Lakeside
Children's Dentistry

PATIENT INFORMATION FORM

Today's Date: _____

Patient Name: _____

Date of Birth: _____ Age: _____

Parent/Guardian Name: _____ DOB: _____

Relationship to patient: _____ SSN: _____

Phone: _____ Email: _____

Address: _____ City: _____ State: ____ Zip: _____

Parent/Guardian Name: _____ DOB: _____

Relationship to patient: _____ SSN: _____

Phone: _____ Email: _____

Address: _____ City: _____ State: ____ Zip: _____

Primary Dental Insurance

Insurance Company: _____

Subscriber Name: _____ Subscriber DOB: _____

Member ID: _____ Group Number: _____

Employer: _____

Secondary Dental Insurance

Insurance Company: _____

Subscriber Name: _____ Subscriber DOB: _____

Member ID: _____ Group Number: _____

Employer: _____

Referral Source (Please Circle):

Social Media Family/Friends Google Doctor

Drive/Walk by Other: _____

Emergency Contact

Name: _____ Phone: _____

Relationship to patient: _____

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Dental History

Patient Name: _____ DOB: _____

Do you have any concerts about your child's teeth?

YES NO If yes, please explain: _____

_____

Is this your child's first dental visit?

YES NO If no, when/where was their last dental visit: _____

_____

Does your child receive fluoride?

Supplements Fluoride Toothpaste

Does your child have any sucking habits? (pacifier, thumb, finger)

YES NO

How does your child tolerate medical and/or dental treatment?

_____

Have there been any injuries to your child's teeth?

YES NO If yes, please explain: _____

_____

Does your child use a bottle or sippy cup?

YES NO If yes, please explain: _____

_____

Parent/Guardian Signature: _____ Date: _____

Medical History

Patient Name: _____ DOB: _____

Please circle the following which apply to you and add any relevant information.

Is your child taking any medication? YES NO

If yes, list medications: _____

Is your child allergic to any medications? YES NO

If yes, list medications: _____

Does your child have any other allergies? YES NO

If yes, list what allergies: _____

Does your child have a history of any major illnesses? YES NO

If yes, list illnesses: _____

Has your child had any major operations? YES NO

If yes, explain: _____

Conditions:

Abnormal bleeding/Hemophilia
Anemia
Arthritis
Asthma
Autism Spectrum Disorder (ASD)
Bone Disorders
Congenital Heart Defect
Diabetes
Dizziness
Down Syndrome
Epilepsy
Gastrointestinal Disorders
Heart Problems
Heart Murmur
Hepatitis / Liver Problems
Herpes
High Blood Pressure
HIV / Aids
Kidney Problems
PDD - NOS
Pneumonia
Nervous Disorders
Prolonged Bleeding
Radiation / Chemotherapy
Rheumatic Fever
Thyroid Problems
Tuberculosis
Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of?

_____

Parent/Guardian Signature: _____ Date: _____

Financial Agreement

I understand that although I may own one or more insurance policies, I, not the insurance companies, am responsible for payment of all charges incurred for my treatment by Lakeside

Children's Dentistry and/or all treating dentists at this location. I agree that my account will be paid at each appointment unless I make other arrangements with the office.

Balance is due and payable in full 10 days from the statement date. A monthly finance charge may be applied to any account balance after 30 days. Please contact our office if you are unable to meet the above terms. Allowances will be made while processing insurance claims up to six weeks after treatment.

A fee of $30.00 will be charged on all returned checks.

I understand that if my account is assigned to a collection agency, that collection agency will charge a commission or fee that may be as much as 50% of the amount I owe. I understand that if my account is assigned to a collection's agency, Lakeside Children's Dentistry may add the amount of the collection agency's commission or fee to the amount that I owe. I agree to pay that additional amount.

I understand and agree that if legal action is commenced to enforce my obligations hereunder, I will pay court costs and reasonable attorney fees.

A 24-business-hour notice is required if you need to change your appointment day or time. If 24-business hour notice is not given you will be charged a $50.00 "Late-Cancel/No Show" fee.

Authorization to Pay Benefits to Dentist:
I hereby authorize and assign all Insurance payments directly to Lakeside Children's Dentistry for all dental benefits for services rendered. Consent is hereby granted as valid authorization.

Parent/Guardian (print name): _____ Date: _____
Signature: _____

Consent to Treat and Communicate

Patient Name: _____ DOB: _____

Consent to treat Policy:

I give my permission for the practice to perform dental procedures, including nitrous and local anesthetic, within the professional scope of dentistry deemed as necessary on my child/children to individuals with my permission.

I acknowledge the understanding that dentistry is not an exact science and hereby request and authorize whatever the doctor deems advisable if any unforeseen condition arises during these designated treatment(s) and/or procedures calling, in their judgment, for procedures in addition to or different from those contemplated. In addition, I have provided as accurate and complete medical history as possible including those antibiotics, drugs, medications, and foods to which my child is allergic.

Communication Policy:

Our top priority is to give you all the information needed to make informed decisions regarding your child's oral health. This includes providing you with the nature of recommended procedures, the risks of those procedures, any alternatives to the procedures recommended, and an estimate of the costs involved in performing those procedures. We hope that open communication is important to you and that any concerns about treatment or our policies will be brought immediately to our attention with the same courtesy and respect. We will do all we can to develop a long-term relationship where your child's oral health and dental experience are number one for both of us.

Communication from Lakeside Children's Dentistry:

I consent to receive relevant communication via Telephone, Text, and Email from Lakeside Children's Dentistry.

I have read and understand the policies listed above.

Parent/Guardian (print): _____ Date: _____

Parent/Guardian Signature: _____

Consent for Use and Disclosure of Health Information

Parent/Guardian Name: _____

Patient Name: _____ DOB: _____

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and health operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice describes our treatment, payment activities, and healthcare operations, the uses, and disclosures we may make of your protected health information, and other important matters about it. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent. Please feel free to ask questions if there is anything you do not understand.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions, by contacting the office manager, at Lakeside Children's Dentistry.

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the office manager. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

I (print) _____ have had the opportunity to read and consider the contents of this consent form and Notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

If you anticipate that you will need or want your medical information to be provided to any persons, please indicate that below so that we may best serve you. By signing below, you authorize the following people to receive information regarding treatment, care, or financial information.

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Parent/Guardian (print): _____ Date: _____

Parent/Guardian Signature: _____

Cancellation Policy/No Show Policy

1. Cancellation/No Show Policy

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an

appointment, you may be preventing another patient from getting much needed treatment. Conversely, a situation may arise where another patient fails to cancel, and we are unable to schedule you for a visit.

If an appointment is not cancelled at least 24 hours in advance you will be charged a fifty-dollar ($50) deposit to schedule future appointments; this will not be covered by your insurance company.

2. Scheduled Appointments

We understand that delays can happen, however we must try to keep the Doctor and Hygienist schedule on time.

If a patient is 15 minutes past their scheduled time, we will have to reschedule the appointment.

Parent/Guardian Print: _____

Signature: _____ Date: _____