Duxbury Children's Dentistry

Please take a few minutes to fill out this form as completely as you can. If you have any questions, we will be happy to help you.

ADULT PATIENT CONSENT FOR DENTAL TREATMENT

Name: _____ **Birthdate:** _____ **Gender (M / F)**

Billing Address: **Street:** _____

City: _____ **State:** _____ **Zip:** _____

Home Phone:_____ **Cell Phone:**_____ **Email:**_____

I consent to receive emails and cell phone confirmations for my appointments. I allow Duxbury Children's Dentistry to leave messages for me at the telephone numbers and email I have provided. _____**Initial**

Do you consent for us to share treatment plan and financial information with your parents? **(YES / NO)**
Do you consent for us to share prescription or referral suggestions with your parents? **(YES / NO)**

DENTAL INSURANCE INFORMATION:

My dental insurance is through my parents and has not changed _____ **(Initial if True)**
Do you have dental insurance through your own job **(Yes / No)** Employer: _____

Person Responsible for Payment on Account: _____

Primary Insurance: (if different than what is on file)	SECONDARY INSURANCE (enter here)
Subscriber Name: _____	_____
Group/Policy#: _____	_____
Insurance Company: _____	_____

Social Security Number of insured: _____ **DOB of insured**: _____
Signature of Insured Person (if you)**:** _____

UPDATED MEDICAL HEALTH HISTORY:

Date of last Physical: _____ **Physician:** _____
Current Medications/Hormones/Vitamins: _____
Any Dental Complaints? _____ **Do you brush twice daily? (Y/ N)** **Do you floss? (Y/ N)**
Allergies: (list all)_____
Do you use any tobacco products (confidential information)?: (**Y/ N) Please List:** _____
If so, are you interested in us helping you quit? (Y/ N)
Past Surgeries: _____**Hospitalizations?** _____
Do you have any of the following? Grinding or nail biting habit? **(Y/N)** History of Trauma to Face or Teeth? **(Y/N)**
Sensitive Teeth? **(Y/N)** Dental Anxiety **(Y/N)** Do you play sports without a mouthguard? **(Y/N)**

Have you been diagnosed or treated for:	Yes	No		Yes	No
A.I.D.S./H.I.V.	☐	☐	Headaches	☐	☐
Anemia	☐	☐	Hearing Problems	☐	☐
Asthma	☐	☐	Heart Murmur/Heart Condition	☐	☐
Autism / Spectrum Disorder	☐	☐	Hepatitis	☐	☐
Autoimmune	☐	☐	Infections	☐	☐
Bladder Problems	☐	☐	Kidney Disease	☐	☐
Prolonged Bleeding/Transfusions	☐	☐	Liver Disease	☐	☐
Blood Clots/Dyscrasias	☐	☐	Mental Illness	☐	☐
Cancer	☐	☐	Muscular Problems	☐	☐
Cerebral Palsy	☐	☐	Physical Disabilities	☐	☐
Cleft Lip/Palate	☐	☐	Sensory Problems	☐	☐
Congenital Birth Defects	☐	☐	Sinus Problems	☐	☐
Convulsions/Seizures	☐	☐	Social Impairment	☐	☐
Diabetes	☐	☐	Speech Problems	☐	☐
Down Syndrome	☐	☐	Thyroid Problems	☐	☐
Drug/Alcohol Abuse	☐	☐	Tuberculosis	☐	☐
Emotional Impairment	☐	☐	ADHD/ADD	☐	☐

Please describe "Yes" or "Other"

_____

CONSENT TO DENTAL TREATMENT AT DUXBURY CHILDREN'S DENTISTRY:

The dentists (Dr. Joy John, Dr. Kierstin Kerr, Dr. Amanda Peer, Dr. Lauren Murphy) at Duxbury Children's Dentistry do everything possible to minimize or completely prevent risks and side effects. You have a right to accept or reject dental treatment. Prior to consenting you should consider the benefits and risks of the procedure (ask for full description of procedure prior), alternative treatments or the option of no treatment. Do not consent unless all of your questions have been answered and you have acknowledged your willingness to accept known risks and complications no matter how slight the risks. Small risks may be, but are not limited to, swallowing or inhaling of saliva or dental materials, discomfort, bleeding, post numbing bite trauma, bruising, swelling, choking, temporary or permanent numbness (rare) and/or allergic reaction. By signing this consent form you are allowing any of these dentists to treat your dental needs while you are a patient at our office.

1. I consent to receive cleanings, dentist examinations, fluoride treatments and x-rays. Should I agree to a treatment plan, I consent to allow the providers at this office do sealants, fillings, and other common procedures within the standards of care for the duration of my time as a patient at Duxbury Children's Dentistry. If I wish not to consent to any of the above I agree to inform the dentist on the day of my appointment and prior to the start of the appointment. I understand that this consent remains in effect while I am a patient of the office.

2. I understand that drugs and medications including, but not limited to, antibiotics, analgesics, and local anesthetics can cause allergic reactions causing redness, swelling of tissues, pain, vomiting or anaphylactic shock (severe allergic reaction)

Signature _____**Print Name** _____**DATE** _____

Provider Signature _____**(for consent and medical history) DATE** _____

OFFICE FINANCIAL POLICY:

I agree that payments/copayments are due the day of a procedure. I agree to have payment arranged from the responsible party. I agree that my dental benefits may only cover portions of my bill and that the remaining amount will be either my responsibility or the responsibility of my parents. I understand that it is my responsibility to ensure that I have insurance coverage and to make sure that my insurance information is up-to-date. I understand that I am responsible for knowing the details of my insurance plan including deductibles, maximum allowances, eligibility and estimated copayments. Late fees are charged to accounts over 90 days. The maximum amount is $35.00 per month unless the account is eligible for a collection fee.

Broken Appointment Policy: We reserve the right to charge a fee for missed appointments . The fee for a missed appointment with the doctor is $80.00 and the fee for a missed appointment with a hygienist is $30.00. These fees are subject to change. Please make every attempt to reschedule appointments with more than 24 hours of advanced notice. Insurance Companies do not cover the cost of Nitrous Oxide, Silver Diamine, or Record Transfer fees. Please be aware that a fee will be charged for these services.

I authorize my insurance provider to pay Duxbury Children's Dentistry directly. I understand that I am responsible for knowing the benefits of my insurance plan. I understand I am responsible for all fees including, but not limited to co-payments, deductibles and rejected charges. There may be a charge for the transfer of dental records (see our website for more information).

Signature _____**Print Name** _____**DATE** _____

Disclosure of Health Information, Patient Rights and HIPAA:

Health information may be used/disclosed for the purpose of treatment, payment, and healthcare operations. We may disclose your information to a healthcare provider treating you. You may give us authorization to disclose health information to anyone (including yourself) for any purpose. Such authorization may be revoked in writing. Your written permission, before any health information may be disclosed, is required. In the event of an emergency, we will disclose information regarding your treatment based on our professional judgement. Your health/dental information may be used to obtain payment for services from your parents (if they are responsible for the bill) or your insurance company. As required by law if we suspect the possibility of abuse, neglect, or domestic violence , we may disclose your health information. Your information may be disclosed in our attempts to provide you with appointment reminders and/or treatment recommendations (i.e. voicemails on cell and home phone, postcards, letters, etc.) Information regarding your health will not be used for marketing purposes without your prior written consent.

You have the right to obtain copies of your health/dental records and radiographs. You have the right to request that additional restrictions be placed on our use or disclosure information. You have the right to request that we communicate with you about your health history by alternative means and at other locations. You have the right to request that we amend your dental or health information. Under certain circumstances, we may deny such a request. In the event that you are concerned that we may have violated your privacy/right or you disagree with a decision we made about access to your health information, or if you disagree with our response to your request to change your health information, you may submit a written complaint to the U.S. Department of Health and Human Services. If you have any further questions about our privacy practices, please contact Dr. Joy John or Dr. Kierstin Kerr.

A personal copy of our Notice of Privacy Practices is available at the front desk as well as on our website for all patients .
I,_____, have been offered a copy of the Duxbury Children's Dentistry Notice of Privacy Practices.

Signature _____**Print Name** _____**DATE** _____