NEW PATIENT INFORMATION

Patient Name:______________________ Nickname:______________ Today's Date:____________

DOB:____________ Age:__________ Gender:_____ School:______________________ Grade:________

Home Address:______________________ City:______________ State:________ Zip:________

Contact phone number for *appointment reminders*:__________________ Primary Language:____________

*How did you hear about Finney Pediatric Dentistry?*__________________________________

PARENT/LEGAL GUARDIAN INFORMATION

Parent/Legal Guardian Name:______________________________________ DOB:____________

Relationship to Patient: ☐Mother ☐Father ☐Step-Parent ☐Grandparent ☐Foster ☐Other:__________

**If Guardian, do you have the required custody paperwork?* ☐Yes ☐No

Do you live at the same address as the patient? ☐Yes ☐No *If you answered NO, please provide your home address:

Home Address:______________________ City:______________ State:______ Zip:______

Cell #:______________________ Email Address:______________________

Employer:____________________ Occupation:______________ Work Phone:______________

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Other:__________ Spouse's Name:____________

Parent/Legal Guardian Name:______________________________________ DOB:____________

Relationship to Patient: ☐Mother ☐Father ☐Step-Parent ☐Grandparent ☐Foster ☐Other:__________

**If Guardian, do you have the required custody paperwork?* ☐Yes ☐No

Do you live at the same address as the patient? ☐Yes ☐No *If you answered NO, please provide your home address:

Home Address:______________________ City:______________ State:______ Zip:______

Cell #:______________________ Email Address:______________________

Employer:____________________ Occupation:______________ Work Phone:______________

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Other:__________ Spouse's Name:____________

EMERGENCY CONTACT

Please provide a contact in case of an emergency in which parent(s) or legal guardian cannot be reached.

Name:______________________________

Phone #:______________________________

Relationship to Patient:______________________________

MEDICAL HISTORY

Child's Name:_______________ **Nickname:**_______________ **DOB:**_______________

Gender: ☐M ☐F **Race:**__________ **Child's Physician/Clinic:**_______________ **Date of last visit:**_______________

PLEASE LIST ANY MEDICATIONS (PRESCRIPTION OR OVER THE COUNTER), VITAMINS, OR DIETARY SUPPLEMENTS YOUR CHILD IS TAKING:

DRUG NAME, **DOSE**, **FREQUENCY**_______________

IS YOUR CHILD ALLERGIC TO ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY)

☐No drug allergies ☐No food allergies

☐ Penicillin ☐ Sulfa drugs ☐ Clindamycin ☐ Local anesthetics ☐ Acrylic ☐ Red Dye
☐ Latex ☐ Amoxicillin ☐ Codeine ☐ Adhesive tape ☐ Metal ☐ Nickel

☐ Food allergy (please list)_______________
☐ Other allergy:_______________

PLEASE ANSWER THE FOLLOWING AND PROVIDE DETAILS WHERE NEEDED:

Is your child being treated by a Medical Specialist(s) at this time? ☐Yes ☐No If yes, explain:
Has your child ever had a serious head or neck injury? ☐Yes ☐No If yes, explain:
Has your child ever been hospitalized or had a major operation? ☐Yes ☐No If yes, explain:
Has your child ever had a reaction to or problem with an anesthetic? ☐Yes ☐No If yes, explain:
Is your child up to date on immunizations against childhood diseases? ☐Yes ☐No
Does your child require SBE prophylaxis (antibiotics) before dental treatment/procedure(s)? ☐Yes ☐No Precautions:
Has your child ever had a reaction/allergy to an antibiotic, sedative, or other medication? ☐Yes ☐No If yes, explain:
Has your child been diagnosed with any of the following: Mononucleosis (Mono), Tuberculosis (TB), Scarlet fever, Cytomegalovirus (CMV), Methicillin Resistant Staphylococcus Aureus (MRSA), or Human Immunodeficiency Virus (HIV/AIDS), COVID-19 ☐Yes ☐No

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING HEALTH PROBLEMS? Check all that apply

☐ Heart defect/disease, heart murmur, rheumatic fever or rheumatic heart disease, high blood pressure
☐ Complications before or during birth, prematurity, birth defects, syndromes, or inherited conditions
☐ Sinusitis, chronic adenoid/tonsil infections
☐ Sleep apnea/snoring, mouth breathing, or excessive gagging
☐ Asthma, reactive airway disease, wheezing or breathing problems, pneumonia
☐ Jaundice, hepatitis or liver problems
☐ Gastroesophageal/acid reflux disease
☐ Bladder or kidney problems
☐ Developmental disorders, learning problems/delays, or intellectual disability
☐ Cerebral palsy, brain injury, epilepsy, or convulsions/seizures
☐ Autism/Autism spectrum disorder
☐ Recurrent or frequent headaches/migraines, fainting or dizziness
☐ Hydrocephaly or placement of a shunt (ventriculoperitoneal, ventriculoatrial, ventriculovenous)
☐ ADHD
☐ Diabetes, hyperglycemia or hypoglycemia
☐ Anemia, sickle cell disease/trait, or blood disorder
☐ G6PD (glucose-6-phosphate-dehydrogenase) deficiency
☐ MTHFR (methylenetetrahydrofolate) gene
☐ Hemophilia, bruising easily or excessive bleeding
☐ Cancer, tumor, malignancy chemotherapy, radiation therapy or bone marrow or organ transplant

Is there any other condition in the child's medical history not listed? ☐Yes ☐No Explain:

CONSENT

The information I have given is correct to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes in my child's medical status. I authorize Dr. Finney to complete a dental evaluation and perform the necessary dental services for my child.

Signature of Parent/Legal Guardian:_______________ Date:__________

Doctor Signature:_______________ Date:__________

DENTAL HISTORY

Patient Name: DOB:

Has your child been examined/treated by another dentist? ☐Yes ☐No

Previous Dentist Name:________________________ **Date of last dental visit:**________________ **Were X-rays taken?** ☐Yes ☐No

Has your child experienced any unfavorable reaction from previous dental treatment or care? ☐Yes ☐No

*If yes, please explain: ____

How often does your child brush his/her teeth?___________**times per**______________

Does someone help your child brush? ☐Yes ☐No

What toothpaste does your child primarily use?__________________________

How often does your child floss? ☐Never ☐Occasionally ☐Daily

Has your child ever had orthodontic treatment (braces, spacers, other appliances)? ☐Yes ☐No

*If yes, briefly describe:____

Does your child participate in any sports or similar activities? ☐Yes ☐No

*If yes, list:____

Is a mouth guard worn during these activities? ☐Yes ☐No

DOES YOUR CHILD HAVE A HISTORY OF ANY OF THE FOLLOWING? **(Check all that apply and briefly describe)**

☐ **Toothache/Pain**_____________________ ☐ **Cavities**____________________ ☐ **Excessive gagging**____________________

☐ **Clenching/grinding**__________________ ☐ **Bad breath**_________________ ☐ **Crowded teeth**______________________

☐ **Bleeding gums**______________________ ☐ **Jaw problems**_______________ ☐ **Canker sores/fever blisters**___________

☐ **Sucking habit after one year of age?**

*If yes, which one? ☐Pacifier ☐Thumb ☐Finger ☐Other__________________ For how long?_________________

Has your child had trauma/injury to teeth, mouth, jaw or gums? ☐ Yes ☐ No

*If yes, describe the incident and when it occurred:____

FLUORIDE HISTORY **(Please check all sources of fluoride your child receives)**

☐Toothpaste ☐Drinking Water
☐Over-the-counter rinse ☐Prescription rinse/gel
☐Prescription drops/tablets/vitamins ☐Fluoride treatment in the dental office
☐Fluoride varnish by Pediatrician ☐Other:______________________

What does your child primarily drink? (check all that apply)

☐Tap Water ☐Bottled Water ☐Fluoridated water
☐Milk ☐Chocolate Milk ☐Juice
☐Soda ☐Sport's Drinks ☐Energy Drinks

What is the primary source of drinking water at home?

☐City/community ☐Private well
☐Bottled water ☐Water filter system

Signature of Parent/Guardian____ Relationship to Patient_________________________

Printed Name of Parent/Guardian____ Date________________________________

INFORMED CONSENT FOR PEDIATRIC DENTAL TREATMENT

State law requires us as health professionals to obtain your consent to provide your child's planned dental treatment or oral surgery. Please read this form carefully, initial each section in the space provided, and ask about anything that you do not understand. We will be happy to explain it.

1. ________ I hereby authorize Dr. Jennifer Finney and her assistants/hygienists to perform upon my child or legal ward for whom I am empowered to consent the following dental treatment or oral surgery procedures. In general terms, the following checked dental treatment or procedure(s) will include:
   A. ____Teeth cleaning and topical fluoride application
   B. ____Radiographs (x-rays) of the teeth
   C. ____Applying plastic "sealants" to the grooves of the teeth
   D. ____Use of local anesthesia to numb the area being treated
   E. ____Treatment of diseased, infected, injured, or broken teeth with dental restorations (fillings, crowns, pulpotomy)
   F. ____Treatment of diseased or injured oral tissues, hard and/or soft
   G. ____Replacement of missing teeth with dental appliance
   H. ____Removal (extraction) of one or more teeth
   I. ____Treatment of malposed (crooked) teeth and/or oral development or growth abnormalities
   J. ____Use of physical restraint by parent or assistant only when required to complete necessary dental procedures.
   K. ____Use of nitrous oxide to control apprehension and/or disruptive behavior
   L. ____Use of general anesthesia to accomplish the necessary treatment
   M. Other____

2. ________ I have had explained to me by Dr. Jennifer Finney 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.

3. ________ Although their occurrence is extremely rare, some risks and complications are known to be associated with dental procedures. **The most common complications with pediatric dental treatment include nausea/vomiting following the administration of topical fluoride; and biting/injuring their tongue or lip following the administration of local anesthesia.** It is the responsibility of the parent/caregiver to closely monitor children who are numb. This will decrease the risk of such complication.

   Less common risks include but are not limited to:
   (a) The possibility of pain or discomfort during the treatment
   (b) Swelling, infection, prolonged bleeding, or discoloration
   (c) Damage to and possible loss of adjacent teeth, surrounding tissue, and/or restorations (fillings)
   (d) Injury to the nerves near the treatment site, and fracture of a tooth root which may require additional procedures for its removal
   (e) Development of a temporomandibular joint disorder (TMJ)
   (f) Temporary or permanent numbness
   (g) Allergic reactions to materials used during dental treatment/procedure(s)
   (h) For children with a heart disease, the risk of subacute bacterial endocarditis (heart infection) following dental treatments exists. Therefore, antibiotics will be prescribed before treatment to minimize the risk (to those whom require antibiotics).

4. ________ 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, demonstration of procedures and instruments, and other techniques.

5. ________ 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. If this is the case, it may be necessary for the assistant(s) or parent/caregiver to hold the patient's hands, stabilize their head and/or control leg movements.

6. ________ In general terms, the behavior management techniques during treatment may include:
   - Tell, Show, Do
   - Distraction
   - Positive Reinforcement
   - Use of voice control to gain the child's attention
   - Nitrous Oxide with oxygen analgesia (laughing gas)

7. ________ The above behavior management techniques have been explained to me both verbally and in writing, and I have had a chance to ask questions. I understand the what, when, how, and why of their use and the risks/benefits/available alternatives.

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

9. _________ 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 the treatment and procedures have already been performed or initiated.

10. _________ I confirm that I have read (or it was read to me) and understand the information on both pages of this form by providing my initials for each section.

In addition, by signing below, I am acknowledging that the proposed treatment has been explained to me, as have any alternative methods of treatment and the advantages/disadvantages of each. I am advised that although good results are expected, the possibility and nature of complications cannot always be accurately anticipated. Therefore, there can be no guarantee as to the result of the treatment.

____ _______________
Printed Name of Parent/Guardian | Relationship to Patient

____ _______________
Signature of Parent/Guardian | Date

____ _______________
Witness | Date

____ _______________
Dr. Jennifer Finney | Date

HIPAA ACKNOWLEDGEMENT

Acknowledgement of Receipt of HIPAA Notice of Privacy Policy Practices

Patient Name: ______________________ **DOB:** ____________

**Please initial and sign below after reading "Notice of Privacy Policy Practices"*

_________ I acknowledge that I have received, read, and understand Finney Pediatric Dentistry's HIPAA Notice of Privacy Policy Practices prior to treatment.

_________ I acknowledge I have been given the opportunity to ask questions about the Privacy Practices presented to me today, and that these are acceptable to me until which time I submit, in writing, they are not.

____
Printed Name of Parent/Legal Guardian

____ _______________
Signature of Parent/Legal Guardian | Date

** It is your right to refuse to sign this acknowledgement**

For Office Use Only

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

☐ Individual refused to sign
☐ Communication Barriers prohibited obtaining the acknowledgement
☐ An emergency situation prevented us from obtaining acknowledgement
☐ Other (Please Specify)_______________________________________

FINANCIAL & INSURANCE INFORMATION

Patient Name: **DOB:**

PRIMARY DENTAL INSURANCE

Policy Holder's Name:______________________ DOB:____/____/____ SSN:______________

Insurance Company:______________________ Insurance Phone #:______________

Subscriber ID #:______________________ Group #:______________

I understand that I am financially responsible for all charges whether or not paid by insurance and agree to reimburse Finney Pediatric Dentistry the fees of any collection agency, which may be based on a percentage at a maximum of 50% of the debt, and all costs, and expenses, including reasonable attorney's fees Finney Pediatric Dentistry incurs in such collection efforts. <u>I understand that quotes presented in office are ALWAYS an estimate and I will be responsible for the difference not covered by insurance.</u>

Printed Name of Parent/Legal Guardian:______________________

Signature of Parent/Legal Guardian:______________________ Date:______________

If you have Dental insurance, please fill out the following statement:

I certify that my minor/child is covered by insurance with ______________(*Name of Insurance Company)* and assign directly to Finney Pediatric Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I have been informed whether my insurance is in or out of network. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic. I have received a copy of the practice's Financial Policy.

Printed Name of Parent/Legal Guardian:______________________

Signature of Parent/Legal Guardian:______________________ Date:______________

OFFICE POLICIES

Please read this form carefully, initial in the space provided, and ask about anything that you do not understand.

Patient Name: **DOB:**

1. ________ I understand the financial policy of Finney Pediatric Dentistry. It is my responsibility to provide the information necessary to process an insurance claim. Ultimately, it is up to me to know my insurance benefits. It is my responsibility to notify Finney Pediatric Dentistry if there is a change in my insurance coverage, residency or phone number.

2. ________ I understand that proposed treatment plans presented in-office are <u>estimates</u> of what the insurance will cover and may change during the course of the treatment. <u>Payment is due at the time of service regardless of who is accompanying the child.</u>

3. ________ I understand that minors must be accompanied by a responsible party, 18 years old or older, to be treated at Finney Pediatric Dentistry. If the child is present with someone other than a parent/guardian, we must have a copy of the appropriate legal documents and/or a signed Caregiver Consent Form.

4. ________ I will call the office at least **24 business hours** prior to my appointment to reschedule. If I am unable to keep my child's rescheduled appointment, I understand that failure to show up to my child's scheduled appointment constitutes as a NO SHOW, and a cancellation fee of $25 for routine appointments and up to $50 for dental treatment may apply.

5. ________ I will turn off my cell phone during my appointment. As the use of cell phones has grown, we have become aware of how they can interfere with communication between the patient and doctor, as well as patient privacy. Because of this, cell phone use is not permitted in patient areas.

6. ________ I understand that <u>no photos or videos are permitted in the clinic areas</u> to protect the privacy rights of all of our patients and our staff. We are a "covered entity" and are abiding by the HIPAA regulations as such. We have a designated photo op area where we allow photos to be taken.

7. ________ I understand there may be a charge of $20 for processing requests for records, made voluntarily by the patient or guardian. The payment for completion of these forms will be collected at the time of the request.

By signing below, I acknowledge that I have read and understand the Office Policies of Finney Pediatric Dentistry.

Printed Name of Parent/Guardian______________________

Signature of Parent/Guardian ______________________ Date______________

CAREGIVER CONSENT

Patient Name: **DOB:**

Finney Pediatric Dentistry requires a parent/legal guardian to accompany children to their dental appointment. If the parent/legal guardian is unable to be present for the child's dental appointment, permission may be given to another adult (18 years or older) to accompany your child.

Please provide names of caregivers you give permission to make medical, dental, and financial decisions for this patient. Please inform the authorized caregiver that they must remain in the office for the duration of the dental appointment.

Name of Authorized Caregiver	Relationship to Patient	Phone #
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________

I, ________________________________the legal guardian of ___________________(Patient Name), authorize the caregiver(s) above to accompany and make medical/dental decisions as needed for the patient(s). I also accept all financial responsibility for any dental procedures completed under the caregiver's supervision.

____
Printed Name of Parent/Guardian

____ ________________
Signature of Parent/Guardian Date

MEDIA RELEASE FORM

Patient Name: **DOB:**

________ I, the undersigned, do hereby consent and agree that Finney Pediatric Dentistry, its employees, or agents have the right to take photographs, videos, or digital recordings of my child, and to use these in any and all media, now or hereafter known, and exclusively for the purpose of marketing and social media. I further consent that my and/or my child's name and identity may be revealed therein or by descriptive text or commentary.

________ I do hereby release Finney Pediatric Dentistry, and its employees all rights to exhibit this work in print and/or electronic form; in a public and/or private platform; and/or for marketing purposes. I waive any rights, claims, or interest I may have to control the use of identities or likeness in whatever media used.

________ I understand that there will be no financial incentives, royalties, or other compensation for recording/photographing my child, either for initial or subsequent transmission or playback.

________ I also understand that Finney Pediatric Dentistry is not responsible for any expense or liability incurred as a result of participating, including medical expenses due to any sickness or injury incurred as a result.

________ I represent that I am at least 18 years of age, have read and understand the abovementioned statements, and am competent to execute this agreement.

I, ________________________ (print name) the parent or legal guardian of __________________(child) grant Finney Pediatric Dentistry my permission to use the photographs/videos/digital recordings as described above for any legal use, including but not limited to publicity, copyright purposes, illustration, advertising and web content. Furthermore, I understand that no financial incentives shall become payable to me by reason of such use.

Parent/Legal Guardian Signature:____ Date:___________________

Address:____Phone #:______________________

Witness (Print):________________________ Witness (Signature):_____________________ Date:______________