SUSANVILLE
DENTAL SPECIALTIES

PATIENT INFORMATION FORM

Patient Name: _____

Today's Date: _____ Date of Birth: _____ Age: _____

Name of Primary Guardian: _____ Date of Birth: _____

Relationship to Patient: _____ Email: _____

Cell Phone: _____ Home Phone: _____ SSN: _____

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

Employer: _____ Work Phone: _____

Name of Secondary Guardian: _____ Date of Birth: _____

Relationship to Patient: _____ Email: _____

Cell Phone: _____ Home Phone: _____ SSN: _____

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

Employer: _____ Work Phone: _____

Primary Dental Insurance

Name of Insurer: _____ Group Name: _____

Name of Primary Person Covered by this Insurance: _____

Date of Birth of Primary Person: _____ SSN: _____

Secondary Dental Insurance

Name of Insurer: _____ Group Name: _____

Name of Primary Person Covered by this Insurance: _____

Date of Birth of Primary Person: _____ SSN: _____

Tertiary Dental Insurance

Name of Insurer: _____ Group Name: _____

Name of Primary Person Covered by this Insurance: _____

Date of Birth of Primary Person: _____ SSN: _____

Primary Care Provider Name: _____ Phone: _____

Preferred Pharmacy with Location: _____

Referred By (Please Circle): Social Media Friends/Family Google Mailer Billboard Doctor

Drive/Walk By Word of Mouth Doctor:_____Other:_____

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Confidential Patient Medical and Dental History

Patient _____ Date of Birth _____

Physician's Name _____ Phone _____ Last Visit _____

Has patient ever been under the extended care of a physician or had any surgeries? ☐ Yes ☐ No

If yes, please explain: _____

CHECK ANY OF THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN TREATED

☐ Heart Conditions (murmur, etc.)	☐ HIV Positive	☐ Hepatitis
☐ Excessive Bleeding	☐ Tuberculosis	☐ Frequent Headaches
☐ Diabetes	☐ Asthma	☐ Kidney Infections
☐ Rheumatic Fever	☐ Epilepsy	☐ Cerebral Palsy
☐ Liver Problems	☐ Birth Defects	☐ Eyesight Problems
☐ Cancer	☐ Infections	☐ Speech Impairments
☐ Nervous Disorders	☐ ADHD	☐ Autism

☐ Other _____

Is the patient currently on any medications? ☐ Yes ☐ No If yes, list: _____

Is the patient allergic to any foods or medicines? ☐ Yes ☐ No If yes, list: _____

Last Dentist's Name _____ Phone _____ Last Visit _____

DENTAL AND ORTHODONTIC HISTORY

Were any x-rays taken at patient's last dental visit? ☐ Yes ☐ No _____

Has patient had any problems with dental exams or treatment in the past? ☐ Yes ☐ No _____

Has patient had any cavities in the past? ☐ Yes ☐ No _____

Does patient brush their teeth daily? ☐ Yes ☐ No _____

Does patient currently take a fluoride supplement tablet, gels, rinses, etc.? ☐ Yes ☐ No _____

Does patient floss their teeth daily? ☐ Yes ☐ No _____

Has patient ever received local anesthetic? ☐ Yes ☐ No _____

Has patient ever had sealants placed? ☐ Yes ☐ No _____

If applicable: Has patient been diagnosed with tooth decay in past two years? ☐ Yes ☐ No _____

Has patient experienced any trauma to the teeth? (falls, blows, chips, etc.) ☐ Yes ☐ No _____

If yes, please explain: _____

Please describe patient's diet (regular/favorite foods) _____

Has patient ever sucked thumbs or fingers? ☐ Yes ☐ No _____

Does patient have speech problems? ☐ Yes ☐ No _____

Has patient ever been informed of any extra or missing teeth? ☐ Yes ☐ No _____

Has patient ever had a previous orthodontic exam? ☐ Yes ☐ No _____

Have any family members ever needed orthodontics in the past? ☐ Yes ☐ No _____

Does patient have any pain in their jaw? ☐ Yes ☐ No _____

Does patient have any popping or clicking of the jaw joint? ☐ Yes ☐ No _____

Any orthodontic concern? _____

Please tell us about the patient's interests (favorite sports, hobbies, TV shows, travel, movies, etc.)

_____

Thank you for taking the time to fill this out!

I certify that the above information is complete and accurate.

Parent/Guardian Signature _____ Date _____

Dentist Signature _____ Date _____

General Consent and Practice Policy

The doctors and staff at this practice have an unwavering commitment to your child's superior oral health. We use sound scientific and ethical principles to provide your child with the highest standard of pediatric dental care available in our area. We also recognize that creating a fun, friendly, and comfortable environment is critical to the child's long-term oral health. We know you have a choice in dental providers, and we hope that these goals are the primary reasons you have chosen our practice. Please remember that the following policies center on accomplishing these two core philosophies.

- **Payment/Insurance Policy:** Payment in full is due at the time of service. We accept all major credit cards, cash, or personal checks. We cannot guarantee any estimated coverage when billing insurance. Patients are responsible for determining if their insurance is contracted for the services that will be provided. Patients are responsible for all balances imposed by their insurance. You are ultimately responsible for any remaining amount unpaid by insurance. There will be a $50 service fee on any returned checks. All unpaid balances are subject to a 10% processing fee and may incur a 1.5% monthly finance charge. All delinquent balances must be paid prior to incurring any new charges. Patients are responsible for determining whether or not our providers are considered part of their insurer's network and will be responsible for all balances imposed by their insurance company. Any service overpaid will automatically be refunded to the patient's original payment method within 60 days. Checks will be issued within 60 days from the payment date for patients who made a cash payment.

- **Missed or Canceled Appointment Policy:** Due to the busy nature of our practice and as a common courtesy to the doctors and staff who are providing important care to your child, we ask that you please make your child's appointment a top priority. If you cannot make your appointment, please give us sufficient time to fill your child's appointment with another child waiting to see the doctor. We ask that you call to reschedule or cancel 24 hours in advance. A second last-minute cancellation or no-show will lead to the end of the doctor-patient relationship. If you miss or break your appointment with less than 24 hours notice, you may be subject to a $50-$100 cancellation fee.

- **Late Appointment Policy:** We ask that all parents make a special effort to be at their child's appointments on time to minimize the impact on their child's care and dental experience as well as those patients scheduled later in the day. If a patient is more than 10 minutes late to a 30-minute or 15 minutes late to a 60-minute appointment, they may be required to reschedule or wait while we care for those patients who were on time for their appointments. Regular tardiness will lead to the end of the doctor-patient relationship.

- **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.
  - 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 in the course of 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.
  - I give my permission to the following individuals to bring my child/children to the practice for their appointments, which may include any and all dental procedures.

- **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 sincerely 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 Bluetree Brands: I consent to receive relevant communication from Bluetree brands and its affiliated partners.
  - Social Media/Photo Consent: I consent to use images taken of me/my child to showcase our extraordinary care. I understand that the office may post my images on any/all social media platforms and websites.

Parent/Guardian's Signature _____ Date _____

Printed Name _____ Relationship to Patient _____

Patient/Parent Name _____ Date _____

Signature _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgment

By signing below, I am stating that I have received a copy of this office's Notice of Privacy Practices:

_____

Please Print Patient Name

_____

Signature of Patient/Legal Guardian

_____

Date

The notice contains a patient's rights section describing your rights under the law. You certify by your signature that you have reviewed our notices before signing this consent. The terms of the notices are subject to change.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but we shall honor this agreement if we do. The HIPAA (Health Insurance Portability and Accountability Act of 1996 Law) allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such revocation will not be retroactive.

By submitting this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as the law allows.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time, and all full disclosures will cease.
- The practice may condition treatment receipt upon this consent's execution.

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. You may communicate with the following individuals relating to the patient's medical or payment information:

FOR OFFICE USE ONLY

An attempt to obtain written acknowledgment of Receipt of our Notice of Privacy Practices was attempted, however acknowledgment could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgment

☐ An emergency situation prevented us from obtaining acknowledgment

☐ Other (Please Specify)

_____