Child Health/Dental History Form

American Dental Association
www.ada.org

Patient's Name (LAST / FIRST / INITIAL)	Nickname	Date of Birth
Parent's/Guardian's Name	Relationship to Patient	
Address (PO OR MAILING ADDRESS / CITY / STATE / ZIP CODE)		
Phone (Home / Work)		Sex M ❑ F ❑

Have you (the parent/guardian) or the patient had any of the following diseases or problems? ❑ Yes ❑ No
1. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3.Cough that produces blood?
If you answer yes to any of the three items above, please stop and return this form to the receptionist.

Has the child had any history of, or conditions related to, any of the following:

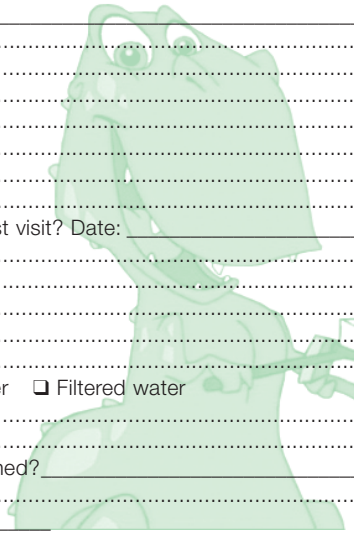
❑ Anemia	❑ Cancer	❑ Epilepsy	❑ HIV +/AIDS	❑ Mononucleosis	❑ Thyroid
❑ Arthritis	❑ Cerebral Palsy	❑ Fainting	❑ Immunizations	❑ Mumps	❑ Tobacco/Drug Use
❑ Asthma	❑ Chicken Pox	❑ Growth Problems	❑ Kidney	❑ Pregnancy (teens)	❑ Tuberculosis
❑ Bladder	❑ Chronic Sinusitis	❑ Hearing	❑ Latex allergy	❑ Rheumatic fever	❑ Venereal Disease
❑ Bleeding disorders	❑ Diabetes	❑ Heart	❑ Liver	❑ Seizures	❑ Other_____
❑ Bones/Joints	❑ Ear Aches	❑ Hepatitis	❑ Measles	❑ Sickle cell	

Please list the name and phone number of the child's physician:

Name of Physician _____ Phone _____

Child's History

		Yes	No
1.	Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? If yes, please list: _____	❑	❑
2.	Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____	❑	❑
3.	Is the child allergic to anything else, such as certain foods? If yes, please explain: _____	❑	❑
4.	How would you describe the child's eating habits? _____		
5.	Has the child ever had a serious illness? If yes, when: _____ Please describe: _____	❑	❑
6.	Has the child ever been hospitalized?	❑	❑
7.	Does the child have a history of any other illnesses? If yes, please list: _____	❑	❑
8.	Has the child ever received a general anesthetic?	❑	❑
9.	Does the child have any inherited problems?	❑	❑
10.	Does the child have any speech difficulties?	❑	❑
11.	Has the child ever had a blood transfusion?	❑	❑
12.	Is the child physically, mentally, or emotionally impaired?	❑	❑
13.	Does the child experience excessive bleeding when cut?	❑	❑
14.	Is the child currently being treated for any illnesses?	❑	❑
15.	Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: _____	❑	❑
16.	Has the child had any problem with dental treatment in the past?	❑	❑
17.	Has the child ever had dental radiographs (x-rays) exposed?	❑	❑
18.	Has the child ever suffered any injuries to the mouth, head or teeth?	❑	❑
19.	Has the child had any problems with the eruption or shedding of teeth?	❑	❑
20.	Has the child had any orthodontic treatment?	❑	❑
21.	**What type of water does your child drink?** ❑ City water ❑ Well water ❑ Bottled water ❑ Filtered water		
22.	**Does the child take fluoride supplements?**	❑	❑
23.	**Is fluoride toothpaste used?**	❑	❑
24.	How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____	❑	❑
25.	Does the child suck his/her thumb, fingers or pacifier?	❑	❑
26.	At what age did the child stop bottle feeding? Age _____ Breast feeding? Age _____		
27.	Does child participate in active recreational activities?	❑	❑



NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature _____ Date _____

For completion by dentist
Comments _____

For Office Use Only: ❑ Medical Alert ❑ Premedication ❑ Allergies ❑ Anesthesia Reviewed by _____
Date _____

Form S707

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or go online at www.adacatalog.org

BRIER CREEK PEDIATRIC DENTISTRY

10411 Moncreiffe Road, Suite 105B Raleigh, NC 27617 (919) 806-0200 Fax: (919)806-0211 www.bcpediatricdentistry.com

Dental Information Release Form

(HIPPA RELEASE FORM)

Patient Name: _____*Date of Birth:* _____

Parents/Guardians please understand that treatment in a pediatric office is sometimes rendered in an open bay. Therefore, there are times where your child's treatment may be discussed with you in the bay. If there is no opposition to this please initial beside this statement. _____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be release to:

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Other _____

[ ] Information is not to be released to anyone.

The office will gladly release patient records upon zero account balance.

The Release of Information will remain in effect until terminated by me in writing.

Please Call: [ ] Home [ ] Work [ ] Cell
If unable to reach me:
[ ] You can leave a detailed message
[ ] Please leave a message asking me to return you call

The best time to reach me is: [ ] Morning [ ] Afternoon

Signed: _____Date: _____
Witness: _____Date: _____

Brier Creek Pediatric Dentistry
10411 Moncreiffe Road, Suite 105B, Raleigh, NC 27617 Phone: (919)806-0200 FAX: (919)806-0211 Christi M. Davis, DDS, MS, PA

OFFICE POLICIES – PEDIATRIC DENTISTRY

Patient Name _____

What You Should Expect During Your Appointment

To expedite the timely start of your appointment, we require that you arrive at our office 15 minutes prior to the scheduled appointment time to complete paperwork and present your insurance card. Please have your child visit the restroom before being called to go back for treatment. When you arrive, please check your child in with a staff member at the front desk. This staff member will announce the patient's arrival, review your paperwork and insurance card and collect any necessary co-payments.

Appointments vary in length from 15 to 60 minutes. We take pride in the fact that we take our time with all children who enter our practice and ask your patience in this regard. If your child is not called back for his/her appointment within 10 minutes of the appointment time, please notify a staff member. Since we work very hard to keep our appointment schedule running as planned, we ask that you return the courtesy by ensuring that you're on time for your appointment. We understand that delays can occur, but if your child in more than 15 minutes late for his/her appointment, we may need to reschedule the visit for the next available day/time. We will make every effort to see your child on a work-in basis, but many times this simply is not possible. If you're going to be late for your appointment, please call the office, so we can advise you if we need to reschedule.

Due to the size of our reception area and the number of patients we see every day, we ask that only one parent/guardian accompanies the child to the appointment. If your child is 4 years old or younger, you will be asked to accompany him/her to the treatment area for the appointment; older children are encouraged to leave parents behind in the reception area. If has been our experience that older children receiving treatment (even those with special needs) are usually more cooperative when parents remain in the reception area. OSHA regulations and liability concerns prohibit us from allowing siblings in the treatment bay; these children can remain in our reception area where there are kid-friendly activities to keep them occupied. If you have question or concerns you wish to discuss with the doctor, the dental assistant will call you back at the conclusion of the visit for a brief consultation. **PLEASE DO NOT BRING FOOD OR DRINKS INTO OUR LOBBY.**

After your child's appointment is over, you should check out with our front desk staff before leaving. At this time, you will be asked to settle your child's account with us and schedule his/her next visit. While we are sensitive to the needs of working parents, the demands that schools place on children, the inconvenience caused by picking children up from school for appointments, and participation in sports or extracurricular activities, we cannot always accommodate requests for specific dates, days of the week, or after-school appointments.

Appointment N0-Show, Cancellations & Rescheduling

It is our office policy regarding appointments that all patients practice common courtesy. If you are unable to keep an appointment time, please provide at least 24 hours notice (preferable 48 hours). Patients who give less than 24 hours notice when rescheduling or who do not show for an appointment will incur a $25 charge and be counted as a broken appointment. If three such instances are noted, the patient will be dismissed from the practice.
Our appointment reminder service is a courtesy; ultimately, the responsibility lies with you to verbally confirm you r appointment at least 24 to 48 hours in advance. For this reason, we must have a current telephone number on file for you at all times. If we cannot verbally confirm your appointment, we reserve the right to offer your time slot to someone else.

In-Office Dental Surgery & Behavior Management Services

If your child is to receive Nitrous Oxide for the appointment, it is very important that your child follow the Nitrous Oxide food guidelines. Your child should not eat/drink anything in the 2 hours immediately before this appointment. Research shows that sedating a child on a full stomach decreases the effectiveness of the medications and increases the chances of nausea/vomiting. If these directions are not adhered to, then it is in the child's best interest to reschedule the appointment. To preserve your child's safety, other behavior management techniques may be needed (I.e., papoose board) to complete his/her treatment. Prior to using these techniques, the dentist will consult with the parent/guardian. If use of these techniques becomes necessary, there is an additional $35.00 fee.

ACKNOWLEDGEMENT

I hereby acknowledge that I have read, understand, and agree to adhere to the practice's Office Policies as outlined above.
Responsible Party Signature _____

Brier Creek Pediatric Dentistry
10411 Moncreiffe Road, Suite 105B, Raleigh, NC 27617 Phone: (919)806-0200 FAX: (919)806-0211 Christi M. Davis, DDS, MS, PA

FINANCIAL POLICIES – PEDIATRIC DENTISTRY

Patient Name

_____

PAYMENT TERMS

In our practice, our foremost concern is patient care. We strongly believe that financial considerations should not be an obstacle to obtaining dental services necessary to restoring and/or preserving good oral health. We are sensitive to the fact that our patients have different needs in fulfilling their financial obligations, and we are happy to provide flexible payment options wherever possible to facilitate treatment. We accept payments using cash, cashier's check, money orders, or Visa/MasterCard debit or credit cards. Personal checks from persons holding North Carolina driver's licenses may be accepted, but these are processed through an electronic system similar to a debit card transaction. Personal checks cannot be accepted from financial institutions who do not participate in this electronic network. If your check cannot be processed electronically, either due to system incompatibility or lack of account funds, you must provide an alternative form of payment.

Any fees quoted to you in advance of the visit are only an estimate; actual fees incurred will be determined at the conclusion of each visit. Account balances delinquent over 30 days are subject to a $35.00 finance charge per month. Checks returned for insufficient funds will be assessed a $25 service charge plus any other applicable fees assessed to us by our financial institution.

FINANCIAL OBLIGATIONS RELATED TO INSURANCE

We file insurance claims as a courtesy. While we do our best to verify coverage for all services rendered, you, as the policyholder, are ultimately responsible for understanding the benefits and limitations of your coverage. Most insurance companies have strict limitations, related to the timing and frequency of covered procedures, so we encourage you to educate yourself as much as possible on this subject. You are responsible for all services not covered by your insurance, including but not limited to co-payment, deductibles, and non-covered services. In instances where non-covered services are rendered, you are responsible to pay 100% of these charges at the time services are rendered. We are considered out of network for all insurance companies. FOR CLARIFICATION: YOUR INSURANCE POLICY IS AN AGREEMENT BETWEEN YOU AND YOUR CARRIER, NOT WITH OUR OFFICE. WE WILL FILE YOUR INSURANCE AS A COURTESY. THEREFORE ANY SERVICES RENDERED THAT ARE NOT COVERED BY YOUR POLICY ARE ULTIMATELY YOUR RESPONSIBILITY.

Self-Pay – If you do not have dental insurance, or if you choose to file claims for treatment yourself, you must pay 100% of the charges at the time services are rendered.

State-Sponsored Insurance Programs –We accept assignment of benefits from Medicaid and North Carolina Health Choice (NCHC). For most appointments, patients with Medicaid insurance will have no out-of-pocket costs except when non-covered services are rendered (i.e., sedation medications, behavior management services, and items such as ToothPrints, water test kits, and disclosing solution). Patients with NCHC will be responsible for co-pays at the time of the appointment. Should ancillary services such as the ones noted above be required, patients with NCHC will also be responsible for these out-of-pocket expenses. For example, NCHC does not cover the cost of nitrous oxide (laughing gas). NCHC patients undergoing procedures that require nitrous oxide must pay this fee at the time of the appointment.

Private Insurance Programs – We accept assignment of benefits from most major dental insurance carriers, but we require patients with private insurance to pay $25 on the day of service regardless of how we anticipate the insurance company to reimburse the claim. Once the claim is filed, it generally takes four weeks for us to receive reimbursement. Depending upon your plan's coverage, you may be entitled to a refund after the claim is paid. Reimbursements to patients are paid out on the 15th and 30th of each month (NO EXCEPTIONS).

If the patient's insurance has changed, you must notify us at least 3 business days prior to the appointment, so that appropriate verification of coverage can take place. If you do not provide this notification, you must pay in full for the dental services provided at the appointment.

Responsible Party – Please note that whichever parent accompanies the patient to their appointment and signs the financial agreement will be considered the responsible party for the patient's account.

ACKNOWLEDGEMENT

I hereby acknowledge that I have read, understand, and agree to adhere to the practice's Financial Policies as outlined above.

Responsible Party_____