HINGHAM
pediatric dentistry

Childs Name _____ Birthdate _____

Nickname_____ Gender: Male/ Female

Home Address _____

Home Phone_____

Cell Phone _____ Work Phone_____

Email address_____

Preferred method of contact: cell phone, home phone, work phone, email

Person responsible for payment of account _____

School Attending _____

Grade _____

Whom may we thank for referring you? _____

What is the reason for your child's dental visit?_____

Please complete if address is different than Child's Address:

Father's Full name
Home address
City
Zip

Employer
Occupation

Mother's Full name
Home address
City
Zip

Employer
Occupation

Child lives with: Both parents, Mother, Father, Other

Primary Insurance:
Subscriber Name
Policy #

Secondary Insurance:
Subscriber Name
Policy #

Payment/co-payment is due at time services are rendered.

In order to comply with most insurance companies, we ask that you sign below so that we may keep your signature on file. I have reviewed the following treatment plan. I authorize realized of any information relating to this client.

_____ _____

Signature of Insured Person Signature of Responsible Person

Child's Name_____

Will today be your child's first visit to dentist?_____

If not, date of last exam? _____

Date of last X-rays _____

Dentist _____

Does child brush daily?	YES/NO	History of cavities?	YES/NO
Does child use fluoride toothpaste?	YES/NO	History of discolored teeth?	YES/NO
Does child floss daily?	YES/NO	History of jaw noise?	YES/NO
Is fluoride is taken in any other form?	YES/NO	Any mouth habits?	YES/NO
Has child complained of tooth pain?	YES/NO	Thumb sucking?	YES/NO
Has child complained of sensitive teeth?	YES/NO	Nail biting?	YES/NO
History of gum infection?	YES/NO	Mouth breathing?	YES/NO
History of trauma to teeth?	YES/NO	Pacifier?	YES/NO
History of crowding/orthodontia?	YES/NO	Sleeping with bottle?	YES/NO
Any dental anxiety/unhappy experiences?	YES/NO	Grinding?	YES/NO

Date of last physical_____ **Physician**_____

Any problems at birth?	YES/NO	Please explain:_____
For children under 5, was child breast fed	YES/NO	Until when? _____
For children under 5, was child bottle fed	YES/NO	Until when?_____
Is child in good health	YES/NO	Please explain:_____
Are child's immunizations up to date?	YES/NO	Please explain:_____
Has child ever had surgery?	YES/NO	Please explain:_____
Is child currently taking any medications?	YES/NO	Please explain:_____
Does child have any allergies?	YES/NO	Please explain:_____
Is child allergic to any drugs/medications	YES/NO	Please explain:_____

Has child ever been diagnosed or treated for?			
A.I.D.S/HIV	YES/NO	Headaches	YES/NO
Anemia	YES/NO	Hearing Problems	YES/NO
Asthma	YES/NO	Heart Murmur/Problems	YES/NO
Anesthesia Complications	YES/NO	Hepatitis	YES/NO
Bladder Problems	YES/NO	Infections	YES/NO
Blood Clots	YES/NO	Kidney Disease	YES/NO
Cancer	YES/NO	Liver Disease	YES/NO
Cerebral Palsy	YES/NO	Mental Illness	YES/NO
Cleft Lip/Palate	YES/NO	Physical Disabilities	YES/NO
Congenital Birth Defects	YES/NO	Sinus Problems	YES/NO
Convulsions/Seizures	YES/NO	Social Impairment	YES/NO
Diabetes	YES/NO	Speech Problems	YES/NO
Drug/Alcohol Abuse	YES/NO	Thyroid Problems	YES/NO
Emotional Impairment	YES/NO	Tuberculosis	YES/NO

Please explain on any of the above for which your response was "YES"

_____

PAYMENT INFORMATION

1. Accounts more than 90 days past due will incur a late charge of 20% of the balance of the account. Families carrying a balance for more than 1 year may be subject to dismissal from the practice
2. Insurance companies may not cover the cost of Nitrous Oxide (laughing gas). Parent's guardians should be aware that a fee may be charge per use.
3. Hingham Pediatric Dentistry's standard filling for teeth is a white colored resin. If your child is having a filling in the back molars, insurance companies may reimburse only at the amalgam (Silver) rate. Your co-pay may be larger if you opt for white fillings. Dr. Caroline is happy to discuss the pro's and con's of both with you.
4. Please be aware that appointment times are important not only to the efficient operation of our practice but also to our patients. A broken appointment fee of $50.00 may be assessed.
5. I authorize my insurance provider to pay directly to my dentist. i realize that benefits vary from provider to provider and that I am responsible for knowing the provisions of my particular plan. I understand that I am responsible for all fees including, but not limited to, co-payments, deductibles, and rejected charges.

DISCLOSURE OF HEALTH INFORMATION

Health information about your child may be used/disclosed for the purpose of treatment, payment, and healthcare operations. We may disclose your child's information to a health provider treating him/her. You may give us written authorization to disclose to anyone for any purpose. Your written permission, before any healthy information may be disclosed to someone other than the child's legal guardian, is required. In the event of any emergency, we will disclose information regarding your child based on our professional judgement. Your child's health information may used to obtain payment for services. As required by law or if we suspect the possibility of abuse, neglect, or domestic violence, we may disclose your child's health information. Your child's health information may be disclosed in our attempts to provide you with appointment reminders and/or treatment recommendations (voicemails, postcards, letters, emails). Information regarding your child's healthy will not be used for marketing purposes without your prior, written consent.

I acknowledge that i have read and agree to the HIPPA contract attached.

Signature_____ Date_____

You have the right to obtain copies of your child's health records.

You have the right to request that additional restrictions are placed on our use of disclosure of information.

You have the right to request that we communicate with your about your child's health history by alternative means and at other locations

You have the right to request that we amend your child's health information. Under certain circumstances, we may deny such a request.

In the event that you are concerned we may have violated your privacy, you disagree with a decision we made about access to your child's health information, or you disagree with our response to your request for the amendment or restriction of disclosure of your child's health information, you may submit a written complaint to the U.S. Department of Health and Human Services. If you have any further question about privacy practices, please contact Dr. Caroline Young.

Signature_____ Date_____

CONSENT FOR DENTAL TREATMENT

You have a right to accept or reject dental treatment. Prior to consenting, you should consider the benefits and risks of the procedure, 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 include swallowing or inhaling of saliva or dental materials, discomfort, bleeding, post numbing bite trauma, bruising, swelling or allergic reaction. Dr Caroline P Young and the staff of Hingham Pediatric Dentistry do everything possible to minimize or completely prevent the risks and side effects. By signing this consent, you are allowing any of these dentists to diagnose and treat your child.

I consent for my child to receive cleanings, dentist examinations, fluoride treatment and x-rays. Should I agree to a treatment plan, I consent to allow the providers at this office to do sealants, fillings and other common procedures within the standards of care for the duration of my time as a patient at Hingham Pediatric Dentistry. If I wish to not consent to any of the above, I agree to inform the dentist the day of my appointment.

_____ Parents Initials

I consent to my child attending appointments by themselves or with another caregiver.

_____Parents Initials

I understand that drugs and medications including antibiotics, analgesics and other medications can cause allergic reactions causing redness, swelling of tissues, pain, vomiting, or anaphylactic shock (severe allergic reaction.

_____ Parents Initials

Signature_____ Date_____

Print Name_____

Provider Signature_____ Date_____

FINANCIAL POLICY

The primary goal of Dr Caroline Young is to provide quality dental care for your child. Inherent in our relationship with your child is a financial relationship with you as the child's parent/guardian. As such, arrangements for the financial aspect of your child's dental care are coordinated/made directly with you. Please make sure you have reviewed the pre-treatment estimation forms. These forms are informational and can be used to should you wish to contact your insurance company to see what portion(s) they will cover. Beware of insurance companies that claim that they cover 80% of restorative treatment because what some don't tell you can bring the actual amount they cover down to 20-40% with hidden stipulations and deductibles.

X-rays may be emailed at no charge to our patients or other providers as well as laser printed copies are also provided to patients at no charge.

PAYMENT IS DUE IN FULL AT THE TIME OF SERVICE ARE RENDERED. WE ACCEPT CASH, PERSONAL CHECK, VISA OR MASTER CARD.

Patients who have dental insurance: Your insurance benefits are determined by the type of plan chosen by you and/or your employer. Hingham Pediatric Dentistry has no say in the selection or determination of your insurance benefits, terms of your policy, determination of your benefits, or method of reimbursement. Our office will make every attempt to assist you with understanding your benefits; however, it is ultimately your responsibility to be knowledgeable about your policy as well as the deductibles, maximum allowances and other provisions with in said plan. Hingham Pediatric Dentistry will submit claims to your insurance company in a timely mannered will submit pre-treatment estimates to your insurance company. Should you choose to complete your child's care without receiving an estimate from your insurance, it is your responsibility to contact your carrier with questions. We reserve the right to collect an estimation of what we feel will be due and will refund or credit you any money that was overestimated and reserve the right to bill for what was not collected on the day of service. if you are concerned about your co-pays, it is wise t make appointments for all non-urgent care at least three weeks after your cleaning in order to allow processing time of the estimates.

Today's Date_____

Patient's Name_____Birth Date_____
Medical problems _____Heart disease _____Bleeding disorders _____ other_____
___Male ____Female ____Home Birth _____ Hospital Birth____ Vaginal Birth ____ C-Section Birth
Are you presently breastfeeding? ____yes ____no
If no, how long since you stopped breastfeeding _____

Medical History: Has your child experienced any of the following problems or treatment?

1. **Infants are usually given vitamin K at birth to prevent bleeding in the first 8 weeks of life. Did you sign a wavier to refuse at the administration of vitamin K? ____yes ____no**
2. Was your infant premature? ____yes ___no
3. Does your infant have any heart disease? ___yes ____no
4. Has your infant has any surgery? ____yes ___no
5. Has your infant experienced any of the following?

____Poor latch ___Reflux ___Thrush ____Other
____Falls asleep while attempting to nurse
____Slides off the nipple when attempting to latch
____ Colic symptoms
____Reflux symptoms (due to excessive clicking or air intake)
____Poor weight gain
____Gumming or chewing of your nipple when nursing
____Unable to hold a pacifier in his or her mouth
____Short sleep episodes requiring feedings every 1-2 hours
____Snoring, heavy breathing or any sleep apnea
____Waking up congested

6. Is your child taking any medications?
   Name of medication_____

7. Has your infant had a prior surgery to correct the tongue or lip tie? ____yes ____no
   If yes (when and where)_____

8. Do you have any of the following signs or symptoms?

____Creased, flattened or blanched nipples after nursing
____Blistered or cut nipples
____Bleeding nipples
____Severe pain when your infant attempts to latch
____Mild pain when your infant latches
____Poor or incomplete breast drainage
____Infected nipples or breasts
____Plugged ducts or mastitis
____Nipple thrush
____Feeling of depression

Birth weight_____ Present weight_____