ROUTE 66
CHILDREN'S DENTISTRY

CHOICE
HEALTHCARE SERVICES
AFFILIATE

PATIENT INFORMATION

NAME: LAST _____ FIRST _____ MI _____ GENDER: M F

BIRTH DATE _____/_____/_____ AGE _____ SS# _____-_____-_____

HOME PHONE _____ CELL _____ OTHER _____

ADDRESS _____ CITY _____

STATE _____ ZIP _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

HEAD OF HOUSEHOLD

NAME: LAST _____ FIRST _____ MI _____ GENDER: M F

BIRTH DATE _____/_____/_____ SS# _____-_____-_____ MARITAL STATUS: S M W D

HOME PHONE _____ CELL _____ WORK _____

EMAIL ADDRESS _____ EMPLOYER _____

ADDRESS (☐ Same as above) _____ CITY _____

STATE _____ ZIP _____ DENTAL INSURANCE _____ ID# _____

RELATIONSHIP TO PATIENT _____

SPOUSE/OTHER PARENT INFORMATION:

NAME: LAST _____ FIRST _____ MI _____ GENDER: M F

BIRTH DATE _____/_____/_____ SS# _____-_____-_____

HOME PHONE _____ CELL _____ WORK _____

EMAIL ADDRESS _____ EMPLOYER _____

ADDRESS (☐ Same as above) _____ CITY _____

STATE _____ ZIP _____ RELATIONSHIP TO PATIENT _____

EMERGENCY CONTACT INFORMATION:

NAME: LAST _____ FIRST _____ PHONE _____

RELATIONSHIP TO PATIENT _____

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DENTAL & MEDICAL HISTORY

IT IS CRUCIAL THAT ANY DENTAL AND MEDICAL HISTORY PROVIDED IS CURRENT

PREVIOUS DENTAL OFFICE _____

PHONE _____ DATE OF LAST DENTAL VISIT _____ X-RAYS TAKEN? Y N

(PLEASE CIRCLE THOSE THAT APPLY)

DOES YOUR CHILD HAVE PERIODONTAL (GUM) PROBLEMS? YES NO

DO YOU FEEL YOUR CHILDS GUMS BLEED, FEEL IRRITATED, OR TENDER? YES NO

DOES YOUR CHILD FLOSS REGULARLY? YES NO

HAS YOUR CHILD HAD ANY PROBLEMS ASSOCIATED WITH PREVIOUS DENTAL TREATMENT? YES NO

IS YOUR HOME WATER SUPPLY FLUORIDATED? YES NO

DOES YOUR CHILD DRINK BOTTLED OR FILTERED WATER FREQUENTLY? YES NO
IF YES, HOW OFTEN? DAILY / WEEKLY / OCCASIONALLY (PLEASE CIRCLE THOSE THAT APPLY)

HAS YOUR CHILD HAD ORTHODONTIC (BRACES) TREATMENT? YES NO

DOES YOUR CHILD EXPERIENCE HEADACHES, EARACHES, OR NECK PAIN? YES NO

ARE YOUR CHILDS TEETH SENSITIVE TO HOT / COLD / PRESSURE / SWEETS? YES NO
(PLEASE CIRCLE THOSE THAT APPLY)

IS YOUR CHILD HAPPY WITH THE APPEARANCE OF THEIR TEETH? YES NO

DENTAL CONCERNS _____

PRIMARY PHYSICIAN INFORMATION:

IS YOUR CHILD UNDER THE CARE OF A PHYSICIAN? YES NO

PHYSICIAN NAME _____ PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

DATE OF LAST PHYSICAL EXAM _____

IS YOUR CHILD TAKING ANY MEDICATIONS? YES NO

LIST MEDICATIONS _____

HAS YOUR CHILD BEEN HOSPITALIZED OR HAD SURGERY? YES NO

PLEASE EXPLAIN _____

CONDITIONS

Does your child have, or has your child had, any of the following?

- ☐ Cancer or Tumor
- ☐ Heart Murmur, Mitral Valve Prolapse, Heart Defect
- ☐ Rheumatic Fever
- ☐ High / Low Blood Pressure
- ☐ Tuberculosis or other lung problems
- ☐ Kidney Disease
- ☐ Hepatitis or other liver disease
- ☐ Blood Transfusions; Date of last transfusion _____
- ☐ Diabetes
- ☐ Epilepsy, seizures, or fainting spells
- ☐ Arthritis
- ☐ Herpes or cold sores
- ☐ AIDS or HIV positive
- ☐ Migraine headaches or frequent headaches
- ☐ Fractured jaw
- ☐ Anemia or blood disorders
- ☐ Hay Fever or sinus trouble
- ☐ Allergies or hives
- ☐ Asthma
- ☐ Autism
- ☐ ADHD / ADD
- ☐ Premature Birth
- ☐ Hearing Problems
- ☐ Intellectual Disability
- ☐ Congenital Birth Defects
- ☐ Speech Problems
- ☐ Behavioral Problems
- ☐ Pregnancy
- ☐ Radiation Treatment
- ☐ Autoimmune System Problems
- ☐ COVID-19; Date of positive test result _____
- ☐ Other:

For those conditions marked, please explain:

Does your child require an antibiotic before dental treatment? **Yes** **No**

If yes, please note antibiotic _____

Preferred Pharmacy _____

Address/Cross Streets _____ Phone _____

ALLERGIES

Is your child allergic to, or has your child reacted adversely to any of the following?

- ☐ Latex
- ☐ Penicillin or Other Antibiotics
- ☐ Local Anesthesia
- ☐ Codeine or Other Drugs
- ☐ Aspirin
- ☐ Other:

I certify that the information I have given is correct to the best of my knowledge. If any changes do occur, I will notify the office and update my file.

Signature _____ Date _____

Welcome to our practice and thank you for choosing us as your dental care providers. We are committed to your treatment being pleasant and successful. Parent(s) / Guardian(s) must read and sign our Office Policies prior to treatment. We ask that you thoroughly read and sign below. Thank you.

Pediatric Dental Brands shall operate in a manner that does not unlawfully discriminate against people based on race, color, national origin, religion, sex (including pregnancy), sexual orientation (including gender identity and expression), disability, or any other basis prohibited by federal, state, or local law.

MINOR PATIENTS

The parent, adult, or legal guardian accompanying the patient during the appointment is responsible for full payment. For an unaccompanied minor, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, credit card, payment by cash or check at the time of service. All children under the age of 18 must be accompanied by their legal guardian. If an adult that is not the legal guardian accompanies the patient, an authorized letter by the legal guardian must be presented to office staff otherwise the appointment will be rescheduled.

NITROUS

Please be aware that we use nitrous oxide for all restorative dental appointments. Most insurances, with the exception of State Medicaid Programs, DO NOT cover nitrous oxide. If for any reason you are not wanting the patient to receive nitrous oxide, please let the office know before the scheduled appointment. The parent of guardian bringing the patient to the appointment MUST stay in the building for the duration of the appointment.

DENTAL INSURANCE

We must emphasize that as dental care providers, our relationship is with you and not your dental insurance company. Your insurance policy is a contract between you and your insurance company. Although we are happy to assist you with your insurance claims, we are not a party to that contract. In the event we do accept assignment of benefits, we require that you pay the deductible (or provide proof that you have done so) and pay the estimated portion of your bill at time of service. We often accept assignment of insurance benefits; however, the balance is your responsibility whether your insurance company pays or not. We are unable to bill your insurance company until you give us your complete insurance information.

We allow 60 days for your insurance company to pay. In the event your insurance has not paid within the 60-day period, the bill will then be turned over to you and you will be responsible to pay the balance within the next 30 days. At that time, we will also resubmit services rendered to your dental insurance company for the last time. A simple call to your insurance company by you will greatly facilitate the payment. Remember, payment for your dental bill is always your responsibility. We allow your insurance company 60 days to pay as a service to you. All percentages and deductibles are due in full at the time of service.

What is collected at time of service is an estimate. After receiving payment from insurance, you will be billed or credited the difference.

PAYMENT AT TIME OF SERVICE

Estimates for major dental treatment are available and will be presented prior to dental treatment being completed. A monthly financial fee of 1.5% is applied to balances not paid by the 1st of the following month after treatment. There will be a $35.00 handling fee in addition to any bank charges for any returned checks. For your convenience we accept cash, check, Visa, Mastercard, American Express, and Discover.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payments regardless of any insurance company's determination of usual and customary rates.

I HAVE READ, UNDERSTAND, AND AGREE TO THE OFFICE POLICIES NOTED ABOVE

Name(print) _____ Signature _____ Date _____

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DENTAL APPOINTMENT POLICY

Scheduled appointments are specifically time managed based on appointment type. We reserve a time slot for the patient with one of our Providers to ensure patient receives the highest level of care. To guarantee maximum access to dental services for all our patients, we ask that you please respect your designated appointment(s) and acknowledge our Dental Appointment Policy.

In the event of running late to a scheduled appointment, please contact the office immediately, providing the office with an estimated time of arrival; this allows the office to adjust the schedule accordingly and update the dental staff. If patient arrives to scheduled appointment 15 minutes ***after*** their scheduled time, the office will reschedule the appointment.

In the event of needing to reschedule or cancel an appointment, please contact the office as soon as possible, but no later than 24 hours prior to patients scheduled appointment. Appointments are very high in demand and by giving us advance notice, this allows us to offer the time slot to another patient who is in need or requesting an appointment.

We ask all patients to honor their reserved time with our Providers. In doing so, we require the following:

Tips to Avoid a "No Show" Appointment

- Confirm your appointment
  - Always make sure we have the most up to date contact information.
- Arrive 5-10 minutes early.
- Give us 24-hour notice when needing to cancel/reschedule an appointment.
  - We understand that emergencies do happen. If you experience extenuating circumstances and must miss an appointment without giving us 24-hour notice, please ask to speak to a member of management. You may contact our office 24 hours a day, 7 days a week. If it is outside of business hours, please leave a message.

Definition of a "No-Show" Appointment

- Does not arrive to the appointment at all
- Cancellation of an appointment with less than 24-hour notice
- Arrives more than 15 minutes late and is consequently unable to be seen

Consequences of "No Show" Appointment (per 12-month period) & Same Day Policy

- 1st missed appointment: reminder about our "No Show" policy.
- 2nd missed appointment: policy reminder and warning. Can result in the office unable to reserve specific appointment times for the patient and the patient will be placed on the same day appointment policy.
- 3rd missed appointment: office will no longer reserve appointment time(s) for the patient. The patient will be placed on the same day appointment policy.
  - Same Day Appointment Policy: As the parent/guardian, you will need to call the office the day you would like the patient to be seen and ask our availability. If the office has available time slot(s), patient(s) will be scheduled. A maximum of two family members per day will be scheduled under the same day policy.
  - If the patient is placed on the same day policy, an appointment is scheduled, and patient does not show up, the patient/family will be dismissed from the practice.

I HAVE READ, UNDERSTAND, AND AGREE TO THE DENTAL APPOINTMENT POLICY NOTED ABOVE

Signature _____ Relationship to Patient _____ Date _____

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PHOTOGRAPHY, VIDEO & OTHER TYPES OF IMAGING

The making, use, or transmission of photos, videos, digital images, and other visual recordings during patient appointments is prohibited. Although patient photography may be common, individual and patient privacy issues need to be considered and federal regulations need to be followed.

Dental Staff and/or Team Members may not be photographed without their permission.

Without taking the proper precautions, photography and video taken by patients or family members may inadvertently make a parent/guardian liable for invasion of privacy. As the legal guardian, you may be subjected to liability for publishing photographs, videos, or other images of our dental team members under the type of invasion of privacy known as public disclosure. Before taking any photography or video, our dental team members must be made aware of why it is being taken and they must be asked if they feel comfortable being photographed or video recorded.

Regulatory: HIPAA standards for the privacy of individually identifiable information include photographs, videos and similar images. HIPAA requires patient authorization for the release of protected health information, which includes patient photography and videography for purposes other than for treatment, payment, and healthcare operations.

I have read, understand, and agree to follow the Photo and Video Policy noted above.

Signature _____ Date _____

COMMUNICATION

Our office communicates with our parents and patients in several ways (i.e., US Postal Service, telephone, and electronic communication; email and/or text messaging). By providing the requested information and signing below, you are agreeing to our terms of use and authorizing consent to contact you by the communication sources mentioned above.

Please note standard text messaging rates may apply.

Email Address _____

Primary Mobile # _____

Secondary Mobile # _____

☐ I choose to opt out of communication sources other than phone call.

I have read, understand, and agree to the Communication Policy noted above

Signature _____ Date _____

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ACKNOWLEDGEMNT OF NOTICE OF PRIVACY PRACTICES

Available upon request, or online.

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I hereby certify that I am aware of, I have reviewed, or I have received a copy of the Notice of Privacy Practices for the following office:

_____
_____
_____
_____

Printed Name of Recipient _____

Signature _____ Date _____

For Office Use only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices from the above referenced individual, but acknowledgement could not be obtained because:

____ Individual refused to sign

____ Communication barriers prohibited obtaining the acknowledgement

____ An emergency prevented us from obtaining acknowledgement

____ Other _____

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CONSENT & AUTHORIZATION OF TREATMENT

Because your child is a minor, it is necessary to have signed permission from a parent or guardian. The signature affixed below authorizes examination and treatment as necessary and the use of procedures the Provider may deem necessary during the performance of his/her services.

I, _____ being the parent or guardian of _____, do hereby request and authorize the Dental Staff to perform necessary dental services for my child, including x-rays, nitrous oxide (laughing gas), administration of anesthesia, restorations, crowns, and extractions and any services recommended by the Provider.

I understand that during the treatment, it may be necessary to change or add procedures because of conditions found while working on my child's teeth that were not discovered during initial examination. I give my permission to the Provider to make any/all changes and additions as necessary with my informed consent.

If anyone other than the legal guardian of the patient accompanies him/her to the office for routine dental care or treatment, we must have a written authorization. This Authorization form is required for reason pertaining to HIPAA as well as the safety of the patient.

You may authorize other person(s) to accompany the patient to the office and authorize routine dental care or treatment by filling out the below.

Patient Name(s) _____ DOB _____

I, _____ herby authorize _____ to accompany my child(ren) for routine dental examinations, cleanings, radiographs, and/or dental treatment.

Relation to patient of the Individual noted above: _____

This authorization shall remain in effect:

- ☐ Until the date of _____
- ☐ Until revoked by me.

Signature _____ Date _____