Welcome!

glad SPECIALIZED FAMILY DENTISTRY

Pediatric Patient Information

Patient's Name: _____ DOB: _____

Address: _____ City: _____ Zip Code: _____

*Home Phone: _____ *Cell Phone: _____

*E-Mail Address: _____ Pediatrician/Medical Group Name: _____

Referred by: _____Friend _____Postcard _____Drive-by/Signage ____Internet ____Other:_____

Responsible Party Information

Mother/Guardian

Name:_____

DOB:_____ Marital Status: ___ Single ___Married

Address:___ Same as Patient

_____

City:_____ Postal Code:_____

Tel (H)_____

Tel (C)_____

Father/Guardian

Name:_____

DOB:_____ Marital Status: ___ Single ___Married

Address:___ Same as Patient

_____

City:_____ Postal Code:_____

Tel (H)_____

Tel (C)_____

Insurance Information

Insurance Company: _____

ID Number: _____

Group Number: _____

Policy Holder:_____

DOB of Policy Holder:____/____/____

Employer:_____

Insurance Company: _____

ID Number: _____

Group Number: _____

Policy Holder: _____

DOB of Policy Holder: ____/____/____

Employer: _____

Dental History

Date of your child's last dental visit:_____Dentist Name:_____

Were x-rays taken at that visit? ☐ Yes ☐ No

Please check Yes or No to any of the following conditions that apply to your child:

Y	N	(Please Check)
☐	☐	Problems Associated w/Previous Dental Treatment
☐	☐	Tooth Pain
☐	☐	Serious Injury to Head/Mouth
☐	☐	Dry Mouth
☐	☐	Home Water Supply Fluoridated

Y	N	(Please Check)
☐	☐	Bleeding Gums
☐	☐	Earaches or Neck Pain
☐	☐	Sores or Ulcers in Mouth
☐	☐	Orthodontic(braces)Treatment
☐	☐	Reports Sensitivity of Teeth to Cold/Heat/Sweets/Pressure

Y	N	(Please Check)
☐	☐	Grinding or Clenching Teeth
☐	☐	Food/Floss Catches Between Teeth
☐	☐	Clicking/Popping/Pain in Jaw
☐	☐	Drinks Bottled or Filtered Water

Patient Name:_____ DOB: _____

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Is your child under a physician's care now? ☐Yes ☐No If yes, please explain: _____

Has your child ever been hospitalized or had a major operation? ☐Yes ☐No If yes, please explain: _____

Is your child taking any medications, pills, or drugs? ☐Yes ☐No If yes, please explain: _____

_____

_____

Is your child currently undergoing chemotherapy and/or radiation treatment? ☐Yes ☐No

If yes, is he/she experiencing dry mouth associated with this treatment? ☐Yes ☐No

Is your child on a special diet? ☐Yes ☐ No If yes, please explain: _____

Does your child currently use tobacco or controlled substances? ☐Yes ☐No If yes, please explain:

_____

Is your child allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

Does your child currently have, or have had, any of the following?

Y N (Please Check)	Y N (Please Check)	Y N (Please Check)	Y N (Please Check)
☐☐ AIDS/HIV Positive	☐☐ ADHD	☐☐ Hemophilia	☐☐ Down Syndrome
☐☐ Anaphylaxis	☐☐ Disabilities/Special Needs	☐☐ Hepatitis A	☐☐ Recent Weight Loss
☐☐ Anemia	☐☐ Cortisone Medicine	☐☐ Hepatitis B or C	☐☐ Renal Dialysis
☐☐ Angina	☐☐ Herpes	☐☐ Rheumatic Fever	☐☐ Yellow Jaundice
☐☐ Artificial Heart Valve	☐☐ Drug Addiction	☐☐ High Blood Pressure	☐☐ Rheumatism
☐☐ Artificial Joint	☐☐ Easily Winded	☐☐ High Cholesterol	☐☐ Scarlet Fever
☐☐ Epilepsy or Seizures	☐☐ Hives or Rash	☐☐ Shingles	☐☐ Venereal Disease
☐☐ Blood Disease	☐☐ Excessive Bleeding	☐☐ Hypoglycemia	☐☐ Sickle Cell Disease
☐☐ Blood Transfusion	☐☐ Excessive Thirst	☐☐ Irregular Heartbeat	☐☐ Sinus Trouble
☐☐ Breathing Problem	☐☐ Fainting Spells/Dizziness	☐☐ Kidney Problems	☐☐ Spinal Bifida
☐☐ Bruise Easily	☐☐ Frequent Cough	☐☐ Leukemia	☐☐ Stomach Disease
☐☐ Cancer	☐☐ Frequent Diarrhea	☐☐ Liver Disease	☐☐ Intestine Disease
☐☐ Autism	☐☐ Frequent Headaches	☐☐ Low Blood Pressure	☐☐ Swelling of Limbs
☐☐ Chest Pains	☐☐ Hay Fever	☐☐ Lung Disease	☐☐ Thyroid Disease
☐☐ Cold Sores/Fever Blisters	☐☐ Heart Failure	☐☐ Mitral Valve Prolapsed	☐☐ Tonsillitis
☐☐ Congenital Heart Disorder	☐☐ Heart Murmur	☐☐ Osteoporosis	☐☐ Tuberculosis
☐☐ Convulsions	☐☐ Heart Pacemaker	☐☐ Parathyroid Disease	☐☐ Tumors or Growths
☐☐ Asthma Controlled: ☐*Yes* ☐*No*	☐☐ Heart Trouble/Disease	☐☐ Psychiatric Care	☐☐ Ulcers

☐☐ Diabetes *If yes, is your child Type 1* ☐ *or Type 2*☐ *Has you/they checked their blood sugar today?* ☐*Yes* ☐*No*

*Indicate their most recent blood sugar/A1C reading*_____

Does your child have or have had a serious illness not listed above? ☐Yes ☐No If Yes, please explain:

_____

_____

Parent Signature Date

_____

Dentist Signature Date

Consent Form for the Authorization of Dental Treatment

I, _____ authorize the following individual(s) to discuss and consent dental treatment for my child(ren).

1. _____Relationship to patient_____

2. _____Relationship to patient_____

3. _____Relationship to patient_____

4. _____Relationship to patient_____

5. _____Relationship to patient_____

Parent/Legal Guardian Signature **Date**

***Note: We require the authorized individual to present a photo ID at the time of the appointment.**

We are privileged you have chosen us as your dental provider. We are committed to providing you and your family with quality patient care. The following is a statement of our Financial Policy, which you need to understand prior to the commencement of dental treatment. If you have any questions, please feel free to ask.

FINANCIAL POLICY

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. We accept cash, checks, and most major credit cards. There will be a $35.00 fee on all returned checks. Also, we reserve the right to charge for appointments cancelled or broken without 24 hours advanced notice.

Regarding Insurance

Your insurance policy is a contract between you and your insurance company. We have no control over their decisions and the amount they decide to pay. However, as a courtesy to our patients, we will file your primary insurance claims for you.

Before treatment, we will verify your coverage and calculate your deductible and co-payments as accurately as possible. Please understand that all treatment plans given are only an estimate based on the information your insurance company provides. All deductibles and co-payments are due the day treatment is rendered.

Please be aware that your insurance company does not guarantee payment over the phone. We will not know the exact amount they will pay until they respond to the claim. **REGARDLESS OF WHAT YOUR INSURANC E COMPANY PAYS, YOU REMAIN FULLY RESPONSIBLE FOR PAYMENT OF YOUR BILL.** Once a payment is received on your claim, we will send you a bill for any remaining balance on your account.

At your discretion, any unpaid balance after 90 days will be sent to collections at which time the patient is responsible for any fees associated with the collection of the balance. I understand that should my account become delinquent, I will be legally responsible for all costs involved with the collection of this account including collection fees and attorney fees.

I have read and understand the above Financial Policy. By signing below, I acknowledge responsibility and agree to the terms above.

Signature of Responsible Party Date

NO SHOW / CANCELLATION POLICY

In an effort to provide the highest quality care and service to our patients, we ask that you notify us 48 hours in advance to cancel and/or reschedule your reserved appointment.

We require confirmation for all appointments. As a courtesy to you we employ the use of a confirmation service to improve the efficiency of your ability to confirm you appointments by

- Email
- Text Message
- Phone Call

This system was implemented to limit the amount of last minute cancelations/no shows due to the high demand for dental care.

Failure to cancel and/or reschedule an appointment within the appropriate time frame will result in a $25.00 charge.

We value our patient/doctor relationships and will do everything we can to accommodate you. Your communication and compliance are not only very much appreciated but will help us to help you achieve a positive outcome.

Thank you in advance for your cooperation. Your cooperation enables us to serve the needs of all our patients.

By signing below, I acknowledge I have read and understand the No Show/Cancelation Policy

_____

Patient Name DOB

_____

Patient/Parent Signature Date

Patient Privacy Consent Form

Privacy of your personal information is an important part of our office. We are committed to collecting, using, and disclosing your personal information responsibly. We also try to be as open and transparent as possible about the way we handle your personal information. It is important to us to provide this service to our patients.
In this Office, Dr. Liliana Gomez-Infante and Dr. Gustavo Infante act as the privacy information officers. All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are all trained in the appropriate uses and protection of your information. Do not hesitate to discuss our policies with any member of our office staff.
At Glad Specialized Family Dentistry, we ensure that only necessary information is collected about you. We only share your information with your consent; storage, retention and destruction of you personal information complies with existing legislation, and privacy protection protocols, our privacy protocols comply with privacy legislation standards of our regulatory body and the law.

We will collect, use, and disclose information about you for the following purposes:

- To deliver safe and efficient patient care
- To ensure continuous high quality service
- To assess your health needs
- To advise you of treatment options
- To communicate with other treating health care providers, including specialists and general dentists, referring dentists, and/or peripheral dentists.
- To enable us to contact and maintain communication with you, to book and confirm appointments.
- To allow us to efficiently follow up on your treatment and ongoing care
- To facilitate the billing process
- To complete and submit dental claims on your behalf
- To comply with legal and regulatory requirements according to the provisions of the regulated health professions Act and also for other regulatory and monitoring purposes.
- To present individual cases for teaching and demonstrating purposes on an anonymous basis.

Our office will not under any conditions supply your insurer with you confidential medical history. In the event this kind of a request is made, we will forward the information directly to you for review, and for your specific consent. By signing the consent section of this patient privacy consent below, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your information; we will seek your approval in advance. You may withdraw your consent for use and/or disclosure of your personal information and we will explain the ramifications of that decision and the process.

Patient Privacy Consent
I have reviewed the above information that explains how your office uses my personal information, and the steps your office is taking to protect my information. I know that your office has a privacy code, and I can ask to see the code at any time. I agree that Glad Specialized Family Dentistry can collect, use and disclose personal information about _____ as set out about in the information about the office's privacy policies.

_____ _____
Signature Date

Signature of Witness: _____