KIDS ARE GREAT
Dental Associates

PATIENT INFORMATION

Date _____

Patient's Name _____ Nickname _____

Age _____ Birth date _____ Sex M [ ] F [ ] School _____

Parent 1 Name _____ Cell Phone _____

Birth date & SS# _____ **(SS# is required for insurance purposes)**

Parent 2 Name _____ Cell Phone _____

Birth date & SS# _____ **(SS# is required for insurance purposes)**

Home Address _____

Email _____ Home Phone _____

Siblings Names and Ages _____

Nanny's Name _____ Cell Phone _____

Does your nanny have your permission to consent to dental treatment for your child in your absence? Yes [ ] No [ ] Comment _____

Child's Physician _____ Phone # _____

Pharmacy _____ Phone # _____

Whom may we thank for referring you? _____

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT

Person responsible for child's financial support _____

DENTAL INSURANCE

Dental Coverage Yes [ ] No [ ]

Insured's Name: _____ Relation: _____

Insured's Birth date: _____ Employer: _____

Insurance Co. Name: _____ Phone #: _____

Insurance Co. Address: _____

Member ID: _____ Group #: _____

HISTORY

Reason for this visit _____

Child's height_____ weight _____

1. Is a physician treating your child at this time? Yes [ ] No [ ]
2. Date of child's last physical _____
3. Has your child ever been a patient in a hospital? Yes [ ] No [ ]
4. Has your child received general anesthesia or sedation? Yes [ ] No [ ]
5. **Does your child have allergies? (Medicine, Food)** Yes [ ] No [ ]
6. Is your child taking any medication at this time? Yes [ ] No [ ]
   If yes, what? _____
7. Has your child ever had a blood transfusion? Yes [ ] No [ ]
8. Does your child smoke or use tobacco products? Yes [ ] No [ ]
9. Has your child previously seen a dentist? Yes [ ] No [ ]
   Date last seen?_____ Name of Dentist _____
10. Has your child ever received fluoride in any form? Yes [ ] No [ ]
11. Does your child suck his/her thumb or fingers? Yes [ ] No [ ]
12. Are your child's teeth brushed once or more a day? Yes [ ] No [ ]
13. At what age did your child stop bottle/breast feeding? _____

Has this child ever had any treatment for any of the following?
Blood-Circulatory [ ] Gastrointestinal (stomach) [ ] Muscles [ ] Bones [ ]
Kidney-Bladder [ ] Nervous System [ ] Endocrine Glands [ ] Heart [ ] Skin [ ] Liver [ ] Ears, Eyes, Nose, Throat [ ] Tonsils/Adenoids [ ]
This child has NOT had any treatment for the above _____

Has this child ever been diagnosed as having the following conditions?
AIDS [ ] Anemia [ ] Allergy [ ] Arthritis [ ] Asthma [ ] Autism [ ] Brain Injury [ ]
Bronchitis [ ] Cancer [ ] Cerebral Palsy [ ] Chicken Pox [ ] Cleft Lip/Plate [ ] Convulsions/ Seizures [ ] Diabetes [ ] Diphtheria [ ] Drug/Alcohol Abuse [ ] Epilepsy [ ]
Eye Problems [ ] Excessive Bleeding Problem [ ] Fainting [ ] Hearing Loss [ ]
Heart Disease [ ] Hemophilia [ ] Hepatitis Type A/B [ ] Jaundice [ ] Leukemia [ ]
Measles [ ] Intellectual Disability [ ] Mumps [ ] Mouth Breathing [ ]
Nutritional Deficiency [ ] Venereal Disease [ ] Whooping Cough [ ]
This child has never been diagnosed as having any of the above conditions_____

Is the anything else that you think we should know about your child?

_____

I certify that I have read and understand the above questions. I will not hold Dr. Lodolini, Dr. Bianchi, or any member of their staff responsible for any errors or omissions I may have made in the completion of this form.

_____ _____ _____

Signature of person completing form Relationship to patient Date

PEDIATRIC DENTISTRY CONSENT FOR DENTAL PROCEDURE AND ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION

State law requires us to obtain your consent for your child's contemplated dental treatment or oral surgery. Please read this form carefully and ask about anything that you do not understand. We will be pleased to explain it. After an oral examination and radiographs, Dr. Lodolini or Dr. Bianchi will explain to you what your child's dental needs are. The appropriate treatment plan, available alternatives, and number of appointments needed will be discussed with you.

1. Radiographs
2. Cleaning of teeth and Fluoride treatment.
3. Sealants
4. Local anesthesia to numb the teeth and tissues.
5. Treatment of diseased or injured teeth with dental restorations (fillings).
6. Removal of one or more teeth.
7. Treatment of diseased or injured oral tissues (hard and/or soft).
8. Treatment of malposed (crooked) teeth and/or oral developmental or growth abnormalities

I hereby state that I have read and understand this consent form, that I have been given an opportunity to ask questions I might have, and that all questions about the procedure or procedures have been answered in a satisfactory manner; and I understand further that I have the right to be provided with answers to questions which may arise during the course of my child's treatment.

I further understand that I am free to withdraw my consent to treatment at any time and that this consent will remain in effect until such time that I choose to terminate it.

Patient's Name _____

Signature of Parent of Guardian _____Date _____
Relationship to Patient _____

I certify that I explained the above procedures to the parent or legal guardian before requesting their signature

_____ _____
Signature of Dentists Date

Authorization and Consent
To Send Unencrypted Patient Information by Email and Other Electronic Means

Until I tell you in writing to stop, I authorize <Kids Are Great Dental> to transmit patient information relating to my treatment, health, or payment by email or other electronic means, without encryption or special security precautions, to me or someone I designate, or to other health care providers, health plans and other involved in my treatment, payment for my treatment, or <Kids Are Great Dental> health care operations. The patient information that may be emailed may include x-rays, health history, and diagnosis, treatment, and payment records.

I understand that:
• I do not have to sign this form.
• My treatment, payment, enrollment and eligibility for benefits will not be affected by my decision about signing this form.
• If I don't sign this form, <Kids Are Great Dental> may use other ways to send my information, U.S. Mail, or may ask me to send my information to third parties myself.
• There is some risk that emails and other electronic messages may be improperly acquired by hackers or received by unintended recipients. If that happens, the information may be re disclosed and no longer protected by privacy law.
• <Kids Are Great Dental> does not email such sensitive personal information as Social Security number, credit card number, mental health diagnosis, genetic information, alcohol/substance abuse, or positive HIV status unless the patient insists.

I can tell you in writing to stop emailing my patient information at any time, but if I do so, this will not affect emails that <Kids Are Great Dental> already sent before receiving my written instructions to stop.

Patient Name (Please print):

_____

Signature: _____
Date: _____