand this form or it was read to me, and that all blanks were filled in and all inapplicable paragraphs, if any, were stricken before I signed below.

13. I understand that payment for my child's services is due on the date that services are rendered.

14. I understand the office of Levi S. Palmer DDS does not carry patient balances or finance dental treatment.

15. I authorize the office of Levi S. Palmer DDS to seek financing for the balance of my child's account through CareCredit if I am unable to provide payment for my child's services after they are rendered.

16. I understand that my insurance is an agreement between my insurance company and me. I also understand that I am responsible for my balance regardless of my insurance.

17. I understand that I may incur a 1.5% or 18% finance charge if my balance goes beyond 90 days.

18. I assign dental benefit payments to be paid directly to **Dr. Palmer** from my insurance company.

_____ _____

Signature of Person Consenting to Treatment Tx Plan Date

_____ _____

Signature of Dr.Palmer Date

_____ _____