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Patient Information

Patient's Full Name_____ Contact Phone #_____

Nickname_____ Date of Birth_____ Age_____ Sex_____

Patient's Address_____
Street city state zip

Mother's Name_____ DOB_____ SSN #_____

Father's Name_____ DOB_____ SSN#_____

For Patient's covered by Insurance

Insurance Carrier_____ Policy #_____

Subscriber's Name_____ DOB_____ SSN #_____

Subscriber's Employer_____ Group Number_____

Insurance Carrier Address_____

Insurance Carrier Phone #_____

Has your child had an exam, cleaning, fluoride treatment or x-ray in the past 6 months? YES or NO

Has your child had dental work including fillings this year? YES or NO

Authorization for Treatment of a Minor

ONLY those persons listed below are authorized to bring your child to their dental appointments and receive personal dental and medical information. The persons listed by you have been authorized by you to discuss treatment needs and give permission for changes to the treatment plan if required. Regardless of who brings the child, you are still responsible for the financial payments on this account. The legal guardian is responsible for making changes regarding the persons authorized on this form.

Authorized Name _____ Relationship to Child_____

Authorized Name _____ Relationship to Child_____

Authorized Name _____ Relationship to Child_____

Consent for Dental Treatment

I certify that all the above patient information is correct. I request and authorize the dentist to examine, clean and provide dental treatment for my child's teeth. I request and authorize necessary dental x-rays for my child to diagnose and/or treat my child's dental problem. I understand that children's dentistry includes behavior management using age appropriate terms and techniques such as praise, variable voice tone, explanation, and demonstration of procedures and instruments to help children cooperate during treatment.

Parent / Guardian Signature_____ Date:_____

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Child's Name:_____

Medical Health History

Name of Child's Physician:_____ Is your child in good health? YES or NO

Is your child Allergic to any medicines? YES or NO If Yes, Please List:_____

Allergic to LATEX? YES or NO Environmental or Food Allergy? YES or NO If Yes, List_____

Please list all medications that your child is currently taking:_____

Has your child ever been hospitalized? YES or NO If Yes, Please explain_____

Is your child currently under the care of a psychiatrist / psychologist for any mental or emotional issues? YES or NO

If Yes, Please explain_____

Was your child breastfed? YES or NO What age did it stop?_____ Bottlefed? YES or NO What age did it stop?_____

Does your child suck their thumb? YES or NO Did they suck their fingers / thumb in the past? YES or NO

Has your child ever had any of the following medical problems? Please **CHECK** below

__ Anemia	__ Cleft Lip / Palate	__ Hearing problem	__ Mental delay
__ Asthma	__ Congenital heart defect	__ Heart disease	__ Physical delay
__ ADD / ADHD	__ Congenital birth defect	__ Heart murmur	__ Rheumatic fever
__ Autism	__ Diabetes	__ Hepatitis	__ Seizures / Epilepsy
__ Adverse drug use	__ Ear Aches/Infections	__ HIV / AIDS	__ Speech delay / Problem
__ Blood/Bleeding disorder	__ Fainting	__ Joint replacement	__ Tobacco Use
__ Cancer / Tumor	__ Frequent infections	__ Kidney problem	__ Tuberculosis
__ Cerebral Palsy	__ Growth problem	__ Liver / GI disease	__ Vision problem

If Yes to any of the above, Please Explain:_____

Has your child experienced any other medical problem not listed above? YES or NO

If yes, Please Explain:_____

May we request release of your child's medical records for our reference YES or NO

Dental History

Is this your child's first Dentist appointment? YES or NO Dentist Name and Date:_____

Does your water at home have fluoride? YES or NO Does your child use Fluoride Toothpaste? YES or NO

Please check below if your child is having problems with any of the following:

__ Toothache	__ Cavities	__ Teeth Crowding	__ Sensitive Teeth	__ Jaw Pain
__ Bleeding Gums	__ Broken Tooth	__ Grinding Teeth	__ Discolored Teeth	__ Trauma

_____ _____

Parent/Guardian Signature **Date**

Reviewed by Dentist _____ **Date**_____

Dr. Rickert / Dr. Watson / Dr. Wasson

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Dental Treatment Consent Form

Initial Visit: I understand that procedures for a patient's initial visit may include a comprehensive or limited exam, dental cleaning, fluoride application, sealants, intraoral photos and necessary radiographs (x-rays). However, this is subject to change depending on several factors including a patient's behavior, amount of future treatment and time. I understand that all treatment, alternative methods of treatment, and advantages and disadvantages of each will be discussed with me.

In general terms the procedures that your child may need include:

- Application of sealants
- Pulpotomies (root canal of primary teeth)
- Stainless steel crowns
- Restoration of broken teeth or fillings
- Treatment of infected teeth or gums
- Extractions of 1 or more teeth
- Use of supports to safely perform necessary dental procedures
- Use of nitrous oxide to help reduce anxiety as needed
- Use of local anesthetics as needed

*I hereby authorize treatment and the use of local anesthetics, nitrous oxide and/or other medications necessary for dental treatment

*The parent or guardian is required to remain in the DENTAL OFFICE during their child's dental treatment.

Treatment: We will advise you that although the best results are expected, there is no way within reason, of anticipating complications. Therefore, it is not possible to guarantee the results of the treatment. I understand that during the course of the patient's dental treatment, something unexpected may arise that may necessitate procedures in addition to or different from those listed on the patient's treatment plan, and that I will be consulted prior to initiation of treatment procedures that are not listed. Although the occurrence is remote, it is known that some risks are associated with dental procedures. I understand that potential complications and problems may include but are not limited to: the possibility of pain or discomfort during treatment, bleeding, swelling, temporary or permanent numbness, discoloration, injury to adjacent teeth and surrounding tissue, development of temporomandibular joint disorder, nausea, vomiting and allergic reactions that may require hospitalization. I authorize the dentists and designated staff members to perform all recommended treatment mutually agreed upon.

Informed Consent and Authorization: I have read and understand what has been reviewed in this consent form, and that all questions about the procedure or procedures have been answered in a satisfactory manner. I also understand that I have the right to be provided with answers to questions which may arise during the course of treatment. I have had sufficient opportunity to discuss the patient's dental condition/problems, the planned procedures and treatment, alternative approaches and/or no treatment. Recognizing the potential problems and risks of dental treatment, authorization is given for dental treatment to be rendered by the dentist and office staff.

Payment: I agree to be responsible for any services rendered on behalf of my dependents. I understand that payment above and beyond the estimated insurance coverage amount is payable at the time treatment is provided. I authorize payment directly to Healthy Smiles, General Dentistry for Children & Young Adults, of any insurance benefits. I authorize release of any information relating to dental insurance claims.

Print Name of Parent/Guardian_____ Child's Name_____

_____ _____
Parent or Guardian Signature Date

_____ _____
Dentist Signature Date

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Financial Policy

The office of Healthy Smiles is a General Dentistry Practice dedicated to the dental care of children and young adults. Our office provides dental care as determined by the American Dental Association. Treatment decisions by the dentists at Healthy Smiles are not made based on your insurance company, but rather your child's best interest and standard of care. Insurance companies may have limits or exclusions for the recommended treatment. It is up to you to know your insurance policy and any possible limitations or exclusions. Please advise us before treatment if you do not want certain types of dental care.

Payment is due at the time treatment is provided. We accept most insurance plans and file dental insurance as a courtesy to our patients if you have provided all required insurance information. There is no guarantee that services will be covered. If you have insurance, we collect the estimated amount or percentage not covered at each visit. In the event of insurance delays or disputed claims beyond 30 days, you are responsible for any balance on your account, whether insurance has paid us or not. We will be glad to send a refund to you once insurance has paid us. Our goal is to help you in maximizing your benefits. Please remember that insurance only assists in payment and rarely covers your full costs. We can only assist you in estimating your portion of the cost of treatment, we at no time guarantee what your insurance will or will not do with each claim. We cannot be responsible for any errors in filing your insurance, once again we file claims as a courtesy to you. Please keep us informed of any insurance changes such as policy name, insurance company address, or a change of employment. There may be additional charges to cover the cost of lab fees, depending on the treatment provided and type of insurance coverage. Patients receiving work such as space maintainers must have their portions completely paid off before the work can be delivered or cemented. Treatment that is delayed could complicate matters as problems may worsen if not treated in a timely manner.

For accounts past due, you will become responsible for the entire balance, regardless of the reason. If a bill becomes outstanding in our office, this office is not obligated to render further treatment until the total amount due has been paid in full. Outstanding balances sent to collections are subject to court costs and administrative fees. Patients needing emergency care who have dental insurance will be required to pay for any needed treatment, including but not limited to exam and radiographs prior to treatment being rendered. Patients needing emergency care on weekends or after normal office hours are required to pay for services rendered in cash, regardless of insurance coverage.

Appointment Policy

We offer courtesy phone calls prior to your visit. Please indicate below if you would like an email and/or text reminder.

Personal E-mail: _____ Text (Mobile phone #):_____

Our Office requires 2 business days notice of cancellation. In the event of an illness, call the office as soon as possible.
We charge a fee of $25 for 'no show' appointments and appointments cancelled without 2 business days notice.
If a patient is more than 10 minutes late for an appointment, we will reschedule the appointment.
Reminder phone calls are a courtesy and are not required.
Parents are responsible to remember and keep appointments and should not depend on reminder phone calls/emails/texts.

There is a $100 fee for after-hours emergency dental visits, to be paid at the time of service.

I acknowledge I have read this financial policy and I am responsible for all charges whether or not paid by insurance.

I hereby authorize payment of the dental benefits, otherwise payable to me, directly to Healthy Smiles.

I understand the financial and appointment policies of Healthy Smiles General Dentistry for Children & Young Adults.

_____ _____

Signature of Responsible Party Date

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Dentist Credentials

Healthy Smiles employs several dentists that have dedicated their careers to providing excellent dental treatment to children and young adults. Dr. Rickert, Dr. Watson, and Dr. Wasson are general dentists and members of the American Dental Association. Our doctors share a genuine love for children and are especially interested in making all of our patients feel right at home. We strive to make your child's visits as comfortable and enjoyable as possible and promise to treat your child as if they were our own.

Shelly Rickert, DDS – General Dentist

University of North Carolina – Chapel Hill School of Dentistry 1994

Crystal Watson, DDS – General Dentist

University of North Carolina – Chapel Hill School of Dentistry 2006

Harpreet Wasson DDS – General Dentist

University of North Carolina – Chapel Hill School of Dentistry 2006

_____ Initial here for Acknowledgement of Credentials

Notice of Privacy Practices Acknowledgement

The Health Insurance Portability and Accountability Act (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act provides safeguards to protect your privacy. A more complete text is available in the office at your request. I understand that as a part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means by which a third-party payer can verify that services billed were actually provided
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and treatment information to my bill
- a tool for routine healthcare operations such as assessing quality and review of the competence of healthcare professionals.

I acknowledge that I have access to your Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices from time to time, and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices. I understand that I have the right to request restrictions as to how my health information may be used or disclosed by providing a written request to the Privacy Officer within this practice. I understand that the organization is not obligated to agree to the request. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we may have already taken actions relying on your authorization.

Patient's Name_____

Print Your Name_____ Relationship to Patient_____

Signature_____ Date _____

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DENTAL RADIOGRAPHS / X-RAY INFORMATION & POLICY

DOES MY CHILD NEED DENTAL RADIOGRAPHS (X-RAYS)?

Yes, dental x-rays show us the condition of your child's teeth, teeth roots, jaw placement, and the overall health of the facial bones. Dental x-rays reveal abscesses, abnormal growths, impacted teeth and pinpoint the location of cavities that are in between the teeth. These cavities would otherwise be impossible to see in the mouth. With x-rays we can catch that cavity well before it causes pain and infection.

HOW OFTEN DO CHILDREN NEED DENTAL X-RAYS?

We only take x-rays that are necessary to provide your child with the best clinical care and this is decided on a case-by-case basis in accordance with the American Dental Association Guidelines. For example, children who have had cavities will need dental x-rays more often than children with no cavities. These intervals usually range from 6 - 12 months and are based on the individual needs of the child.

CAN MY CHILD RECEIVE DENTAL TREATMENT IF I REFUSE DENTAL X-RAYS?

No. Treatment without necessary x-rays is considered substandard. If a patient refuses to have necessary x-rays, then the dentist may refuse to provide dental care to the patient.

HOW MUCH RADIATION WILL MY CHILD BE EXPOSED TO FROM DENTAL X-RAYS?

We understand your concern with exposing your child to x-rays. Our state of the art digital x-ray equipment allows us to obtain the best diagnostic images while using the smallest amount of radiation possible. Digital radiography has decreased the amount of radiation exposure by 90% compared to standard x-ray film. The daily radiation we receive from the sun or from travel in an airplane are much higher than that of being exposed to a dental x-ray.

Type of Exposure	Estimated Exposure
Dental radiographs – Bitewings (4 images)	0.038
Dental radiographs – Full Mouth series (18 images)	0.150
Medical Chest X-ray	0.080
Medical Upper GI X-ray series	2.440
Average radiation in the U.S. from natural sources (per year)	3.000

http://www.ada.org/en/member-center/oral-health-topics/x-rays

NOTE: During your visit, if x-rays are needed for records or to make decisions regarding the patient's dental treatment, we will inform you prior to taking the necessary x-rays. If your feeling about dental x-rays conflicts with what we feel is necessary for the dental examination of your child, we will stop treatment and refer you to another dental provider.

Patient Name_____

_____ _____

Signature of Parent / Guardian Date

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