

# pediatric dentistry

*dentistry from infancy through adolescence*

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To the Parents of Our New Patients,

We would like to welcome you to Pediatric Dentistry. Your interest and presence tells us that you realize the importance that good oral health plays into your child's well being. The primary goal of our doctors and staff is to make your child's experience at the dentist one that is both positive and pleasant.

The philosophy of pediatric dentistry is that children are not just miniature adults but require an atmosphere and environment that is appropriate for their age and development. Our pediatric dentists are state board recognized specialists in children's dentistry. Our doctors have completed a two-year specialty residence following graduation from dental school. During their two-year post-doctoral training they obtained the necessary skills and techniques to successfully treat children from infancy through adolescence including children that are developmentally compromised.

We emphasize an early start to a child's dental experience beginning at one year of age or 6 months after the eruption of the first tooth. At this time, parents will receive instructions in proper oral hygiene techniques as well as preventive measures such as fluoride supplementation and diet counseling.

Please complete the enclosed forms and return to our office in the provided envelope prior to your scheduled appointment. **Please note that a parent or legal guardian must be present at the initial appointment.**

Because of the demand in this area for our specialty, we ask that you are aware in advance of possible arrangements that may need to be made to work and school schedules.

Thank you for entrusting Pediatric Dentistry with your child's dental care. Please feel free to contact our staff with any concerns or questions you may have regarding your child's dental health.

Sincerely,

Dr. Iten, Dr. Jones, and Staff of Pediatric Dentistry

### First Dental Visit

On your first visit with our office one adult and your child will be invited to our exam room together. Our doctor and staff will explain everything to both you and your child. An oral exam will then be completed. Preferably a cleaning and x-rays will be taken as well when it is age appropriate and your child is comfortable. After our doctor has reviewed the findings and x-rays, if there is any need for restorative treatment we will provide a copy of the estimated treatment and cost for each needed appointment and schedule. If no restorative treatment is required, we will schedule another exam and cleaning appointment.

### Referred Consultation

On your first visit both your child and one adult will be invited to our exam room together. Our doctor will discuss your previous experience and reasons for referral. An oral exam will be performed to confirm needed treatment, behavior, and any special needs that will need to be addressed in future visits. If the referring dentist took x-rays, please have these forwarded to our office prior to this visit. Our email to forward the x-rays to is [office@pedotoothdr.com](mailto:office@pedotoothdr.com). We will sometimes need to take additional x-rays in order to determine treatment. **Regardless of dental insurance, we require the \$79.00 consultation fee to be paid on this visit. If x-rays are taken that will be an additional charge of at least \$47.00.**

### Additional Visits for Restorative or Preventive Treatment

**All restorative treatment is scheduled between 8:00 a.m. and 12:00 p.m. daily.** One of Pediatric Dentistry's primary goals is to instill confidence and trust in all our patients. We believe, with few exceptions, a child returning for treatment or for checkups does better if the parents or other family members remain in the lobby during the appointment. Feel free to contact our office prior to the appointment if you have concerns about this proven approach. An experienced staff member will answer all your questions.

### Cancellations

**Please give at least 24 hours notice if you need to change an appointment.** By not keeping an appointment, be aware that the delay may cause treatment to change. We will always contact you by phone or mail to confirm your scheduled appointments. We require verbal confirmation for scheduled appointments as we are the only specialist in the area. We have a voicemail that you can leave a message for us.

**There will be a charge for appointments missed /cancelled in less than 24 hours.**

# Welcome to Pediatric Dentistry!

We strive to make each of your child's visits pleasant and comfortable. Our goal is to teach your child oral habits which will help keep their smile beautiful for their lifetime.

PATIENT # \_\_\_\_\_

DATE \_\_\_\_\_

## How did you hear about us?

- ☐ Advertisement
- ☐ Friend
- ☐ Your Doctor
- ☐ Your Dentist
- ☐ Other

Name \_\_\_\_\_

## Your Child

Name \_\_\_\_\_  
Nickname \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_  
Birthdate \_\_\_\_\_ School \_\_\_\_\_  
Child's Home Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Who to Contact in Case of Emergency: Name \_\_\_\_\_  
Relationship to patient \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

## Mother

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Work or Cell Phone \_\_\_\_\_  
Social Security # \_\_\_\_\_  
Employer \_\_\_\_\_  
Occupation \_\_\_\_\_  
Birthdate \_\_\_\_\_

## Father

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Work or Cell Phone \_\_\_\_\_  
Social Security # \_\_\_\_\_  
Employer \_\_\_\_\_  
Occupation \_\_\_\_\_  
Birthdate \_\_\_\_\_

## Siblings

Name \_\_\_\_\_ Age \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Parents Marital Status

- ☐ Single ☐ Divorced ☐ Separated
- ☐ Married ☐ Widowed

## Who is responsible for making appointments

Name \_\_\_\_\_ Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_ Ext \_\_\_\_\_  
Best Time to call \_\_\_\_\_ (Time) (Days)

Verbal confirmation is required  
to reserve appointments.

## 24 Hours Notice Required for Changing or Cancelling Appointments

## Stepmother/Guardian

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_  
Social Security # \_\_\_\_\_  
Employer \_\_\_\_\_  
Occupation \_\_\_\_\_  
Birthdate \_\_\_\_\_

## Stepfather/Guardian

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_  
Social Security # \_\_\_\_\_  
Employer \_\_\_\_\_  
Occupation \_\_\_\_\_  
Birthdate \_\_\_\_\_

## Primary Dental Insurance

Insured's Name \_\_\_\_\_ Address if Different from Child \_\_\_\_\_  
Phone \_\_\_\_\_ Relationship \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_  
Employer \_\_\_\_\_ Date Emp. \_\_\_\_\_ Occupation/Dept. \_\_\_\_\_  
Insurance Co. & Address \_\_\_\_\_ Group # \_\_\_\_\_ Emp. # \_\_\_\_\_  
Ins. Co. Phone \_\_\_\_\_ Deductible \_\_\_\_\_ Amount Already Used \_\_\_\_\_ Max annual Benefit \_\_\_\_\_  
Orthodontic coverage ☐ Yes ☐ No

## Secondary Dental Insurance

Insured's Name \_\_\_\_\_ Address if Different from Child \_\_\_\_\_  
Phone \_\_\_\_\_ Relationship \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_  
Employer \_\_\_\_\_ Date Emp. \_\_\_\_\_ Occupation/Dept. \_\_\_\_\_  
Insurance Co. & Address \_\_\_\_\_ Group # \_\_\_\_\_ Emp. # \_\_\_\_\_  
Ins. Co. Phone \_\_\_\_\_ Deductible \_\_\_\_\_ Amount Already Used \_\_\_\_\_ Max annual Benefit \_\_\_\_\_  
Orthodontic coverage ☐ Yes ☐ No

## Additional Dental Insurance

Insured's Name \_\_\_\_\_ Address if Different from Child \_\_\_\_\_  
Phone \_\_\_\_\_ Relationship \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_  
Employer \_\_\_\_\_ Date Emp. \_\_\_\_\_ Occupation/Dept. \_\_\_\_\_  
Insurance Co. & Address \_\_\_\_\_ Group # \_\_\_\_\_ Emp. # \_\_\_\_\_  
Ins. Co. Phone \_\_\_\_\_ Deductible \_\_\_\_\_ Amount Already Used \_\_\_\_\_ Max annual Benefit \_\_\_\_\_  
Orthodontic coverage ☐ Yes ☐ No

CONTINUED ON BACK

No Changes/Date \_\_\_\_\_

## Authorization, Release, and Agreement to Pay For Service Rendered

I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

If I have dental insurance, I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependents during the period of such dental care to third party payors and/or other health practitioners.

I authorize and hereby request my insurance company to pay directly to the dentist (or dental group) insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services and I am responsible for any balance even if they pay nothing.

I authorize any employment and credit checks that are necessary. I agree that all information on this form is correct to the best of my knowledge.

### Please note the following:

If you are married, your spouse must sign below, **or**

Any of the following must also sign below: guardian, divorced parent, step-parent, grandparent, other responsible party

**In the case of a minor child with divorced parents, we need the signatures of both parents.**

We must have all required signatures or we will be unable to bill your insurance. Therefore, payment will be due in full on date of service and you will need to get reimbursed from your insurance company.

x _____ Signature of parent	_____ Date
x _____ Signature of spouse (or other parent)	_____ Date
x _____ Signature of guardian or other responsible parties	_____ Date

## Financial Arrangements

**Payment is to be paid in full at each appointment.** If you have dental insurance, your deductible and patient portion is due on date of service. Please keep in mind that we can only estimate your insurance and it is not a guarantee of payment. You are responsible for any balance. If you are sending a minor child in by themselves or with a friend or relative, you will need to send payment with them.

For your convenience, we offer the following methods of payment.

\_\_\_\_ Cash      \_\_\_\_ Personal Check  
\_\_\_\_ Visa      \_\_\_\_ MasterCard      \_\_\_\_ Discover Card  
Card # \_\_\_\_\_ Expiration Date \_\_\_\_\_  
Signature \_\_\_\_\_

For larger balances, our outside financing companies are American General and Norwest Financial. You may make monthly payments for up to one year with no interest or finance charges. You pay back only the amount that you borrow. Ask for an application if you are interested. You must be pre-approved.

If you have any questions concerning financial arrangements, please ask for assistance.

## Late Charges

If there is any remaining balance after your insurance company pays, the balance is due upon receipt of statement. A service charge of 1.5% will be added after 30 days on any unpaid balance and will be assessed each month. Failure to keep this account current may result in our being unable to provide additional dental services to you except for dental emergencies or you may be required to pre-pay for any future services. In the case of default of payment on this account, you will be responsible for and billed for all collection costs, court fees and attorney fees incurred in collecting this amount or any future outstanding account balances.

## MISSED OR CANCELLED APPOINTMENTS

Every effort is made to keep on schedule, so we ask our patients to be prompt and to keep their appointments. We try to remind patients by telephone prior to their appointment, but please do not depend on this courtesy. If we are unable to contact you, your appointment card will serve as the confirmation of your appointment and implies your obligation to be present. That time has been reserved especially for you. We have an extensive list of patients who are waiting for an appointment. If you need to change your appointment, **we require at least 48 hours notice to avoid a charge for lost time.** Exceptions to this rule can be determined only on an individual basis according to circumstances. Repeated instances of missed appointments may result in you being asked to pre-pay for your appointment or you may be dismissed from our practice.

**Thank you** for taking the time to fill out this form completely and making yourself familiar with our office policies. Our goal is to provide you with a positive, comfortable and satisfying dental experience as one of our valued patients. The information you have provided will help us to serve your dental healthcare needs more effectively and efficiently. If you have any questions at any time, please ask us. We are always happy to help.

Patient Initials \_\_\_\_\_

Patient # \_\_\_\_\_

Date \_\_\_\_\_

**PATIENT NAME** \_\_\_\_\_**Health History**

Your child's overall health as well as any medications which your child takes could have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely.

Has your child had any difficulty with previous dental visits ☐ YES ☐ NO If yes, please explain: \_\_\_\_\_

Has your child ever had any of the following? If yes list below \*

Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Behavioral Issues	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Congenital Heart Defect	<input type="checkbox"/> Yes <input type="checkbox"/> No	Breathing Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Handicaps/Disabilities	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hospital or ER Visits	<input type="checkbox"/> Yes <input type="checkbox"/> No
HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	Convulsions/Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	ADD	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	ADHD	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Abnormal Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	Autism	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies-Seasonal	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight	_____
Allergies to Medications	<input type="checkbox"/> Yes <input type="checkbox"/> No	(If marked yes for Heart Murmur, we need a letter from physician clearing your child for dental treatment)			

\* If yes to any of the above, please explain \_\_\_\_\_

Please explain any medical problems or changes in your child's health \_\_\_\_\_

Please explain any current dental problems or difficulties \_\_\_\_\_

Present medications including vitamins or fluoride tablets \_\_\_\_\_

Why? \_\_\_\_\_

**Child's Habits**

Is this your child's first dental visit? _____	Does your child:	
How often does your child brush? _____	Suck thumb/finger/pacifier (Circle One)	<input type="checkbox"/> Yes <input type="checkbox"/> No
How often does your child floss? _____	Suck/bite lips	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental visit _____	Bite/chew nails	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of previous dentist _____	Chew hard objects-pencils-etc.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child's Physician _____	Grind Teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Phone Number _____	Clench Jaws	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child's Birthdate _____	Any specific questions or concerns? _____	
Is your child's water fluoridated? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Does your child take fluoride supplements? <input type="checkbox"/> Yes <input type="checkbox"/> No		

**Authorization and Release**

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such Dental care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X \_\_\_\_\_

Signature of patient or parent if minor

Date

**Dentist's Review**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Date \_\_\_\_\_  
 Signed Dr. \_\_\_\_\_

**Health History Update**

Date \_\_\_\_\_ Comments \_\_\_\_\_  
 \_\_\_\_\_  
 Signature \_\_\_\_\_  
 Date \_\_\_\_\_ Comments \_\_\_\_\_  
 \_\_\_\_\_  
 Signature \_\_\_\_\_

# pediatric dentistry

*dentistry from infancy through adolescence*

## Billing and Insurance

We are happy to bill your dental insurance for you. Based on the information given to us by your insurance company we ask the "co-pay" amounts and any deductible be paid on the date of service. We will be glad to wait up to 30 days on your dental insurance to pay us for their estimated portion. We are not able to process medical insurance of any kind for any reason but will be happy to provide you with paid receipts for reimbursement. We would be glad to assist you by submitting a pre-determination to your dental insurance. Some fees such as Nitrous, Specialist behavior management fees, I.V. Sedation fees which are only charged by a specialist that has been certified to provide sedation are not covered through insurance companies. We try to make sure you are given a clear understanding of the next treatment and your obligation prior to scheduling so arrangements can be made in advance. However, the insurance contract is between you and your insurance carrier. The estimates that are given are only estimates and any remaining balance that your insurance does not pay will be your responsibility. If someone other than a parent is bringing your child for treatment please contact our office to make arrangements for payment or give credit card information as we do not bill. We are unable to do 3rd party billing, but we will be happy to give you paid receipts for your records and to get reimbursed.

We accept cash, personal checks, and all major credit cards. We also offer outside financing through Care Credit with approved credit.

Please let us know if you have any questions concerning your insurance prior to your visit. We will assist you any way you can.

Parent signature \_\_\_\_\_ Date \_\_\_\_\_

# Notice of Privacy Practices and Disclosure Allowances

## Acknowledgement of Receipt

I, \_\_\_\_\_, acknowledge that I was provided a copy of the notice of  
(Print Parent/Guardian Name)  
Privacy Practices.

\_\_\_\_\_  
(Parent/Guardian Signature)

\_\_\_\_\_  
(Date)

Relationship to patient \_\_\_\_\_.

Patient Name/Date of Birth \_\_\_\_\_  
(Last name) (First name) (DOB)

I authorize the disclosure of my child's health and financial information to the following family members or personal representatives:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Print Parent/Guardian Name

\_\_\_\_\_  
Signature of Parent/Guardian