PATIENT INFORMATION

LAST NAME:_____ FIRST NAME:_____ SEX: M F

DATE OF BIRTH: _____ AGE: _____ SOC. SEC #: _____ - _____ - _____

ADDRESS Street: _____ APT #: _____

CITY: _____ STATE: _____ ZIPCODE: _____

CELL PHONE #: _____ HOME PHONE #: _____

E-MAIL: _____ APPT REMINDERS: TEXT & / or E-MAIL ***(circle one or both)***

Please LIST your child's current medications (prescribed and OTC): OR NONE

Is your child under the care of a physician?	Y	N	NAME:
Has your child had any serious illnesses?	Y	N	explain:
Has your child ever had surgery or been hospitalized?	Y	N	explain:

Has your child had a history of any of the following? Please indicate YES or NO:

	Y	N		Y	N		Y	N
AIDS / HIV			Cold Sores			Malignant Hyperthermia		
Anaphylaxis			Congenital Birth Defect			Mitral Valve Prolapse		
Anemia			Cough (persistent)			Nervous Problems		
Arthritis, Rheumatism			Developmental Delays			Pacemaker		
Artificial Heart Valves			Diabetes			Radiation Treatment		
Artificial Joint(s) (location):			Environmental Allergies			Rheumatic / Scarlet Fever		
_____			Epilepsy / Seizure / Fainting			Sensory Disorder		
Asthma / TB / Respiratory			Food Allergies			Shortness of Breath		
Autism / Spectrum Disorder			Headaches			Sinus Trouble		
Bleeding Disorder			Heart Murmur			Speech Problems		
Blood Disorder			Heart Problems (describe):			Stroke		
Cancer / Tumor (type):			_____			Thyroid / Glandular Problems		
_____			Hepatitis Type A / B / C			Tobacco / Vaping Habit		
Chemotherapy			Kidney Infection			Tonsillitis		
Circulatory Problems			Liver Problems			Tuberculosis		
Cleft lip / Palate			Low Blood Pressure			Other:		
FEMALE: Are you Pregnant?			Hormone Therapy?			Taking Birth Control?		

ALLERGIES

(check all that apply)

- Aspirin
- Codeine
- Local Anesthetics
- Penicillin
- Latex
- Sulfa
- Other: _____

Additional Health History Details / Explanations:

DENTAL INFO	Y	N
Do you assist / supervise brushing?		
Does your child take fluoride supplements?		
Have any cavities been noted in the past?		
Has your child sustained any injuries to teeth? (ie falls/ chips / etc)		

When Was Your Child's Last Dental Visit? _____

When Do They Brush?

- Upon Rising
- Before Going to Bed
- Right After Meals/Snacks
- After eating ANY food

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.

GENERAL LIABILITY RELEASE: I understand that if the patient listed above is to proceed to play in the playground activities here at Parkland Pediatric Dental, such activities / actions can be dangerous or hazardous. By signing below, I agree that the participation can cause harm to the patient listed above. I release Parkland Pediatric Dental from all liability, costs and damages that could arise in such participation. I agree to accept financial responsibility for the costs related to such needed treatment in case of emergency; and give my final confirmation by signing below.

Patient/Guardian SIGNATURE: _____ DATE: _____

PARKLAND Pediatric Dental

Ph 480.269.3389 4024 E Guadalupe Rd, #105, Gilbert, AZ 85234 Fax 480.771.9545

Thank you for choosing our office for your dental needs. We are committed to providing the highest quality of dental care. In order to reduce potential miscommunications, we have adopted the following policies and request that you read, initial, & sign prior to your child beginning treatment.

PATIENT INFORMATION: Personal information, including your insurance carrier, address, telephone numbers and other pertinent contact information **MUST BE UPDATED ON AN ANNUAL BASIS**. It is your responsibility to know your insurance benefits, terms and exclusions. We work with many insurance companies and hundreds of plans, and although we are happy to assist you in understanding your coverage, it is not possible that we know each policy in detail. If you take issue with the denial of a claim, it is your responsibility to contact your insurance company directly.

_____
initial

MINORS: A parent or legal guardian must accompany a minor to his/her visit at our office, so we can obtain permission to treat the minor patient. A minor may be treated on subsequent visits without a parent or guardian if we have written permission from the parent or legal guardian. The adult accompanying the minor patient is responsible for patient co-pay at the time of service. The following person(s) have my permission to seek dental care for the named patient:

_____

_____
initial

INSURANCE DEDUCTILBES & CO-PAYS: Our insurance contracts require us to collect deductibles and co-pays **AT THE TIME OF SERVICE**. If you have insurance with a plan that we do not participate with, or you have no dental insurance coverage, full payment for services rendered is due at the time of service. We do accept Visa, Master Card, American Express, Discover, Care Credit, cash and personal check as payment methods. A $35 fee will be charged for all returned checks.

_____
initial

APPOINTMENT CONFIRMATIONS AND CANCELLATIONS: It is your responsibility to remember your appointment. Reminder calls/texts are made as a courtesy only. Do not rely on them. Appointments must be cancelled 24 hours prior to the scheduled appointment time. **A $50 fee may be charged for all appointments missed without 24 hour notice.**
NOTE: WE USE TEXT/EMAIL FOR CONFIRMATION. IF YOU OPT OUT OF THIS SERVICE, YOU WILL BE RESPONSIBLE FOR REMEMBERING YOUR APPOINTMENTS.

_____
initial

LOCAL ANESTHETIC: You understand that local anesthetic is used during certain dental procedures. Although very rare, risks and complications associated with this may include; bruising, pain at the injection site, needle breakage, and paresthesia.

_____
initial

RELEASE AND ASSIGNMENT: You hereby authorize Parkland Pediatric Dental to release necessary information to your insurance company for the purpose of claim filing and payment of your dental services. You understand that you are financially responsible for all charges NOT paid by the insurance company. You are responsible to pay any deductibles, co-pays, and non-covered services under the terms of your insurance contract. You understand that once your insurance company has paid their portion of your bill, it will be your responsibility to remit payment within 30 days of receipt of a statement.

_____
initial

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT: You are aware that Parkland Pediatric Dental's HIPAA policy is posted in the office and a copy is available to you upon request.

_____
initial

I have read, understand, and agree to the above Waivers, Financial and Privacy policies.

Patient/Guardian SIGNATURE: _____ DATE: _____

PARKLAND Pediatric Dental

Ph 480.269.3389 4024 E Guadalupe Rd, #105, Gilbert, AZ 85234 Fax 480.771.9545

Responsible Party / Legal Guardian Info

LAST NAME:_____ FIRST NAME:_____ SEX: M F

DATE OF BIRTH: _____ AGE: _____ SOC. SEC #: _____ - _____ - _____

ADDRESS Street: _____ APT #: _____

CITY: _____ STATE: _____ ZIPCODE: _____

CELL PHONE #: _____ HOME PHONE #: _____

E-MAIL: _____ RELATIONSHIP TO PATIENT:

Additional Legal Guardian Info

LAST NAME:_____ FIRST NAME:_____ SEX: M F

DATE OF BIRTH: _____ AGE: _____ SOC. SEC #: _____ - _____ - _____

ADDRESS Street: _____ APT #: _____

CITY: _____ STATE: _____ ZIPCODE: _____

CELL PHONE #: _____ HOME PHONE #: _____

E-MAIL: _____ RELATIONSHIP TO PATIENT:

PRIMARY DENTAL INSURANCE INFORMATION	Insurance Co:
Subscriber Name:	DOB:
Sub SS#:	Sub ID#:
Employer:	Group #:

SECONDARY DENTAL INSURANCE INFORMATION	Insurance Co:
Subscriber Name:	DOB:
Sub SS#:	Sub ID#:
Employer:	Group #:

Please List Below the Patients that the above information applies to.

Name Date of Birth

Name Date of Birth

Name Date of Birth

Name Date of Birth