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Rrimary"Rctgpv"I wctf kcp""

____

Relationship to patient ___________________________

Date of Birth (MM/DD/YYYY) ______ / ______ / _______

Occupation/Position _____________________________

Address ____

City __________________________ Zip ____________

Cell (_____) __________________

Work (_____) __________________

Other: _________________________

Email ____

Second Parent/Guardian

____

Relationship to patient ___________________________

Date of Birth (MM/DD/YYYY) ______ / ______ / _______

Occupation/Position _____________________________

Address ____

City __________________________ Zip ____________

Cell (_____) __________________

Work (_____) __________________

Other: _________________________

Email ____

Parent/Guardian Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

If divorced - child resides with: ___________________________ Who has custody: ________________

DENTAL INSURANCE INFORMATION

Does your child have dental insurance ☐ Yes ☐ No

Primary Insurance Policy Holder Name __________________________Member/Enrollee ID#____________________

Dental Insurance Company _______________________Insurance Company State __________________

Policy Holder DOB ______________________________ Policy Holder SSN _________________________

Employer ____Group #_____________________________

Secondary Insurance Holder Name (if applicable) __________________Member/Enrollee ID#__________________

Dental Insurance Company _______________________Insurance Company State __________________

Policy Holder DOB ______________________________ Policy Holder SSN _________________________

Employer ____Group #_____________________________

CHILD'S HISTORY

Name ____ Preferred Name __________________________

Date of Birth (MM/DD/YYYY) _______ / _______ / _________ Age ____________ Weight ______________________

☐ Male ☐ Female | Preferred Pronouns _____________________ Gender Identity ______________________________

School Name ____

Interests _______________________________________aaaaaaaaaaaaaaaaaaaaaaaaaaaa"aaa___________________

Name of former dentist ____________________________________ City ________________ Last Visit _____________

How did you hear about our office? ____

Has any member of your family been a patient of this office before? ☐ Yes ☐ No | Name(s) ________________________

Current dental concerns ____

As a courtesy, our office will bill your insurance. We do our very best to collect from your carrier. However, you are ultimately responsible to know your benefits and assume full responsibility for any outstanding account balance.

Parent/Guardian Signature ____ Date ____________________

Informed Consent for Pediatric Dental Treatment

Patient Name:

Please read this form *carefully*! If you do not understand something to your satisfaction, please ask questions. We will be pleased to explain it! Our goal is to prevent decay and have all of our patients "cavity-free"!

1. I request and authorize the taking of oral dental x-rays and the use of such anesthetics as may be considered necessary to treat the patient's dental problem(s).
2. The usual and most frequent risks or complications occurring from the planned treatment and procedures include, but are not limited to the following: the possibility of pain or discomfort during the treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of a temporomandibular joint disorder, temporary or permanent numbness, and allergic reactions.
3. **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* not listed. I am aware that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the dental treatment that the patient receives in our office.
4. **I understand** that treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Behavior will be guided using praise, explanation and demonstration of procedures and instruments, using variable voice tone and loudness.
5. **I understand** that should the patient become uncooperative during dental procedures with movement of the head, arms and/or legs, dental treatment cannot be ***safely*** provided. During such disruptive behavior, it may be necessary for the assistant(s) to hold the patient's hands, stabilize the head and/or control leg movements.
6. For the purpose of advancing medical-dental education, I give permission for the use of clinical photographs of the patient for diagnostic, scientific, educational or research purposes.
7. I give my permission for photo(s) of my child to be displayed on Saratoga Pediatric Dentistry's Facebook or webpage. These photos would not contain your child's first name. I can revoke this permission at any time, or ask that the photo be removed from the site at any time.
8. I understand that dental materials information is available at https://www.ada.org/en/resources/practice/dental-standards/standards-committee-on-dental-products/products-standards-technical-specifications-and-technical-reports. Some manufacturers do not release full content due to proprietary nature.
9. **I understand** that I may revoke this consent to treatment at any time and that no further action based on this consent will be initiated except to the extent that treatment and procedures have already been performed or initiated.
10. **I confirm** that I have read and understand this form or it was read to me, and that all blanks were filled in and all inapplicable paragraphs, if any, were stricken before I signed below.

Signature of Legal Guardian ______________________ Date ______________

Witness Certification ______________________ Date ______________

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is 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.

Does your child have any health concerns?	☐ Yes ☐ No	If yes
Has your child ever been hospitalized or had a major operation?	☐ Yes ☐ No	If yes
Have you declined any recommended immunizations (vaccinations) for your child?	☐ Yes ☐ No	If yes
Is your child sensitive or allergic to any drug(s), food(s), or latex products?	☐ Yes ☐ No	If yes
Is your child taking any drug(s) or medicine	☐ Yes ☐ No	If yes

Does your child have or had a history of: ☐ No ☐ Yes If yes mark all that apply

☐ asthma	☐ heart murmur	☐ speech impediment	☐ liver disease
☐ emotional problems	☐ heart condition	☐ rashes, eczema, or skin problems	☐ kidney disease
☐ autism/autism spectrum disorder	☐ seizures	☐ hearing difficulty	☐ hemophilia
☐ attention deficit disorder	☐ diabetes	☐ cerebral condition	☐ excessive gagging
☐ mental disturbance			

Does your child have any other special healthcare needs? ☐ Yes ☐ No If yes

Has your child been examined by another dentist? (If yes, please indicate date of last visit)	☐ Yes ☐ No	If yes
Does your child take any fluoride supplements?	☐ Yes ☐ No	If yes
Do you help your child brush and floss?	☐ Yes ☐ No	If yes
Does your child drink liquids other than water from a bottle/sippy cup?	☐ Yes ☐ No	If yes
How do you think your child will react to dental treatment?		
How often does your child brush and floss ?		
What toothpaste does your child use?		

Additional comments:

If patient has significant medical conditions, please provide physician information

Name of physician:

Physician's address:

Physician's phone number:

Medical record number:

Print name of responsible party signing this form: ______________________

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature ______________________ Date: ______________________

Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can access this information.
Please review it carefully.
At *Saratoga Pediatric Dentistry*, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.
The law permits us to use or disclose your child's health information to those involved in your child's treatment. For example, a review of your child's file by a specialist doctor whom we may involve in their care.
We may use or disclose your child's health information for payment of their services. For example, we may send a report of your child's progress to your insurance company.
We may use or disclose your child's health information for our normal healthcare operations. For example, one of our staff will enter you and your child's information into our computer.
We may share your child's dental information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect you and your child's privacy.
We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your child's appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.
In an emergency, we may disclose your child's health information to a family member or another person responsible for your child's care.
We may release some or all of your child's health information when required by law.
We will make every effort to keep your health, treatment, and/or payment information confidential. However, due to our open office environment, some information may be inadvertently overheard by other patients, their family or representatives.
If this practice is sold, you and your child's information will become the property of the new owner. Except as described above, this practice will not use or disclose your child's health information without your prior written authorization.
You may request in writing that we not use or disclose your child's health information as described above. We will let you know if we can fulfill your request.
You have the right to know of any uses or disclosures we make with your child's health information beyond the above normal uses.
As we will need to contact you from time to time, we will use whatever address or telephone number you prefer. You have the right to transfer copies of your child's health information to another practice. We will mail your child's files for you with applicable administrative fees.
You have the right to see and receive a copy your child's health information, with a few exceptions. Give us a written request regarding the information you want to see.
You have the right to request an amendment or change to your child's health information. Give us your request to make changes in writing. If you wish to include a statement in your child's file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your child's file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.
You have the right to receive a copy of this notice. If we change any of the details of this notice, we will notify you of the changes in writing.

This notice goes into effect as of September 23, 2021.

Acknowledgement

I have read this copy of *Saratoga Pediatric Dentistry* Notice of Privacy Practices.

______________________________	______________________________
Date	Patient's Name
______________________________	______________________________
Signature	Parent/Guardian (Print Name)