3224 Henderson Boulevard
813-874-0111
www.TampaPedo.com

Welcome back! Dr. Lesley and the South Tampa Pediatric Dentistry team are excited to see you again.

MEDICAL HISTORY UPDATE

Patient: _____ **Today's Date:** _____

Please list any changes in this child's medical history, including any new medications, since his/her last exam:

_____

_____

Please list any concerns you would like us to pay close attention to at today's visit: _____

_____

_____

Have there been any changes in your insurance plan? **Yes** **No**

If you have recently moved or changed your phone number, please update the contact information we have on file for you:

_____

_____

_____

_____

OFFICE POLICIES

We reserve your appointment time specifically for you. Please arrive early for all appointments. If you need to reschedule, please give at least 48 business hours notice so we may give someone else the opportunity to use that time. A fee may be charged for late arrivals, late cancellations, and missed appointments.

All children must be accompanied to all appointments by an adult aged 18 or older. This adult must remain on the premises during the entire appointment.

Cell phone, tablet, and other electronic device usage is prohibited during appointments. The use of cameras, audio, and video recording devices is prohibited without express written consent.

CONSENT FOR DENTAL TREATMENT

I, the undersigned parent/legal guardian, hereby give consent for the doctor(s) and/or clinical staff to examine this child, clean his/her teeth, perform all necessary dental treatment, administer local anesthetics, administer medications, apply topical fluoride, take diagnostic radiographs (X-rays), take clinical photographs, obtain study models and other records necessary for an accurate diagnosis for my child. I understand that dental treatment for children involves behavior guidance, which may include the use of praise, explanation and demonstration of procedures and instruments, variable voice tone, mouth props, nitrous oxide (laughing gas), or protective stabilization when necessary to promote cooperative behavior and a positive experience and to protect my child from potential injury.

FINANCIAL POLICIES

Payment is expected at the time of service. For your convenience, we gladly accept cash, checks, Visa, MasterCard, American Express, Discover, PayPal cards, and Care Credit. We will also file your insurance paperwork for you so that you may be reimbursed for services rendered. Please note that your insurance reimbursement rates may differ from the fees at South Tampa Pediatric Dentistry. In cases where the fees of South Tampa Pediatric Dentistry exceed those of your insurance reimbursement, you will be responsible for paying the difference. I agree that I am responsible for all charges for this child's dental treatment. I authorize South Tampa Pediatric Dentistry to file my dental insurance reimbursement paperwork and to call me regarding this account.

HIPAA NOTICE OF PRIVACY PRACTICES

I have legal authority for the patient and acknowledge that I have received and reviewed by copy of South Tampa Pediatric Dentistry's HIPAA Notice of Private Practices.

Signature: _____ Name: _____

Date: _____ Relationship to Patient: _____

Revised 9/4/15