Patient health history

SOUTHMOOR PEDIATRIC DENTISTRY, P.C.
SouthmoorKids.com

Patient Information

Child's name | Date

Date of birth | Current weight ((lbs.))

So that we may know and better understand your child, and be better prepared to render the best possible health service, it is requested that you complete the following:

Dental History

Date of last dental exam | Date of last dental x-rays

Has your child had dental treatment elsewhere?

WWhat was his or her reaction to prior dental treatment?

2. Does your child have any dental complaints? | If yes, how long?

3. Is there anything you would like us to know so that we can better care for your child?

Medical History

Has your child ever had:

- ○ Abnormal Heart Condition
- ○ ADD/ADHD
- ○ Asthma/Respiratory Disease
- ○ Autism Spectrum Disorder
- ○ Blood Disorders ((ex: Anemia, Hemophilia, HIV, Hepatitis))
- ○ Cancer
- ○ Diabetes

Is your child allergic to:

- ○ Penicillin
- ○ Sulfa
- ○ Any Medication?

Has your child ever had a local anesthetic?

○ No ○ Yes

Is your child current on immunizations?

○ No ○ Yes

- ○ Genetic Disorder Syndrome
- ○ Intestinal/Stomach Problems
- ○ Kidney Problems
- ○ Liver Problems
- ○ Mental, Emotional or Development Delays
- ○ Neurologic Disorder (ex: CP, Seizures)
- ○ Any Surgical History
- ○ Frequent Headaches — Relieved by
- ○ TMJ (Jaw Joint Dysfunction) — Relieved by
- ○ Congenital Birth Defects — Relieved by

Does your child suck a finger, thumb or pacifier?

○ No ○ Yes — Relieved by

Does your child sleep with a nursing bottle?

○ No ○ Yes — Relieved by

Date of last physical exam

Does your child have any special health care needs?

Is your child taking any medication? | If so, what?

Name of physician | Physician phone

Physician address

May we contact your child's physician for additional information, if necessary?

Briefly describe your child's personality/temperment

Consent

SOUTHMOOR PEDIATRIC DENTISTRY, P.C.

SouthmoorKids.com

Patient Information

Child's name _____ Date _____

Because your child is a minor it is necessary that a signed permission form be obtained from a parent or legal guardian before any treatment can be started or completed by one of our doctors. This form is for the purpose of explaining our usual office policies and procedures regarding patient care. While signing this form gives consent to us to treat your child, we encourage you to speak to any of our staff members, especially our doctors, if you have any questions regarding your child's specific needs or the treatment being provided. We always prefer to discuss your child's proposed treatment beforehand, whether it is diagnostic or restorative.

Our examination will include a hard tissue and soft tissue examination. Dental x-rays may or may not be taken, depending on your child's age, specific dental needs and their ability to cooperate. While not every patient gets dental x-rays every visit, diagnostic x-rays are necessary from time to time as your child grows. Photographs for diagnosis, treatment planning and teaching may also be taken.

Restorative and surgical treatments may be needed depending on your child's specific needs; you will be consulted in advance before any treatment. The restorative materials used may include composite resin fillings, dental sealants, silver amalgam fillings, composite resin crowns and stainless steel crowns. Restorative treatment may include nerve treatment ("pulpotomy" or "pulp capping") when necessary due to deep dental decay. Surgical treatment may include but not limited to tooth removal and minor gum or soft tissue surgery. Local anesthesia is routinely used if necessary for your child's comfort. Your child's treatment needs, if any, will be reviewed with you by the doctor at the end of the examination appointment, and before any treatment is started.

No sedative drugs are used, including nitrous oxide ("laughing gas") without prior consent by a parent. If a cooperation problem arises and we feel such sedation is indicated, you will be consulted in advance. Physical restraint is not used without a parent's consent, except as needed to protect a child from accidental self-injury during treatment. An assistant may hold your child's hands if we are concerned your child will reach up while the doctor is working.

I acknowledge that I will be responsible for arranging for payments of any bills incurred for the dental treatment on the above child.

Parent/guardian signature _____ Witness _____

Health History Updates

Patient information

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Patient Information

First name | Last name | Preferred name

Date of birth | ○ Female ○ Male

Whom may we thank for referring you to our office?

Parent or Guardian One (Primary Contact)

Name | Mobile phone

Home phone | Email address

Mailing address | City | State | Zip

Social security number | Date of birth

Driver's license number

Place of employment

Parent or Guardian Two (If Applicable)

Name | Mobile phone

Home phone | Email address

Mailing address | City | State | Zip

Social security number | Date of birth

Driver's license number

Place of employment

Emergency Contact

Name | Phone

Mailing address | City | State | Zip

I acknowledge that the above information is current and accurate.

Parent or Guardian Signature | Date

Insurance verification

SOUTHMOOR PEDIATRIC DENTISTRY, P.C.

SouthmoorKids.com

Patient Information

First name | Last name | Date of birth

Insurance company name

Phone | Group #

Mailing address | City | State | Zip

Subscriber name (Employee) | Date of birth (Employee)

Subscriber ID/SS#

Employer

Acknowledgement of privacy practices

SOUTHMOOR PEDIATRIC DENTISTRY, P.C.
SouthmoorKids.com

I acknowledge that a copy of the Notice of Privacy Practices for the office of Southmoor Pediatric Dentistry is available to me upon request. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or the performance of office health care operations. The Notice of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information.

Southmoor Pediatric Dentistry reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. If privacy practices change, a copy of the revised Notice of Privacy Practices may be provided to me upon request.

I, _____ , authorize Southmoor Pediatric Dentistry to disclose my protected health information to only the persons indicated below.

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

Signature of Patient or Guardian _____ Date _____

Financial policy

SOUTHMOOR PEDIATRIC DENTISTRY, P.C.
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In an effort to provide the best service to you and your children, we try to provide a treatment plan which fits your timetable and budget. Payment for professional services is due at the time dental treatment is provided. We accept cash, personal checks, and most major credit cards.

We file dental insurance as a courtesy to our patients. If we have received all your insurance information on the day of the appointment, we will be happy to file your claim for you. You must be familiar with your insurance benefits as most insurance agreements require a patient responsibility for dental services. Your estimated patient portion is due at each visit. You are responsible for any balance on your account after 30 days, regardless of any outstanding insurance claims. We will be glad to issue a refund if your insurance company pays any portion after you have paid your bill. We can provide you with a claim form if you need to follow up with your insurance carrier, but please remember that our financial relationship is with you and we are not responsible for how your insurance company handles its claims or for what benefits they pay on a claim.

A 1.5% finance charge (18% annually) will be added to any balance over 90 days.

I have read and accept the above Financial Policy and agree to the terms therein.

Parent or Guardian Signature _____ Today's date _____

Media consent and release

SOUTHMOOR PEDIATRIC DENTISTRY, P.C.

SouthmoorKids.com

Authorization to release orthodontic treatment information

Photos and other digital media that reflect your child's treatment success and positive experience can help others decide that Southmoor Pediatric Dentistry is the right choice for their child's dental care.

○ I hereby consent to Southmoor Pediatric Dentistry's and its affiliates' use of photographs and media related to my/my minor child's treatment, along with details regarding the related dental services, for marketing and advertising purposes. This consent form is optional and I understand that Southmoor Pediatric Dentistry will not condition treatment on whether I sign this authorization form.

I authorize Southmoor Pediatric Dentistry and its affiliates to use photograph(s), video(s), and/or media representation(s) (whether such material was provided by me or produced by Southmoor Pediatric Dentistry) related to my or my minor child's care. I understand that these materials might be used in advertisements, office displays, online (e.g., websites, Facebook, Instagram, etc.), and in any other format that Southmoor Pediatric Dentistry chooses. I release the photographer, Southmoor Pediatric Dentistry, their affiliates, employees, agents, and designees from liability for any violation of any personal or proprietary right I or the patient may have in connection with such use. I waive any rights to inspect or approve promotional materials which include these materials related to my treatment.

This authorization shall expire upon completion of all Southmoor Pediatric Dentistry's promotional activities. I understand that I may revoke this authorization by sending a written request for revocation to Southmoor Pediatric Dentistry's Privacy Officer. If I revoke this authorization, Southmoor Pediatric Dentistry will no longer use or disclose my medical information for the reasons covered by this authorization, except to the extent it has already relied upon this authorization (for example, if my photographs are already being used in an ongoing advertising campaign). I understand that when Southmoor Pediatric Dentistry discloses information pursuant to this authorization, the information may no longer be protected by federal or state privacy rules and may be subject to re-disclosure by the recipient of the information.

○ I do not consent to the use of these materials of myself or the listed patient.

Patient information

Patient name _____ Date of birth _____

Legal guardian full name (if patient is a minor) _____

Responsible party signature _____ Date _____