pediatric dentistry
dentistry from infancy through adolescence
419•522•KIDS (5437)
fax: 419•522•1631

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 dentist is a state board recognized specialist in children's dentistry. Our doctor has completed a two-year specialty residence following graduation from dental school. During his two-year post-doctoral training he 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 and Staff of Pediatric Dentistry

245 Sterkel Blvd. • Suite 101 • Mansfield, OH 44907

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 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 costs for each needed appointment and schedule. If no restorative treatment is required, we will schedule a 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 prior to this visit. We will sometimes need to take additional x-rays in order to determine treatment. Regardless of dental insurance, we require the $75.00 consultation fee be paid on this visit. If x-rays are taken there will be an additional charge of at least $45.00.

Additional Visits for Restorative or Preventive Treatment

All restorative treatment is scheduled between 8:00am and 12:00pm 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 older than 3 ½ 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 scheduled appointments 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 have a voicemail phone system that accepts messages.

We reserve the right to charge for appointments not canceled within 24 hours.

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 that the "co-pay" or amounts not covered by your insurance 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 covered procedures. 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 most 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 the 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 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 interest-free financing thru 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 we can.

Parent Signature _____ Date _____

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 _____

Stepmother/Guardian

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

Father

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

Stepfather/Guardian

Name _____
Address _____
City, State, Zip _____
Home Phone _____
Work 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

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	❑ Yes	❑ No	Rheumatic Fever	❑ Yes	❑ No	Behavioral Issues	❑ Yes	❑ No
Cancer	❑ Yes	❑ No	Congenital Heart Defect	❑ Yes	❑ No	Breathing Problems	❑ Yes	❑ No
Hepatitis	❑ Yes	❑ No	Handicaps/Disabilities	❑ Yes	❑ No	Hospital or ER Visits	❑ Yes	❑ No
HIV/AIDS	❑ Yes	❑ No	Convulsions/Epilepsy	❑ Yes	❑ No	ADD	❑ Yes	❑ No
Hemophilia	❑ Yes	❑ No	Tuberculosis	❑ Yes	❑ No	ADHD	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No	Abnormal Bleeding	❑ Yes	❑ No	Autism	❑ Yes	❑ No
Allergies-Seasonal	❑ Yes	❑ No	Heart Murmur	❑ Yes	❑ No			
Allergies to Medications	❑ Yes	❑ 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?_____

How often does your child brush?_____

How often does your child floss?_____

Date of last dental visit_____

Name of previous dentist_____

Child's Physician_____

Phone Number_____

Child's Birthdate_____

Is your child's water fluoridated? ❑ Yes ❑ No

Does your child take fluoride supplements? ❑ Yes ❑ No

Does your child:

Suck thumb/finger/pacifier (Circle One)	❑ Yes	❑ No
Suck/bite lips	❑ Yes	❑ No
Bite/chew nails	❑ Yes	❑ No
Chew hard objects-pencils-etc.	❑ Yes	❑ No
Grind Teeth	❑ Yes	❑ No
Clench Jaws	❑ Yes	❑ No

Any specific questions or concerns?_____

_____

_____

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_____

NOTICE OF PRIVACY PRACTICES AND DISCLOSURES 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/DOB _____
(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
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____
Print Parent/Guardian Name Signature of Parent/Guardian