Patient Information

Patient Personal Information

First Name: _____ MI: ____ Last Name: _____

Preferred Name: _____

Date of Birth: _____

Gender: _____

Patient Contact Information

Home Phone #: _____

Cell Phone #: _____

Work Phone #: _____

Email: _____

Mailing Address: _____

_____

Responsible Party Personal Information

Who is the responsible party (parent or guardian)?: _____

First Name: _____ MI: ____ Last Name: _____

Preferred Name: _____

Date of Birth: _____

Driver's License #: _____

Responsible Party Contact Information

Home Phone #: _____

Cell Phone #: _____

Work Phone #: _____

Email: _____

Mailing Address: _____

_____

Patient Information

Preferred Communication (check all that apply):

☐ Phone ☐ Email ☐ Text Message

Insurance Notice

Please do not forget to bring your insurance card if this is your first appointment with us OR if your insurance information has changed.

Parent/Guardian Printed Name: _____

Signature: _____ Date: _____

Insurance Information

Patient Information

First Name: _____ MI: ____ Last Name: _____

Primary Insurance

Do you have insurance or will you be paying for yourself? (circle one):

Self-Pay **Insurance**

Insurance company name: _____

Type of plan: _____

Subscriber ID: _____

Group #: _____

Medicaid ID #: _____

Subcriber Information

First Name: _____ MI: ____ Last Name: _____

Date of Birth: _____

Social Security Number: _____

Address: _____

_____

Employer

Is the plan through an employer? (Circle one) **YES** **NO**

Company Name: _____

Address: _____

_____

Insurance Information

Secondary Insurance

Do you have a secondary dental insurance? **YES** **NO**

If yes, please provide the policy information below.

Insurance company name: _____

Type of plan: _____

Subscriber ID: _____

Group #: _____

Medicaid ID #: _____

Subcriber Information

First Name: _____ MI: ____ Last Name: _____

Date of Birth: _____

Social Security Number: _____

Address: _____

_____

Employer

Is the plan through an employer? (Circle one) **YES** **NO**

Company Name: _____

Address: _____

_____

Parent/Guardian Printed Name: _____

Signature: _____ Date: _____

Health History

Patient Name: _____

Pediatric Medical History

Although dental personnel primarily treat the area in and around the mouth, your mouth is a part of your entire body. Health problems that your child may have, or medication that your child may be taking, could have an important interrelationship with the dentistry your child will receive. Thank you for answering the following questions.

Legal Guardian #1 (Name and phone number): _____

_____

Legal Guardian #2 (Name and phone number): _____

_____

MEDICAL HISTORY

Who is your child's primary care provider? _____

Date of child's last physical exam? _____

Name, address and phone of child's physician? _____

Any history of emergency hospital care, sugery or hospitalization?

_____

Does your child have a heart problem that require antibiotics before dental care? _____

Is your child taking ANY medications? If yes, list medication name(s) and reason: _____

_____

Does your child or any member of the family have any problems with general anesthetics?

_____

Any history of syndromes or other genetic disorders? If yes, please explain: _____

_____

Is your child adopted? _____

ALLERGIES

Is your child allergic to any of the following?

	YES	NO		YES	NO		YES	NO
Penicillin	☐	☐	**Latex**	☐	☐	**Foods**	☐	☐
Acrylic	☐	☐	**Sulfa Drugs**	☐	☐			
Metal	☐	☐	**Local Anesthetic**	☐	☐			

Does your Child have any allergies not listed above? If yes, please specify:

Health History

Health History

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

	YES	NO		YES	NO
AIDS/HIV Positive	☐	☐	Frequent Cough	☐	☐
Cortisone Medicine	☐	☐	Kidney Problems	☐	☐
Hemophilia	☐	☐	Spina Bifida	☐	☐
Radiation Treatments	☐	☐	Tuberculosis	☐	☐
Diabetes	☐	☐	Cold Sores/Fever Blisters	☐	☐
Hepatitis A	☐	☐	Heart Murmur	☐	☐
Irregular Heartbeat	☐	☐	Tumors or Growths	☐	☐
Sinus Trouble	☐	☐	Congenital Heart Disorder	☐	☐
Blood Disease	☐	☐	Heart Pacemaker	☐	☐
Recent Weight Loss	☐	☐	Anaphylaxis	☐	☐
Hepatitis B or C	☐	☐	Renal Dialysis	☐	☐
Anemia	☐	☐	Rheumatic Fever	☐	☐
High Blood Pressure	☐	☐	Epilepsy or Seizures	☐	☐
Scarlet Fever	☐	☐	Excessive Bleeding	☐	☐
Hives or Rash	☐	☐	Artificial Joint	☐	☐
Sickle Cell Anemia	☐	☐	Asthma	☐	☐
Fainting Spells/Dizziness	☐	☐	Blood Transfusion	☐	☐
Leukemia	☐	☐	Stomach/Intestinal Disease	☐	☐
Frequent Headaches	☐	☐	Liver Disease	☐	☐
Stroke	☐	☐	Bruise Easily	☐	☐
Low Blood Pressure	☐	☐	Cancer	☐	☐
Lung Disease	☐	☐	Thyroid Disease	☐	☐
Thyroid Disease	☐	☐	Chemotherapy	☐	☐
Seasonal Allergies	☐	☐	Mitral Valve Prolapse	☐	☐
Tonsilitis	☐	☐	Autism	☐	☐
Heart Trouble/Disease	☐	☐	ADD/ADHD	☐	☐
Psychiatric Care	☐	☐	Cerebral Palsy	☐	☐

Health History

	YES	NO		YES	NO
Speech/Hearing Problems	☐	☐	Emotional or mental Problems	☐	☐
Learning or school related problems	☐	☐	Juvenile Rheumatoid Arthritis	☐	☐
Cleft lip and/or palate	☐	☐	Vision Trouble	☐	☐
Artificial Heart Valve	☐	☐	Breathing Problems	☐	☐
Pain in Jaw Joints	☐	☐	Cold Sores/Fever Blisters	☐	☐
Does your child have or ever had any serious illness not listed above?				☐	☐

DENTAL HISTORY

Does your child suck his/her thumb, finger(s) or pacifier? _____

Does your child receive any form of fluoride? (city water, vitamin supplement, rinse, toothpaste)?

_____

Has your child had an unfavorable past dental experience?

_____

Do you think your child will be cooperative? _____

Is there a disagreement between the parents regarding dental care?

_____

Has your child had any injuries to the teeth or mouth?

_____

Was/is your child bottle fed? _____

Was/is your child breast fed? _____

Has your child been weaned? If so, please indicate at what age. _____

Purpose of today's visit? (List specific concerns):

_____

Printed name of parent/guardian: _____

Signature: _____ **Date:** _____

Myo Sleep Kids Questionnaire

Patient Name: _____

Please answer the following questions based on your child's average sleep habits/quality during the past month. If you are unsure about an answer to a question, please answer with "?".

GOING TO SLEEP	**YES**	**NO**	**?**
1. Does your child have any problems going to bed or falling asleep?	☐	☐	☐
2. Does your child have a regular bedtime?	☐	☐	☐
3. Does your child have a regular wake time?	☐	☐	☐
4. Does your child's bedtime/wake time differ greatly between weekdays and weekends?	☐	☐	☐

WHILE SLEEPING	**YES**	**NO**	**?**
1. Does your child wake up often at night after falling asleep?	☐	☐	☐
2. Does your child snore for mor than half the night's sleep duration?	☐	☐	☐
3. Does your child always snore while sleeping?	☐	☐	☐
4. Does your child snore loudly?	☐	☐	☐
5. Does your child have heavy or loud breathing habits while sleeping?	☐	☐	☐
6. Does your child have their mouth open while sleeping?	☐	☐	☐
7. Does your child have difficulty breathing at night while sleeping?	☐	☐	☐
8. Does your child ever stop breathing while sleeping?	☐	☐	☐
9. Does your child have regular nightmares, sleepwalking, or other unusual sleep behaviors?	☐	☐	☐
10. Do you think your child is getting enough sleep for his/her age?	☐	☐	☐

WHILE AWAKE	**YES**	**NO**	**?**
11. Does your child seem overtired or sleepy during the day?	☐	☐	☐
12. Does your child wake up feeling unrefreshed in the morning?	☐	☐	☐
13. Does your child find it difficult to wake up in the morning?	☐	☐	☐
14. Does your child wake up with headaches in the morning?	☐	☐	☐
15. Does your child take excessive naps during the day for their age?	☐	☐	☐

	YES	NO	?
16. Does your child tend to breathe through their mouth while awake?	☐	☐	☐
17. Does your child have a dry mouth when they wake up?	☐	☐	☐
18. Does your child occasionally wet the bed?	☐	☐	☐
19. Did your child stop growing at a normal rate at any time since birth?	☐	☐	☐
20. Is your child overweight?	☐	☐	☐
21. Has a teacher or other supervisor commented that your child appears unusually sleepy during the day?	☐	☐	☐
22. Does your child appear to not listen when spoken to directly?	☐	☐	☐
23. Does your child have difficulties organizing tasks and activities for their age?	☐	☐	☐
24. Does your child get distracted easily by surrounding stimuli?	☐	☐	☐
25. Does your child appear to fidget with hands and feet or struggle to sit still?	☐	☐	☐
26. Does your child appear excessively "on the go" or act as if "driven by motor"?	☐	☐	☐

Please provide any additional feedback that you feel may be relevant to your child's sleep habits:

Signature: _____ Date: _____

Privacy Policy Consent

CLIENT RIGHTS AND HIPAA AUTHORIZATIONS The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA"). 1. Tell your provider if you do not understand this authorization, and the provider will explain it to you. 2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to provider at the following address (insert address of provider): 3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, payment, enrollment or your eligibility for benefits. However, you may be required to complete this authorization form before receiving treatment if you have authorized your provider to disclose information about you to a third party. If you refuse to sign this authorization, and you have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a patient in their practice. 4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA. If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations. 5. You may inspect or copy the protected dental information to be used or disclosed under this authorization. You do not have the right of access to the following protected dental information: psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act ("CLIA") prohibits access, or information held by certain research laboratories. In addition, our provider my deny access if the provider reasonably believes access could cause harm to you or another individual. If access is denied, you may request to have a licensed health care professional for a second opinion at your expense. 6. If this office initiated this authorization, you must receive a copy of the signed authorization. 7. Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes. HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. Except for

limited circumstances set forth in HIPAA, in order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other dental records. 8. You have a right to an accounting of the disclosures of your protected dental information by provider or its business associates. The maximum disclosure accounting period is the six years immediately preceding the accounting request. The provider is not required to provide an accounting for disclosures: (a) for treatment, payment, or dental care operations; (b) to you or your personal representative; (c) for notification of or to persons involved in an individual's dental care or payment for dental care, for disaster relief, or for facility directories; (d) pursuant to an authorization; (e) of a limited data set; (f) for national security or intelligence purposes; (g) to correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody; or (h) incident to otherwise permitted or required uses or disclosures. Accounting for disclosures to dental oversight agencies and law enforcement officials must be temporarily suspended on their written representation that an accounting would likely impede their activities.

☐ I confirm and agree.

Printed name of Parent/Guardian: _____

Signature: _____ Date: _____

Consent for Dental Treatment

As the parent and/or legal guardian of the patient, I do hereby request and authorize Lakeside Smiles Pediatric Dentistry and their staff to examine, clean, and provide dental treatment on my child. I further request and authorize the taking of dental x-rays as may be considered necessary to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or child's teeth for diagnostic or educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them understand the treatment in terms appropriate for their age. We will provide an environment that will help your child learn to cooperate during treatment including praise, explanations, and demonstrations of procedures and instruments, and using variable voice tones. The usual and most frequent risks or complications occurring from dental operative treatment include but are not limited to, the possibility of pain or discomfort during the treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of a temporomandibular joint disorder, temporary or permanent numbness, and allergic reactions. I understand I will be responsible for any charges incurred for my child for dental treatment. I affirm that the information above is correct to the best of my knowledge. I understand it is my responsibility to inform Lakeside Smiles Pediatric Dentistry of any changes in my child's medical status.

☐ **I confirm and agree.**

Signature _____ Date _____

Financial and Appointment Policy

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment. It is our hope that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choices related to your care.

INSURANCE: Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services, including a pre-treatment estimate which we send to the insurance company at your request. It is physically impossible for us to have the knowledge and keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you. If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf. Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion.

PAYMENT: Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by the dentist. FULL PAYMENT is due at the time of service. If insurance benefits apply, ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES are due at the time of service, unless other arrangements are made. UNPAID BALANCE over 90 days old will be subject to a monthly interest of 1.0% (APR 12%). If payment is delinquent, the patient will be responsible for payment of collection, attorney's fees, and court costs associated with the recovery of the monies due on the account.

MISSED APPOINTMENTS: We require at least 24 hours advance notification if you need to cancel an appointment. You may be charged $50 for cancelling with less than 24 hours notice. In addition, 2 or more missed or short notice cancellations within a 12 month period may result in dismissal from the practice. Please help us maintain the highest quality of care by keeping scheduled appointments. I have read, understand and agree to the terms and conditions of this Financial Agreement.

☐ I confirm and agree.

Signature _____ Date _____