Patient Information

Patient: ______________________________ Today's Date: ______________

Nickname/Preferred Name: ______________________ Date of Birth : ________ Age: _____ Sex: M F

School: ______________________________ Grade: ______________

Home Address: ______________________ City: ______________ Zip: _______

Phone Number: ______________________ Social Security Number: ______________

Who has legal custody of this patient? ______________________________

Dr. Lesley should thank ______________________ for referring us to South Tampa Pediatric Dentistry.

Reason for today's visit: ______________________________

Mother's Information:

Name: ______________________________ Date of Birth:______________

Employer: ______________________ Social Security Number: ______________

Work Phone #: ____________ Home Phone #: ____________ Cell Phone #: ____________

Father's Information:

Name: ______________________________ Date of Birth:______________

Employer: ______________________ Social Security Number: ______________

Work Phone #: ____________ Home Phone #: ____________ Cell Phone #: ____________

Person Financially Responsible For Account:

Name: ______________________________ Relationship to Patient:______________

Billing Address: ______________________ City: ______________ Zip: _______

Work Phone #: ____________ Home Phone #: ____________ Cell Phone #: ____________

E-mail address: ______________________________

Insurance Information

Dental Insurance Company: ______________________ Group #: ______________

Phone #: ______________________ Name of Insured: ______________________

Health Information

Physician's Name: ______________________________ Phone #: ______________

Date of last physical: __________ Y N Are all of your child's immunizations up to date?

Y N Has your child ever been hospitalized? If yes, please describe when and why: ______________

Y N Has your child ever been treated in the emergency room? If yes, please describe when and why:

____

Y N Has your child ever had surgery? If yes, please describe when and why: ______________

Y N Does your child need pre-medication with antibiotics before dental appointments?

Patient Name: ____

Please list all current medications this patient is taking, including the reason for taking the medication:

____

____

Please list any known allergies: ____

Has your child ever been diagnosed with or treated for the following?

Y N ADHD/hyperactivity	Y N breathing problems	Y N heart murmur	Y N premature birth
Y N allergies	Y N cancer/tumor	Y N hepatitis	Y N rheumatic fever
Y N anaphylactic reaction	Y N cerebral palsy	Y N high blood pressure	Y N seizures/epilepsy
Y N anemia	Y N cleft lip/palate	Y N HIV/AIDS	Y N sleep apnea
Y N arthritis	Y N delayed speech	Y N kidney disease	Y N sickle cell disease
Y N artificial joints	Y N developmental delay	Y N latex sensitivity	Y N sinus problems
Y N asthma	Y N diabetes	Y N liver disease	Y N STD
Y N birth defects	Y N fainting spells	Y N low birth weight	Y N tonsillectomy
Y N bladder disease	Y N head/neck injury	Y N mental/nervous disorder	Y N tuberculosis
Y N bleeding problems	Y N hearing impairment	Y N pacemaker	Y N vision problems
Y N blood disorder	Y N heart condition	Y N pregnancy	Y N other

If other, please specify: ____

Please elaborate on any of the above marked yes: ____

____

Dental Information

When was your child's last dental visit? ____

Previous dentist's name and address: ____

Why did your child leave his/her previous dentist? ____

When were X-rays last taken of your child's teeth? ____

Y N Do you have any concerns regarding his/her teeth?

Y N Do you supervise or assist your child in brushing his/her teeth?

Y N Does your child have any tooth, jaw, or muscle discomfort?

Y N Does your child only drink bottled, highly-filtered, or well water?

Y N Does your child have a click, pop, or other noise in the jaw joint?

Y N Does your child frequently eat sweets and/or drink juices or sodas?

Y N Are any of your child's teeth uncomfortable for him/her when he/she bites?

Y N Do your child's gums bleed when brushing or flossing?

Y N Does your child have any concerns about the appearance of his/her teeth?

Y N Does your child have a history of an accident or injury involving the teeth/jaws?

Y N Does your child have a habit of snoring or mouth breathing?

Y N Does your child have a current or previous habit involving a pacifier or thumb/finger sucking?

Y N Does your child have a history of going to sleep with a baby bottle or on demand breast feeding?

Y N Does your child use dental floss?

Y N Does your child use fluoride tablets or rinses?

Y N Does your child use toothpaste with fluoride?

Y N Does your child get cold sores or canker sores?

Y N Does your child clench or grind his/her teeth?

Y N Does your child have frequent headaches?

Y N Are your child's teeth sensitive to hot or cold?

How has your child reacted to previous medical or dental procedures? ____

How do you expect your child to react in the dental chair? ____

What are your child's interests and hobbies? ____

Please list any conditions or concerns regarding your child's health that have not been covered in this questionnaire:

____

I, the undersigned parent/legal guardian of this child, certify that the above is accurate and complete to the best of my knowledge. I will notify Dr. Lesley and/or the staff of ***any*** change in the above prior to ***any*** appointment.

Signature: ______________________ Name: ______________________

Date: ____________ Relationship to Patient: ______________________

Appointment Policy

We reserve your appointment time specifically for you. If you need to reschedule, please give us at least 24 hours notice so that we may give someone else the opportunity to use that time. A fee may be charged for late cancellations and/or missed appointments.

CONSENT FOR DENTAL TREATMENT

I, the undersigned parent/legal guardian, hereby give consent for Dr. Lesley 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.

Signature: ______________________________________ Name: ____

Date: ____________ Relationship to Patient: ____

FINANCIAL POLICIES

Payment is expected at the time of service. For your convenience, we gladly accept cash, checks, Visa, MasterCard, American Express, and Discover. 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.

Signature: ______________________________________ Name: ____

Date: ____________ Relationship to Patient: ____

NOTICE OF PRIVACY PRACTICES: HIPAA

Disclosure of Health Information

We use and disclose health information about your child for treatment, payment, and healthcare operations. We may disclose your child's information to a healthcare provider treating him/her via telephone, mail, or email. You may give us written authorization to disclose health information to anyone for any purpose. This authorization may be revoked in writing. We need written permission before any health information is disclosed to any caregivers besides the child's legal guardian. In the event of an emergency, we will disclose information based on our professional judgment. We may use your child's health information to obtain payment for services. We will not use health information for marketing purposes. If we suspect a possible victim of abuse, neglect, or domestic violence, we may disclose your child's health information as the law requires. We may disclose your child's health information to provide you with appointment reminders/confirmations or treatment recommendations (such as voicemails, postcards, emails, or letters).

Appointment Reminders

We may email you or leave a message with a person or on an answering machine/voicemail to reconfirm appointments. These emails/messages will be of a non-sensitive nature and will include the doctor's name and/or the practice name. You may inform us in writing if you prefer to not have emails/messages of this nature left for you.

Please send appointment reminders and other information regarding this child's appointments to the following email address: ____

Patient Rights

Access: You have the right to look at or obtain copies of your child's health information. If you request copies, we will charge you for each page, for staff time to locate and copy the information, and postage if you request that the copies be mailed.
Restriction: You have the right to request that we place additional restrictions on our use or disclosure of information.
Alternative Communication: You have the right to request that we communicate with you about your health history in alternative means.
Amendment: You have the right to request that we amend your child's health information. We may deny your request under certain circumstances.

Questions and Complaints

If you are concerned that we may have violated your child's privacy rights or disagree with a decision we made about access to your child's health information or in response to a written request to amend or restrict the disclosure of health information, you may submit a written complaint to the U.S. Department of Health and Human Services. If you have any further questions about our privacy practices, please ask a staff member.

Signature: ______________________________________ Name: ____

Date: ____________ Relationship to Patient: ____