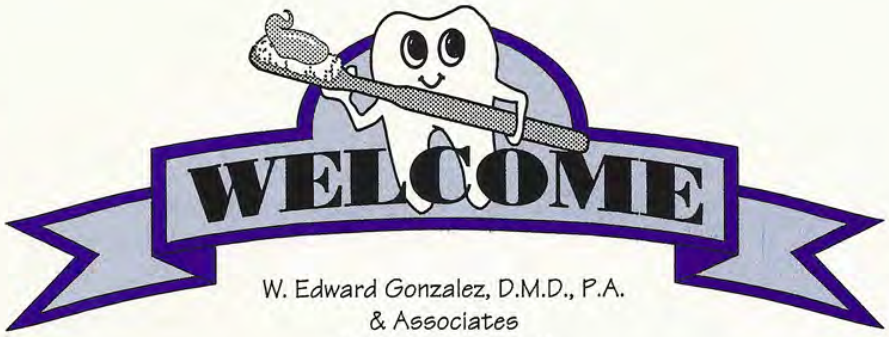

W. Edward Gonzalez, D.M.D., P.A.
& Associates
Pediatric Dentistry

1 Tell Us About Your Child

Today's Date: _____

Child's Name: _____

Nickname: _____ ☐ Male ☐ Female

Child's Birthdate: ____/____/____ Child's Age: _____

School: _____ Grade: _____

Child's Home #: _____ S.S. #: _____

Child's Home Address: _____

_____

Email: _____

2 Who is Accompanying the Child Today?

Name: _____

Relation: _____

Do you have legal custody of the child? ☐ Yes ☐ No

Whom may we THANK for referring you: _____

Other Children in family (Names & Ages) _____

_____

Are they currently patients here: ☐ Yes ☐ No

Previous/Present Dentist: _____

Last visit date: _____

3 Person Responsible for Account

Mother's Information:

☐ STEP MOTHER ☐ GUARDIAN

Name: _____ Date of Birth____/____/____

Address: _____ For How Long?_____

_____

Employed By: _____ For How Long?_____

Occupation: _____ SS#: _____

Driver's License #: _____

Business Phone: _____ Home Phone: _____

Father's Information:

☐ STEP FATHER ☐ GUARDIAN

Name: _____ Date of Birth____/____/____

Address: _____ For How Long?_____

_____

Employed By: _____ For How Long?_____

Occupation: _____ SS#: _____

Driver's License #: _____

Business Phone: _____ Home Phone: _____

4 Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

_____

Insurance Co. Phone: _____

Group #, (Plan, Local, or Policy #) _____

Insured's Name: _____

Relationship to patient: _____

Insured's Birthday ____/____/____ SS#: _____

Insured's Employer: _____

Orthodontic coverage? ☐ Yes ☐ No

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

_____

Insurance Co. Phone: _____

Group #, (Plan, Local, or Policy #) _____

Insured's Name: _____

Relationship to patient: _____

Insured's Birthday ____/____/____ SS#: _____

Insured's Employer: _____

Orthodontic coverage? ☐ Yes ☐ No

5 Has the Child ever had the Following Medical Problems?

Y	N	Heart Murmur	Y	N	Congenital Heart Defect
Y	N	Cancer	Y	N	Convulsions/Epilepsy
Y	N	Diabetes	Y	N	Abnormal Bleeding
Y	N	Rheumatic Fever	Y	N	Hearing Impairment
Y	N	HIV+/AIDS	Y	N	Any Operations
Y	N	Hemophilia	Y	N	Any stays in a hospital
Y	N	Asthma	Y	N	Kidney/Liver Problems
Y	N	Hepatitis	Y	N	Handicaps/Disabilities
Y	N	Tuberculosis	Y	N	Allergies to any drugs

Has your physician ever advised you that your child should be premedicated with antibiotics before dental treatment? ☐ Yes ☐ No

7 Does the Child have the Following Habits?

Y N Thumb/Finger Sucking
Y N Lip Sucking/Biting
Y N Nail Biting
Y N Nursing Bottle Habits
Y N Pacifier

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

6 Why did you Bring the Child to the Dentist Today?

_____

_____

Has the child ever had a serious/difficult problem associated with previous dental work? ☐ Yes ☐ No

Is the child's water fluoridated? ☐ Yes ☐ No

Is the child taking fluoridated vitamins? ☐ Yes ☐ No

Has the child ever had any pain/tenderness in their jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Does the child brush their teeth daily? ☐ Yes ☐ No

Floss their teeth daily? ☐ Yes ☐ No

Child's Physician: _____

Phone #: _____ Last Visit Date: _____

Is the child currently under the care of a physician? ☐ Yes ☐ No

Describe the child's current health: ☐ Good ☐ Fair ☐ Poor

Please list all drugs that the child is currently taking:

_____

_____

_____

_____

Please list all drugs/latex that the child is allergic to:

_____

_____

_____

8

I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status.

I authorize the dental staff to perform the necessary dental services my child may need and I am responsible for the cost of this treatment at the time of visit unless prior arrangements have been made.

Signature of parents or guardian: _____

OFFICE USE ONLY *Office Use Only* OFFICE USE ONLY *Office Use Only*

I verbally reviewed the medical / dental information above with the parent / guardian & patient named herein.

Initials: _____ Date: _____

Doctor's Comments: _____

_____

_____

_____

_____

Medical History Update:

PEDIATRIC DENTAL CENTER

Important dental insurance information for our patients

Understanding your insurance coverage can be quite challenging. Our goal is to assist you in obtaining your maximum dental benefits. We care for patients from hundreds of different companies. Each company pays an insurance premium for specific coverage, which fits *your employer's budget for the year*. Traditionally these coverage's can change from year to year. They do not notify us of any changes in your policy. It is absolutely necessary that you *become familiar with your network, policy, exclusions, deductibles and required co-pays.* For instance some insurance do not cover white fillings and have age restrictions. You will be asked to approve all treatment your child may need. It will be your *responsibility* to cover all payment differences between the office fee and you insurance reimbursements.

I hereby authorize Dr. Gonzalez and his Associates to release to my insurance company information acquired in the course of my child's dental care. I hereby authorize benefits to be paid directly to Dr. Gonzalez. *I understand I am responsible for any unpaid balance.*

_____ Date _____, 20__

Signature of Parent or Guardian authorizing treatment

PEDIATRIC DENTAL CENTER

Important dental insurance information for our patients

Understanding your insurance coverage can be quite challenging. Our goal is to assist you in obtaining your maximum dental benefits. We care for patients from many different companies. Each company pays an insurance premium for specific coverage, which fits the company budget. Each plan is slightly different in its covered services. We encourage you to become familiar with your policy exclusions, deductibles and required co-payments.

Our courtesy service to you includes:

** Filing your insurance within 24 hours of your visit and requesting payment of your benefits to our office.
** Electronically filing your insurance for short turnaround.
** Re-filing your insurance a second time within 60 days.
** Following the American Dental Association guidelines for coding procedures and filing insurance.
** You will receive a monthly statement from our office until the balance on the account has been paid.

Our expectations of you as the owner of the policy:

** Payment of fees not covered by your insurance plan at the time the service is delivered.
** Understanding that the insurance policy belongs to you and we have no leverage to obtain payment from your insurance carrier.
** Realizing that dental insurance policies restrict payment for some services, use restricted fee schedules (called Usual and Customary Rates) and exclude some procedures based on prior conditions or length of time on the plan. All restrictions are based on the premium paid for the type of insurance you contracted for not our fees or recommended treatment plan.
** Taking responsibility for payment if the insurance company does not pay our office within 60 days.
** Keeping our office informed of any changes in your insurance coverage or employment.
** Our office is a dental facility, and the medical insurance will not pay our office for services rendered. Therefore, we ask all patients to pay for treatment the day services are rendered and seek reimbursement from your medical carrier. We will provide all necessary documentation.

Thank you for your cooperation with your dental coverage. Please sign the space below and have your insurance card ready for us to copy for our files.

I hereby authorize Dr. Gonzalez and his Associates to release to my insurance company information acquired in the course of my child's dental care. I hereby authorize benefits to be paid directly to Dr. Gonzalez. I understand I am responsible for any unpaid balance.

_____ Date _____
Signature of Insurer

pediatric
DENTAL CENTER

Consent for Fluoride Treatment

Fluoride is effective in preventing and reversing the early signs of dental caries (tooth decay). Researchers have shown that there are several ways through which fluoride achieves its decay preventive effects. Fluoride incorporates into the tooth structure making it stronger resulting in teeth that are more resistant to acid attacks. Fluoride also acts to repair or remineralize areas in which acid attacks have already begun.

Fluoride application is an important part of your child's comprehensive preventative program at Pediatric Dental Center. Fluoride not only helps prevent new decay from developing, it also helps protect existing dental work so that fillings are replaced less frequently, decreases sensitivity, makes teeth last longer and saves you money! Fluoride is most effective when applied after the dental cleaning and all the plaque and build up have been removed from the tooth's surface. It is our office protocol to apply fluoride varnish at each routine care appointment for your child to receive maximum benefit.

Child's Name:_____

I _____, give consent to apply fluoride treatment twice a year. Most insurance companies cover fluoride twice a year; however, some insurance companies are only paying for once a year application. **I agree that if my insurance company does not pay for the second application that I am responsible for payment.** I am aware that it is my responsibility to check benefits for service coverage.

Parent Signature:_____ Date:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES / USE AND DISCLOSURE FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. We provide this form to comply with the Health Insurance Portability and Accountability Act (HIPAA). Please review the Notice of Privacy Practices thoroughly before signing this acknowledgement form. If terms of our Notice change, a revised copy will be made available to you.

By signing this form, you acknowledge that our practice may use and disclose PHI about you for treatment, payment and healthcare operations. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or healthcare operations.

_____ _____

Signature of Patient or Legal Representative | Date

_____ _____

Printed Name of Patient | Legal Relationship to the Patient *(If required)*

We cannot discuss your health information with anyone other than yourself unless you authorize us to do so. Please list below names of the individuals you authorize our office to discuss care with.

I give you permission to share my health information with:

1. Name _____ Relationship _____ Phone_____

2. Name _____ Relationship _____ Phone_____

Consent to email or text for appointment reminders and other healthcare communication.

If you approve, we may contact you via email and/or text messaging to remind you of an appointment or provide general health reminders or information. I understand that once I have consented to receive communications via text or email, I still have the right to revoke the consent at any time.

The cell phone number I authorize to receive text messages for appointment reminders and general health information is _____. Please initial _____.

The email address that I authorize to receive email messages for appointment reminders and general health information is _____. Please initial _____.

Or

_____ **I decline** to receive communications via **text**.

_____ **I decline** to receive communications via **email**.

Revocation – Use this area to document revocation of a previous form of communication.

_____ I hereby revoke my request to receive future appointment reminders or healthcare updates via text.
_____ I hereby revoke my request to receive future appointment reminders or healthcare updates via email.

Patient signature_____ Date requested: _____

Reminder - Keep information to the minimum necessary and encrypt emails and texts whenever possible

Dear Parent and or Guardian,

It is a pleasure to have you in our family of patients.

We will do our best to accommodate your schedule. We understand that sometimes things come up and you might not be able to make your child's appointment.

Please have the courtesy to give us a call 24 hours in advance to cancel and re-schedule.

Any missed appointments are unfair to other children who may have needed your child's appointment time. It is also very unfair to our Doctor and staff who prepared to treat your child. Together we can provide the best care for your child.

If you do not arrive on time for your appointment or you do not show for your appointment without giving a 24 hour notice, you will be referred back to your insurance company. At that time they will assign your child to another dental office.

I have read and understand the above: _____

_____
Date

Thank you,
Dr. Ed Gonzalez
Pediatric Dental Center