VINEYARD
PEDIATRIC DENTISTRY
AND ORTHODONTICS

The information below must be filled out by a parent or legal guardian. If you do not have the legal right to fill out this form, please inform the front desk.

PATIENT INFORMATION

Child's legal name:_____ Nickname:_____ Date of Birth:_____ Today's Date: _____
Height: _____ Weight: _____ ☐ Male ☐ Female Does your child speak English? ☐ YES ☐ NO
Name and phone number of person completing this form: _____ Relationship to Child: _____
Name/age and relationship of others living in the household: _____
_____

GUARDIAN INFORMATION

Mother's Name _____
E-mail Address _____
Date of Birth _____ SSN _____
Address _____
City _____ State _____Zip _____
Home Phone _____ Cell Phone _____
Employer _____ Employer's Phone _____
Employer's Address _____

Father's Name _____
E-mail Address _____
Date of Birth _____ SSN _____
Address _____
City _____ State _____Zip _____
Home Phone _____ Cell Phone _____
Employer _____ Employer's Phone _____
Employer's Address _____

INSURANCE INFORMATION

Primary Dental Insurance
Company Name _____ ID Number_____ Group Number _____
Policy Holder Name _____ Policy Holder DOB _____ Policy Holder SSN _____

Secondary Dental Insurance (if applicable)
Company Name _____ ID Number_____ Group Number _____
Policy Holder Name _____ Policy Holder DOB _____ Policy Holder SSN _____

Emergency Contact 1 _____ Relationship _____
Address _____ Phone _____
Emergency Contact 2 _____ Relationship _____
Address _____ Phone _____

Tell us how you heard about our office!

☐ Internet Search/Google ☐ Our Building Sign ☐ Our Website ☐ Facebook/Instagram ☐ Insurance
Friend _____ Family_____
Healthcare Provider _____ Other_____

PERSON RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT
By signing this form, you are taking responsibility for your child's account with this office and any charges incurred from provided services.

Name of Parent/Guardian:_____ Relationship:_____

Signed: _____ Date: _____

In consideration of the professional services rendered to my child, I agree to accept responsibility for the payment of such services.

DENTAL HISTORY

Is this the patient's first dental visit? ☐ YES ☐ NO Date of last visit: _____ Reason for today's visit: _____
How would you describe your child's oral health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
How often does your child brush his/her teeth? _____ times per _____ Does someone help your child brush? ☐ YES ☐ NO
How often does your child floss his/her teeth? ☐ Never ☐ Occasionally ☐ Daily Does someone help your child floss? ☐ YES ☐ NO
Is your child experiencing pain today? ☐ YES ☐ NO
In general, what has the patient's past dental experience been? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
If poor, please explain:_____

Does your child have a history of the following?

YES	NO		YES	NO	
☐	☐	Thumb or finger sucking	☐	☐	Nighttime breastfeeding past the age of 12 months
☐	☐	Pacifier use	☐	☐	Orthodontic treatment or appliances
☐	☐	Use of bottle/cup in bed	☐	☐	Grinding or clenching of teeth
☐	☐	Nighttime breastfeeding past the age of 12 months	☐	☐	Fluoride supplements

MEDICAL HISTORY

Primary physician: _____ Last visit: _____ Medical specialists: _____ Last visit: _____
Is your child currently under the care of a physician? Reason _____ ☐ YES ☐ NO
Is your child taking any medications (prescription or over the counter), vitamins, or dietary supplements? ☐ YES ☐ NO
List name, dose, & frequency _____
Has your child ever had surgery or been hospitalized overnight? ☐ YES ☐ NO
If yes, please list date and describe _____
Is your child frequently exposed to tobacco smoke? ☐ YES ☐ NO
Is your child up to date on immunizations against childhood diseases? ☐ YES ☐ NO
Does your child have any allergies (including latex, food, medications, etc.)? ☐ YES ☐ NO
If yes, please list_____
Is there anything you wish to discuss with the doctor in private? ☐ YES ☐ NO

Please mark YES if your child has a history of the following conditions. For each "YES", provide details in the box at the bottom of this list. Mark NO after each line if none of those conditions applies to your child.

Autism/Autism Spectrum Disorder ☐ YES ☐ NO
Asthma, reactive airway disease, or other breathing problems ☐ YES ☐ NO
Blood disorders, anemia, hemophilia, Sickle cell disease/trait, bruises easily ☐ YES ☐ NO
Cancer, tumor, or other malignancy; chemotherapy, radiation therapy, or bone marrow or organ transplant ☐ YES ☐ NO
Cerebral Palsy, brain injury, epilepsy, or convulsions/seizures ☐ YES ☐ NO
Congenital heart disease/defect, heart murmur, rheumatic fever, or rheumatic heart disease ☐ YES ☐ NO
Cystic Fibrosis ☐ YES ☐ NO
Developmental disorders, learning problems/delays, or intellectual disability ☐ YES ☐ NO
Diabetes, hyperglycemia, or hypoglycemia ☐ YES ☐ NO
Food allergies, dietary restrictions, nutritional deficiencies, or acid reflux/GERD ☐ YES ☐ NO
Hearing Loss, impaired visions, or speech difficulty ☐ YES ☐ NO
Jaundice, hepatitis, or liver problems ☐ YES ☐ NO
Kidney or bladder problems ☐ YES ☐ NO
Mononucleosis, tuberculosis (TB), scarlet fever, cytomegalovirus (CMV), methicillin resistant staphylococcus aureus (MRSA), sexually transmitted disease (STD), or human immunodeficiency virus (HIV)/AIDS ☐ YES ☐ NO
Skin problems including hives, rash, or eczema ☐ YES ☐ NO
Sinusitis, chronic adenoid/tonsil infections ☐ YES ☐ NO
Sleep apnea/snoring, mouth breathing, or excessive gagging ☐ YES ☐ NO
Thyroid or pituitary problems ☐ YES ☐ NO
Provide details here:_____
_____
_____

Is there any other significant medical history **pertaining to this child or his/her family** that the dentist should be told? ☐ YES ☐ NO
If YES, please describe _____

☐ I am the parent or legal guardian for this child and by checking this box I understand I will be financially responsible for any services rendered.

I certify that I have read and understand the above. I acknowledge that my questions if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold Dr. Wilson, Dr. Rask, or any members of the staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature of Parent/ Guardian_____ Date _____ Dentist's signature _____

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Standard of Care Policy

At our routine six-month appointments, we uphold the Standard of Care set by the American Dental Association and the American Academy of Pediatric Dentistry.

These services include:

- Prophylaxis (dental cleaning)
- Fluoride varnish application
- Radiographic images or x-rays *(Types are dependent upon age and behavior determined by the doctor)*
- Comprehensive Oral Exam

If you **would not** like us to provide one or more of these services during your child's appointment, please let us know. Otherwise we will provide this Standard of Care to all our patients.

I HAVE READ AND UNDERSTAND THE ABOVE POLICY.

SIGNATURE: _____ DATE: _____

Policy on the Use of Nitrous Oxide or "Laughing Gas"

Children of all ages generally experience some level anxiety or nervousness at dental visits. This can cause restlessness in the dental chair and can create difficulty during dental procedures. In order to calm patients fears and increase efficiency during appointments, nitrous oxide or "laughing gas" is administered to most patients who require restorative or surgical dental procedures.

The use of "laughing gas" is extremely beneficial to the patient and has a significant effect on the quality of the work that the dentist can perform. Most insurance policies will not cover this charge, leaving the patient responsible for this fee. If you would like to know the current fee for this service please talk to any or our receptionists.

Although we are a specialty practice, we choose to keep our fees low to help families afford the care and quality dental work they deserve. As a result of this ideal, it is our policy to use "laughing gas" on nearly every patient who needs restorative work performed, even though some insurance policies will not cover the charges.

I have read and understand the above policy.

SIGNATURE: _____ DATE: _____

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Insurance Policy

Vineyard Pediatric Dentistry & Orthodontics provides their services to you, not your insurance company. Because of this fact, you are responsible for payment of any bill incurred in this office. We cannot provide services under the assumption that the insurance company pay on completed procedures. However, as a courtesy to you, we will bill your dental insurance company for any charges incurred in this office. If payment to our office has not been made by your insurance company within 60 days, you will be expected to pay the balance in full. You are responsible for all deductibles and charges not covered by insurance. It is your responsibility to understand your own insurance policy and eligible benefits and that you are responsible for payment on all non-covered or denied services. Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations. That is **your responsibility**. Please contact your insurance company to inquire if we are a preferred provider for your insurance.

Our office is happy to be a preferred provider for many insurance companies. Our contract states that we will provide a discount for their customers on covered benefits. Since your plan coverage and benefits are contracted between you and your insurance company it is **your responsibility** to know what your plan covers. Additionally, some insurance companies consider us a *Specialist*. Please be aware of this and what it may do to your eligible benefits. Contact your insurance company to inquire if we are a preferred provider for your insurance.

Insurance Billing
On the day of service, we will submit all dental claims with the insurance information you have provided. We will allow 60 days for reimbursement from your insurance company. After that time if no reimbursement has been received the balance will be solely your responsibility.

Secondary Insurance Coverage
If you have secondary insurance coverage, we will send any dental claims with the insurance information you have provided. It is your responsibility to know which insurance policy is primary and secondary. Insurance carriers may require additional information from subscribers to determine primary and secondary coverage. It is your responsibility to provide any additional information that your insurance may require. We will allow 30 days from the date we sent the secondary claim to receive reimbursement. After that time if no reimbursement has been received the balance will be solely your responsibility.

Supplemental Insurance Policy
If you have supplemental insurance, such as Aflac, we will not bill directly from our office unless it is the primary insurance. However, we will provide you with a copy of the claim and dental notes upon request. If you would like us to bill from our office, we will charge a $15 charge for this service.

I, _____, have read and will comply with the above policies. I will not hold Vineyard Pediatric Dentistry & Orthodontics responsible for insurance discrepancies and/or insurance non-payments.

SIGNATURE: _____ DATE: _____

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OFFICE FINANCIAL POLICIES AND FEDERAL TRUTH-IN-LENDING STATEMENT

As a condition of your treatment by this office, financial arrangements must be made in advance. This practice depends upon reimbursement from our patients for the costs incurred in their care to remain viable. Therefore, financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are rendered.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the insurance forms of our patients or assist in making collections from insurance companies and will credit any such collections received to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid in full by an insurance company. I assign my payable dental insurance benefits to Vineyard Pediatric Dentistry & Orthodontics.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be assessed on all accounts exceeding sixty days from the date of service unless previously written financial arrangements are satisfied. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request for my minor child or ward by the dentist, I agree to pay, therefore, the reasonable value of said services to paid dentist or his assignee at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree to pay all costs and reasonable attorney fees to collect monies owed by me, including interest charges, processing fees, collection costs/commissions (up to 40% of total due) that may be assessed by any collection agency retained to pursue this matter. I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc. to the dentist's collection agency or collection attorney should collection procedures as described become necessary.

I grant my permission to you or your assignee to telephone me at home or at my workplace to discuss matters related to this form. I also agree to let this office leave messages concerning appointments and/or results on my answering machine or with a family member.

This agreement supersedes all prior agreements signed, including any and all mediation or mediation/arbitration agreements. I acknowledge that any prior mediation or mediation/arbitration agreements signed previously related to financial arrangements or quality of care are null and void.

I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile, or paper form to my insurance carrier or any related entities that require such information to be submitted.

I acknowledge that I have received a copy of this office's Privacy Policies. I agree to disclose to the dentist names of any individuals with whom I authorize the dentist to discuss my dental care.

I certify that I have answered all questions on this and all forms accurately and to the best of my knowledge. I hereby agree to abide by the conditions outlined herein.

SIGNATURE: _____ DATE: _____

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CONSENT TO PROCEED

I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.

I authorize Stanton C. Allen, DDS, Erin Wilson, DMD, Hailee Rask, DDS MSD and/or such associates or assistants as they may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor(s) or other individual(s) for which I have responsibility, now and in the future, including arrangement and/or administration of any sedation (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and, as a rare occurrence, temporary or permanent numbness. I understand that occasionally needles break and may require surgical retrieval.

I understand that as part of the dental treatment, including preventative procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of the treatment. After lengthy appointments, jaw muscles may also be sore or tender. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in very rare cases, require bronchoscopy or other procedures to ensure safe removal. I understand that this situation is atypical.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child/children or ward(s). I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

SIGNATURE: _____ DATE: _____

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Patient HIPAA Consent Form

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treat my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you and your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that ABC Pediatric Dentistry has the right to change its Notice of Privacy Practices from time to time and that I may contact them as the above address to obtain a current copy.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revise this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____ Date: _____

Signature: _____ Relationship to patient if under 18: _____