Sandhills Pediatric and Family Dentistry

Dr. Sidney Brooks and Dr. Bryan Dunston, DDS, PLLC

Pediatric Demographic Information

Date _____

Patient_____
Nickname_____
Date of Birth_____ Age_____ Sex: M_____ F_____
Child's SSC# _____
Home Address_____
street city state zip
Home Phone_____
Cell Phone_____ Email_____

Insurance Information

Name of Insured_____
Relationship to Patient_____ Date of Birth_____
SSC# _____
Employer_____
Insurance Company _____ Group #_____
Insurance Phone_____

Names and ages of other children in family_____

Child's Physician _____
Physician Address_____
street city state
Physician Phone_____

Child's School Name _____
Grade_____

Parent/Guardian-#1 _____Relationship to Patient_____
Parent/Guardian-#1 _____SS#_____
Parent/Guardian-#2 _____Relationship to Patient_____
Parent/Guardian-#2 _____SS#_____

Guardian's Employer _____ Phone _____
Who has legal custody of patient? _____
Whom may we thank for referring you? _____
Is this your child's first dental visit? _____

What is the reason for your child's dental visit? _____

Pediatric Health History

Is your child in good health? Yes _____ No _____
Name of child's physician _____ Date of last physical exam _____

Has your child ever had a health problem? Yes _____ No _____
If yes, please explain.

_____

Has your child ever been **hospitalized/had surgery**? Yes _____ No _____
Please give reason(s)/surgeries and dates.

_____

Is your child allergic to any medications? Yes _____ No _____

Is your child currently taking any medications? Yes _____ No _____
Please give medication, dose, and reason for taking medication.

_____

Were there any problems at birth? Yes _____ No _____

Please check if your child has been treated for any of the following:

Heart disease	Heart murmur	Tuberculosis	Problems at birth
Liver/GI disease	Kidney disease	Speech/hearing	Cerebral palsy
Tonsils/Adenoids	Skin/Eczema	Cancer/Tumors	Sickle cell anemia
Bleeding/Transfusions	Anemia	Seizures	Rheumatic fever
Headaches	Injuries	Sleep	Congenital birth defects
Asthma/Breathing	Diabetes	Hepatitis	Cleft lip/palate
Endocrine/growth	Autism	ADD/ADHD	Adverse drug reaction
AIDS/HIV	Mental delays	Physical delays	Other problems

Please explain all items checked/circled:

_____

_____

Pediatric Dental History
Has your child been to the dentist before? Yes _____ No _____
If yes, what is the name of the dentist? _____
When was the **last dental visit**? _____

Has your child experienced any unfavorable reaction from previous dental care? Please explain

_____

Does your child suck a finger? _____ Thumb? _____ Pacifier? _____
Does your child have tooth pain? Yes _____ No _____
If yes, where is the pain? _____
Was your child breast fed?_____ Bottle fed? _____ Date stopped _____
Does your child **sleep with a sippy cup or bottle**? Yes _____ No _____
If yes, what beverage is normally in the sippy cup and/or bottle? _____

Who helps your child **brush** his/her teeth? _____
How often are your child's teeth brushed? _____

Who helps your child **floss** his/her teeth? _____
How often are your child's teeth flossed? _____

Please check if your child currently has or has had problems with the following:

◊ **Cavities** ◊ **Toothache** ◊ **Gum Infections** ◊ Jaw Sounds
◊ Teeth Sensitivity ◊ Color of teeth ◊ **Tooth/Face Injury**
◊ Grinds Teeth ◊ Bad Odor ◊ Orthodontics ◊ Other

Comments:
_____

Fluoride History	**Yes**	**No**
Is your home water supply fluoridated?**	_____	_____
Does your child use a fluoride toothpaste?	_____	_____
Does your child use a fluoride mouthrinse?	_____	_____
Does your child participate in a school fluoride rinse program?	_____	_____

****Harnett, Cumberland and Lee Counties have fluoridated water****

Pediatric Consent for Dental Treatment

To the best of my knowledge, the answers I have given are accurate. I agree to report any changes to my child's medical or dental status. I give permission to the dentist to obtain additional information from my child's physician regarding medical history needed to provide dental treatment. I request and authorize Dr. Dunston, Dr. Brooks and Associates (and staff at the doctors' direction) to clean, and provide dental treatment on my child's teeth. I further request and authorize the dentist to take the necessary dental x-rays needed 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 to understand the treatment in terms appropriate for their age. The dentist will provide an environment dedicated to help children learn to cooperate during treatment by using praise, explanation/demonstration of procedures, and using variable voice tone. I will be responsible for any charges incurred on this child for dental treatment. I understand that my signature shall remain on file and I give my permission to Sandhills Pediatric and Family Dentistry to file my dental insurance claims on my behalf.

Signature _____ **Date** _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

STREET CITY STATE ZIP

Telephone: _____ Email: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Our Management Staff
(T) 919.499.9950 (F) 919.499.9940 Email: sandhillsdental@gmail.com
55 Amarillo Lane
Sanford, NC 27332

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on the Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

SECTION C: PERMISSION TO DISCLOSE INFORMATION

Do you give permission to disclose your health information, treatment, appointment, or payment to a family member (s), friend(s), or other person(s)? If so, please list them below.

Name: ______________________________ Relationship to Patient: ____________________

Disclose information pertaining to: ______health information; ______treatment; ______ appointment; ______payment

If the patient is a minor, do you grant the person above permission to bring your child to an appointment and make treatment decisions on your behalf? _____ yes _____ no

Name: ______________________________ Relationship to Patient: ____________________

Disclose information pertaining to: ______health information; ______treatment; ______ appointment; ______payment

If the patient is a minor, do you grant the person above permission to bring your child to an appointment and make treatment decisions on your behalf? _____ yes _____ no

Name: ______________________________ Relationship to Patient: ____________________

Disclose information pertaining to: ______health information; ______treatment; ______ appointment; ______payment

If the patient is a minor, do you grant the person above permission to bring your child to an appointment and make treatment decisions on your behalf? _____ yes _____ no

Name: ______________________________ Relationship to Patient: ____________________

Disclose information pertaining to: ______health information; ______treatment; ______ appointment; ______payment

If the patient is a minor, do you grant the person above permission to bring your child to an appointment and make treatment decisions on your behalf? _____ yes _____ no

Name: ______________________________ Relationship to Patient: ____________________

Disclose information pertaining to: ______health information; ______treatment; ______ appointment; ______payment

If the patient is a minor, do you grant the person above permission to bring your child to an appointment and make treatment decisions on your behalf? _____ yes _____ no

SECTION D: PHOTOGRAPHIC RELEASE AND CONSENT

I, ______________________________, hereby authorize and consent to **Sandhills Pediatric and Family Dentistry** and its representatives the irrevocable and unrestricted right to reproduce, publish, print, use and distribute digital photographs and/or diagnostic x-rays of me, either in an official medical publication or in lectures for educational purposes. I further grant permission for my photos to be used on the Sandhills Pediatric and Family Denistry website, social media sites, or any other lawful purpose for advertising. I release Sandhills Pediatric and Family Dentistry and its employees and legal representatives from any and all claims, actions and liability relating to its use of said photographs.

The following exclusions may apply:

____

Signature: ______________________________ Date: ______________

MINORS ONLY:

If signature above is by a person under the age of 21, parent or guardian should sign below:

I ______________________ the parent or guardian, hereby consent to the foregoing.

Signature: ______________________________ Date: ______________

SANDHILLS PEDIATRIC & FAMILY DENTISTRY FINANCIAL RESPONSIBILITY

Payment is due at the time of service. We accept cash, debit cards, VIS, MASTERCARD, DISCOVER, CareCredit, and CitiHealth as a means of payment. As a courtesy, if you have dental insurance, we will file it for you. We encourage you to become familiar with the limitation of your dental plan (i.e., coverage, deductibles, frequencies, of procedures and copayments), as we will collect your cost share the day of service. On average, insurance claims are paid within 30-45 days. If your insurance claim is not paid within that time, you will receive a bill for payment. Upon receipt of payment from your insurance, we will kindly remit the credit balance to you. Your account will be assessed additional fees and collection charges of 1.5% if not paid within 30 days.

To avoid broken appointment and cancellation fees, we request a 24-hour courtesy call to cancel your reservation with us. A 48-hour courtesy call is requested for Saturday and appointments requiring an extended amount of time (i.e., root canal therapy; IV Sedation; oral sedation; oral surgery). You will be advised of the proper cancellation policy when you schedule your appointment.

SANDHILLS PEDIATRIC & FAMILY DENTISTRY AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and accurate. It is my responsibility to inform Sandhills Pediatric and Family Dentistry, Brooks and Dunston DDS, PLLC of any changes in my personal information (Ie., telephone number, address, insurance carrier, and/or health.)
I understand that I am financially responsible for all charges, whether paid by insurance or not, at the time services are rendered. I authourize the use of my signature and authorize this office to submit claims, and assign benefits on my behalf to _____Insurance Company. Sandhills Pediatric and Family Dentistry, Brooks and Dunston DDS, PLLC may use my health care information and may disclose information to my Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

Signature of Patient: _____ Date: _____

Signature of Parent or Legal Guardian: _____ Date:_____