all about smiles pediatric dentistry

Patient Information

Child's Full Name _____ Name Called By _____ Age _____
Birthday ___/___/___ Sex: M__ F __ Place of Birth _____ Primary Phone ( ) _____
Child's Home Address _____
City _____ State _____ Zip Code _____ Alternate Phone ( ) _____

Child's Favorite Hobbies/Interests _____
Name of School/Day Care _____
Brothers (Names & Age) _____
Sisters (Names & Age) _____

Child's Physician _____ Phone ( ) _____
Address _____ Date of Last Exam _____

What is your Child's Current Weight? _____ What is your Child's Current Height? _____

Parent/Guardian Information

Parent/Guardian Name _____ Relationship to Patient: _____
S.S.# _____-_____-_____ Birthday: _____/_____/_____ Home Phone ( )_____
Employer _____ Work/Mobile Phone ( )_____

Parent/Guardian Name _____ Relationship to Patient: _____
S.S.# _____-_____-_____ Birthday: _____/_____/_____ Home Phone ( )_____
Employer _____ Work/Mobile Phone ( )_____

Email Address _____

How did you find out about our office? _____

Emergency Contact (Friend or Relative NOT living with you)

Name _____ Phone ( )_____
Address _____ City _____ State _____ Zip Code _____

Insurance Information

Insured's Name _____ Birthday: _____/_____/_____
S.S.# _____-_____-_____ Insurance Company _____
Group Number _____ Employer _____ Relationship to Patient _____

I have honestly answered the questions to the best of my knowledge. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or portion of such charge. To the extent permitted by law, I authorize the release of any information relating to insurance claims filed. I hereby authorize payment of the dental benefits otherwise payable to me directly to Dr. Katherine T. Cotton, DMD, MS at All About Smiles Pediatric Dentistry. ***I understand that all balances over 30 days are subject to a 1.5% per month finance charge and for any missed appointment without 24 hours notice, a $25.00 fee will be charged. Appointments scheduled for 3:00pm or later require a 48 hour cancellation request, if the appointment is broken, a $35.00 fee will be charged and the afternoon appointments will no longer be available. If missed appointments re-occur, the patient will be dismissed and referred to another Pediatric Dentist.***

Signature _____ Date _____/_____/_____

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phone: 480.963.4636 *fax:* 480.963.4637 *web:* allaboutsmilesaz.com *email:* allaboutsmilesaz@gmail.com

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Child's Name: _____

MEDICAL HISTORY

Please indicate with a YES or NO.
Does your child currently have/previously had any of the following health problems?

_____ **Allergies (Food, Dust, Drug, Unknown)**
If yes, Please List _____
_____ **Rheumatic Fever/Rheumatic Heart Disease**
_____ **Congenital Heart Disease or Heart Murmur**
If yes, is Premed Needed? _____
Name of Pharmacy: _____
Pharmacy Phone Number ( ) _____
_____ **Asthma or Hay Fever (Please Indicate)**
If yes, please list any current medications: _____
_____ **Arthritis or Rheumatism (painful, swollen joints)**
_____ **Convulsions, Seizures, Fainting, Epilepsy**
_____ **Anemia or Blood Disorders**
_____ **Speech, Learning or Hearing Disorders**

_____ **High/Low Blood Pressure**
_____ **Any Current/Recent Injuries**
_____ **Childhood Illnesses**
_____ **Blood Transfusion**
_____ **Any Prolonged Bleeding/Bruises Easily**
_____ **Kidney or Bladder Problems**
_____ **Tuberculosis or Pneumonia**
_____ **Glandular or Hormonal Problems**
_____ **Diabetes/Blood Sugar Problems**
_____ **Liver Problems, Jaundice or Hepatitis**
_____ **Accidents or Severe Infections**
_____ **Psychological or Emotional Problems**
_____ **Any Pending or Recent Surgery**

Are your child's Immunizations Current? _____
Please explain any other medical concerns/Current Medication(s): _____
_____

DENTAL HISTORY

Date of Last Dental Visit _____ By Dr. _____
Do you have any Current Records (including x-rays) from another practice? **YES** **NO**
Has your child complained about any dental problems? _____
Any injuries or surgeries to mouth, teeth or head? **YES** **NO** If yes, please describe _____
_____
Does your child still take the bottle or sippy cup? _____
Does your child brush daily? **YES** **NO** How often? _____
Do you assist your child w/Brushing? **YES** **NO** How often? _____
Is dental floss used? **YES** **NO**

Please indicate with a YES or NO.
Does your child have any of the following Mouth Habits:

_____ Thumb Sucking _____ Finger Sucking _____ Pacifier Other: _____
_____ Mouth Breathing _____ Nail Biting _____ Grinding _____

How does your child receive Fluoride?

_____ Water Supply _____ Toothpaste _____ Tablets Other: _____
_____ Dentist _____ Vitamins _____ None _____

Child's Attitude Towards Dentistry: _____
Reason for Today's Visit/Chief Concerns: _____
_____

I hereby certify that all of the above information is correct and true. I have answered to the best of my knowledge and I understand that providing false information is hazardous to the patient's health. Because the above named child is a minor, it is necessary that a signed permission is obtained from a parent or guardian before any and/or all necessary dental treatment can be commenced. Furthermore, I will be responsible for any professional fees incurred for dental services for my child. I understand that I am responsible for all the above answers provided and for charges whether or not covered by the insurance.

Signature _____ Date _____/_____/_____

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OFFICE FINANCIAL POLICY

Thank you for choosing Dr. Cotton and All about Smiles Pediatric Dentistry. Our goal is to provide and maintain a respectable patient relationship. Letting you know in advance our office financial policy allows for a beneficial flow of communication, enabling us to achieve our goal. Should you have any questions, please do not hesitate to ask a member of our staff.

1. On arrival, please sign in at the front desk and present your current insurance card at **every visit**. You will be asked to sign and date the file copy of the card. This is your verification of the correct insurance and consent to bill them on behalf of you or your insured.

2. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.

3. We do not submit secondary insurance; we will provide you with all documentation for you to submit, However - YOU ARE RESPONSIBLE FOR THE BALANCE ON YOUR ACCOUNT.

4. It is your responsibility to understand your insurance benefit plan, and to know if a written referral or authorization is required for specific procedures. **We strongly urge** you to contact your insurance company prior to your appointment for detailed benefit coverage, policy limitations, and non-covered services.

5. If you do not have insurance, or have a plan that our office does not accept, payment in full is expected at the time of the appointment. For scheduled appointments, all balances must be paid in full before the next appointment.

6. If you have a co-pay, it will be due at time of service. If you fail to have your co-pay you may be asked to reschedule.

7. Missing, canceling, and changing appointments not only affects you, but our other patients as well. All About Smiles requires 24 hour notice to modify any appointment – Failure to notify will result in a $25 charge for regular appointment times and $35 for prime appointments (prime appointments are considered any appointment landing on ANY school holiday or after 2:00 pm any weekday)

8. If arrangements have not been made with our billing department, any balance over 90 days is subject to being placed with our collection agency. You will be responsible for any collection costs or fees associated with the collection of this debt.

9. A $25.00 fee will be charged for any checks returned, along with any bank fees incurred.

10. Requests for dental records will incur a copy charge of $.50 per page due at the time of delivery.

11. Should you need our office to review, complete or sign any forms and documents please allow a 24 hour turn around window. Additionally, depending on the complexity of the request there may be a $25 charge.

I have read and understand **All about Smiles Pediatric Dentistry** Financial Policy and agree to comply and accept responsibility for any payment that becomes due as outlined previously.

Patient Name(s) _____DOB_____

Responsible party member's name_____ Relationship_____

Responsible party member's signature_____ Date_____

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Treatment Policy

All About Smiles adheres to the American Academy of Pediatric Dentistry guidelines, which advocate the following schedule of treatment every six months. It is the responsibility of each policy holder to know their own insurance benefits and eligibility, and to inform our front office staff prior to every appointment if you'd like to opt out of any recommended preventative treatment.

Dr. Cotton will prescribe treatment based on patient needs and not insurance coverage.

Each Preventative Visit May Include:

Exam, Cleaning, Fluoride, X-rays

Most insurance policies cover exams, cleanings, fluoride, and x-rays twice per year. Some require a co-payment for everything but the exam, and other policies only cover fluoride once per year. As a courtesy, we estimate your insurance coverage at the time of your appointment. You will be responsible for your payment portion upon the completion of your dental visit.

_____

Please print Patient Name

_____ _____

Please print your name (Parent/Guardian) Relationship to Patient

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Behavior Management Policy

Providing quality dental care for children requires expertise in directing child behavior. Our goal is to instill in the child a positive attitude towards dentistry. Maintaining proper behavior of children while in the dental office demands skill of verbal guidance, prevention of inappropriate actions, and reinforcement of appropriate behavior. These techniques are used only for behavioral modification and not to reprimand or punish a child.

The following are various behavior management techniques used in this office:

Positive Reinforcement: Social reinforcement such as verbal praise and non-social reinforcement such as rewards (toys, stickers).

Tell-Show-Do: Explain procedures and instruments to the child with the use of modified terms such as "sleepy juice," "whistler," and "happy gas" rather than "shot," "drill," and "nitrous oxide."

Distraction: Use of distraction to divert the patient's attention from what he/she may perceive as unpleasantness.

Voice Modification: Change of voice volume or tone to gain a child's attention and direct his/her behavior.

Nitrous Oxide/Oxygen Sedation: This is a very safe and effective conscious sedation method which is easily monitored. The onset of this sedation is quick and recovery is fast (5 minutes) and complete before the child leaves the office.

Pediwrap or Patient Stabilizing System: In very rare cases and only as a last resort a blanket type wrap may be used to partially or completely immobilize a child to protect them during dental procedures. Due to the nature of this method, it is only utilized when all other methods have failed and after consultation with the child's parent/guardian.

It is our office policy to minimize the use of more extreme forms of behavior management techniques and to implement them only when necessary.

SIGNATURE: _____ DATE: _____

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Nitrous Oxide Consent Form

As a pediatric practice we make every effort to provide a warm and relaxing environment for our young patients. Majority of the time our staff succeeds in making your child feel special and secure in the treatment they will be receiving; however there are cases where a child needs a little more than gentle and compassionate surroundings to calm their anxiety. In these cases, the Doctor may recommend utilizing Nitrous Oxide and Oxygen as a way to help the patient relax.

Nitrous Oxide and Oxygen is a safe and effective relaxing agent, and in administering it Dr. Cotton adheres to the guidelines set by the American Academy of Pediatric Dentistry. Below is some general information provided from the American Academy Pediatric Dentistry website:

Q: What is nitrous oxide/oxygen?

A: Nitrous oxide/oxygen is a blend of two gases, oxygen and nitrous oxide. When inhaled, it is absorbed by the body and has a calming effect. Normal breathing eliminates nitrous oxide/oxygen from the body.

Q: How will my child feel when breathing nitrous oxide/oxygen?

A: Your child will smell a sweet, pleasant aroma and experience a sense of well-being and relaxation. If your child is worried by the sights, sounds, or sensations of dental treatment, he or she may respond more positively with the use of nitrous oxide/oxygen.

Q: How safe is nitrous oxide/oxygen?

A: Very safe. Nitrous oxide/oxygen is perhaps the safest sedative in dentistry. It is non-addictive. It is mild, easily taken, then quickly eliminated by the body. Your child remains fully conscious, keeps all natural reflexes, when breathing nitrous oxide/oxygen.

Q: Are there any special instructions for nitrous oxide/oxygen?

A: First, give your child little or no food before the dental visit. (Occasionally, nausea or vomiting occurs when a child has a full stomach.) Second, tell the doctor about any respiratory condition that makes breathing through the nose difficult for your child. It may limit the effectiveness of nitrous oxide/oxygen. Third, tell the doctor if your child is taking any medication on the day of the appointment.

Q: Will nitrous oxide/oxygen work for all children?

A: Pediatric dentists know that all children are not alike! Regardless of wide diversity, nitrous oxide/oxygen is proven effective in 97 percent of patients. Remember that every service is tailored to your child as an individual.

By signing below, I agree that I have read, understand, and I am giving consent for Dr. Katherine Cotton to treat my child with nitrous oxide/oxygen.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY ACTS

(You may refuse to sign this acknowledgement.)

I, _____, acknowledge that I have received a copy of the Notice of Health Insurance Portability and Accountability Act (HIPAA), as given to me by the staff of All About Smiles Pediatric Dentistry. The notice describes how All About Smiles Pediatric Dentistry providers may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

_____ _____

Please print Patient Name **Relationship to Patient**

_____

Please print your name (Parent/Guardian)

_____ _____

Signature of Parent or Guardian **Date**

For Office Use Only

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

Individual refused to sign

Communication barriers prohibited obtaining acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (Please specify)_____

_____

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