BUSH

PEDIATRIC DENTISTRY

EM'BARK ON A HEALTHY SMILE

Today's Date _____/_____/_____ ☐Male ☐Female

Child's Name _____ Preferred Name _____

Child's Birthday _____/_____/_____ Cell # (_____) _____-_____ Home # (_____) _____-_____

Child's Address _____ City _____ Zip _____

How were you referred to our office? _____

Who is accompanying this child today? _____ Relation to child _____

Do you have legal custody of this child? ☐Yes ☐No

Mother's Name _____Email Address _____

Mother's Address ☐Check if same as child's _____

Mother's Cell # (_____) _____-_____ Home # (_____) _____-_____Work # (_____) _____-_____

Mother's Social Security # _____ Birthdate _____/_____/_____ Employer _____

Father's Name _____Email Address _____

Father's Address ☐Check if same as child's _____

Father's Cell # (_____) _____-_____ Home # (_____) _____-_____Work # (_____) _____-_____

Father's Social Security # _____ Birthdate _____/_____/_____ Employer _____

Primary Dental Insurance

Insurance Co Name _____ Address _____

Phone # (_____) _____-_____ Insured ID # _____ Group # _____

Insured's Name _____ Relation to Patient _____

Birthdate _____/_____/_____ Insured's Employer _____

Secondary Dental Insurance (if applicable)

Insurance Co Name _____ Insured ID # _____ Group # _____

Account Information (Person ultimately responsible for this account)

Name _____ Billing Address _____

Social Security # _____ Birthdate _____/_____/_____

Cell # (_____) _____-_____ Work # (_____) _____-_____

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Medical History Form

Child's Name _____ Child's Birthdate ____/____/____

Does child have regular medical exams? ☐Yes/ ☐ No Are immunizations up to date? ☐ Yes/ ☐ No

Is child taking any medications? ☐ Yes/ ☐ No If yes, what? _____

_____

Child's Physician _____ Phone # (____) _____-_____

Child's Allergies: ☐ Latex ☐Penicillin/Amoxicillin ☐ Nickel ☐ Dental Anesthetics ☐ Aspirin ☐ Food Allergies

☐ Other(s): _____

Does child currently have, or has child ever had, any of the following diseases, medical conditions, or procedures?

☐ Heart Murmur	☐ Tonsillitis	☐ Brain Injury
☐ Rheumatic Fever	☐Asthma/Difficulty Breathing	☐Autism
☐ Artificial Heart Valves	circle: Mild/Moderate/Severe	☐ Liver/Kidney/Organ
☐ Congenital Heart Defect	☐ Respiratory Problems	☐ HIV + AIDS
☐ Physically Challenged	☐ Blood Transfusion(s)	☐ Tuberculosis (TB)
☐ Surgeries/Operations	☐ Leukemia/Anemia	☐ Psychiatric Problems
☐ Cancer/Tumors	☐ Diabetes/Hypoglycemia	☐ Hyperactive
☐ Chemotherapy	☐ Hemophilia	☐ ADD/ADHD
☐ Jaw Problems TMJ/TMD	☐ Abnormal Bleeding	☐ Fainting/Seizures/Epilepsy
☐ Hearing Problems	☐ Cleft Lip/Palate	☐ Cerebral Palsy
☐ Sickle Cell or Trait (please specify)	☐ Birth Defects	☐ Down Syndrome

Please list any other medical conditions, present or past, including any hospitalizations:

_____

Child's Dental Information

Reason for today's visit: ☐ Cleaning/Exam ☐ Treatment ☐ Emergency ☐ Consultation

Is your child in pain? ☐ No ☐ Yes If yes, for how long?

Does your child require pre-medication with antibiotics for treatment? ☐ Yes ☐ No

Previous Dentist _____Last Dental Visit ____/____/____ Last Dental X-Rays ____/____/____

Times per day child brushes _____ Is child's water fluoridated? ☐ Yes ☐ No ☐ Don't Know

Does child do any of the following? ☐ Thumb Sucking ☐ Tongue Thrusting ☐ Heavy Snoring ☐ Mouth Breathing

☐ Lip Sucking/Biting ☐ Tooth Grinding/Clenching

Parent/Guardian Signature _____ Date _____/_____/_____

Staff Signature _____ Date _____/_____/_____

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Informed Consent

Thank you for choosing us as your dental care provider. We will make every effort to ensure that your child has a pleasant dental experience. On his/her initial visit, he/she will see one of our dental hygienists to have his/her teeth cleaned. Usually by age 1, we will begin fluoride treatments. We usually begin dental radiography (X-Rays) between the ages of 3 and 4. Bitewings or cavity disclosing X-Rays are recommended at least once per year to check for cavities between the back teeth. If a patient has a high incidence of dental decay, we may repeat the X-Rays at his/her 6-month re-care visit. Once a child reaches the age of 5, we generally take a panoramic X-Ray of the entire mouth to check the position of permanent teeth and check for missing teeth or other pathology. These radiographs are very important if orthodontics may be needed in the future. This X-Ray is usually repeated at 3 year intervals. Following the visit with the hygienist, Dr. Bush will go over all findings with you, address any concerns you may have, and make recommendations for future treatment.

We again thank you for the privilege of having you as a patient!

- Dr. Samuel W. Bush, D.M.D. and Staff

By my signature I acknowledge that the above procedures have been explained to me. I understand the risks and benefits of these procedures and give my consent for Dr. Samuel W. Bush, D.M.D. and staff to complete the above procedures on your child as necessary.

The following non-guardian individual(s) has permission to accompany my child(ren) to appointments. The person(s) listed may make decisions about treatment at any future visit.

Name(s) of person(s) allowed to make decisions about my child's treatment:

_____

_____

_____

Any procedure that you do NOT wish to be done on your child, plead initial below:

☐ Cleaning ☐ X-Rays ☐ Fluoride

May we leave messages on your voicemail regarding your child's dental care, account status, and/or appointments?

☐ Yes ☐ No

May we send you text messages regarding your child's dental care, account status, and/or appointments?

☐ Yes ☐ No

May we send you email messages regarding your child's dental care, account status, and/or appointments?

☐ Yes ☐ No

Preferred method of contact: ☐ Voicemail ☐ Email ☐ Text Message

Primary Cell Phone # (_____) _____-_____ Primary Email _____

Parent/Guardian Signature _____ Date _____/_____/_____

Staff Signature _____ Date _____/_____/_____

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Financial Policy

We are honored that you have chosen us for your child's dental care. We wish to establish a long and pleasant relationship with you and your child. We understand that filing dental insurance can be very complicated and time-consuming. We want to assist you in any way possible to receive the maximum benefit from your insurance. Your understanding of and cooperation with the following guidelines is appreciated.

We are contracted as a Preferred Provider for the following dental insurance companies:

Aetna
Cigna
FEP Blue Dental
Metlife
United Concordia (Tricare)
Anthem
Blue Cross/Blue Shield of AL,TX,IL,NM,OK
Delta Dental
Guardian
Southland
United Healthcare

All applicable deductibles, co-pays, and coinsurance amounts are due at the time services are rendered. We accept cash, check, Master Card, Visa, Discover, and most forms of mobile payments (Apple Pay, ect). Some dental services may not be covered by your contract. In the event that a given procedure is not covered, payment for these services is your responsibility. Balances not paid in a timely manner will be turned over to collections. If account is turned over to collections, the responsible party agrees to pay a standard 33.33% fee of the balance to the collection agency.

If your insurance is not with one of the above companies:

Please check your contract carefully to determine if you are required to see a preferred provider for that company. Understand that if you choose to see a non-preferred provider, your insurance may not pay the full amount or pay at all. Your insurance is a contract between you and your insurance company. Our office is NOT a party to that contract.

While the filling of insurance claims is a courtesy that we gladly extend to you, all charges are ultimately your responsibility from the date services are rendered.

In order to facilitate accurate and prompt reimbursement, we request that you give us complete and correct information. If you have any questions regarding your insurance coverage or our financial policy, please do not hesitate to ask.

Cancellation Policy

Any appointment cancelled or rescheduled less than 24 hours in advance will count as a missed appointment. If a patient misses two appoints, a $50 charge will be applied to his/her account. After three separate missed appointments, he/she will be subject to dismissal from the practice.

By my signature, I acknowledge that the above financial policy has been thoroughly explained to me in writing and I understand and agree to comply with said policy.

Responsible Party's Signature _____ Date _____/_____/_____

Staff Signature _____ Date _____/_____/_____

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Behavior Management Techniques

The following information is provided to allow you to consider the risks, benefits and options, in order that you may make an informed decision about your child's dental treatment. Please read this form carefully and ask about anything you do not understand.

We treat our patients the same way we would want our own family members treated. However, some patients exhibit behaviors that make it difficult or impossible to provide high quality dental care. In this instance, you as the guardian and we as the dental professionals must come to an agreement about how to handle the behavior so that the necessary treatment can be delivered safely.

Among the behaviors that can interfere with quality professional dental care are: hyperactivity, resistive movements, refusing to open mouth or keep it open, and even aggressive or physical resistance to treatment, including but not limited to, kicking, screaming or grabbing the dentist's hands or instruments.

Our goal is to help our patients master the dental experience. Some patients may cry as part of this learning process. Crying can be a natural release of anxiety and/or an avoidance technique. All efforts will be made to obtain the cooperation of our patients by use of warmth, friendliness, persuasion, distraction, humor, gentleness, kindness and understanding.

In the event that these efforts fail, there are several recognized management techniques that are used by pediatric dentists to gain cooperation, and to prevent patients from causing injury to themselves. We combine the following recognized techniques individually for each patient:

Tell,Show,Do: The patient is told what is to be done, and then shown what is to be done on a dental model, finger, or other object. Then the procedure is done exactly as told. Praise is given to reinforce positive behavior.
_____ Initials

Positive Reinforcement: This technique rewards cooperative behavior. Rewards include praise, compliments, a pat on the back or a prize, etc.
_____ Initials

Mouth Rest: A device placed in the patient's mouth to prevent accidental closing and/or injury and to allow jaw muscles to relax for ease of swallowing.
_____ Initials

Stabilization by Parent and/or Dentist/Staff: If indicated and following verbal parental consent, holding the hands, legs, and/or upper body for reassurance and to prevent the patient from making sudden unsafe movements.
_____ Initials

I hereby acknowledge that I have read and understand this consent, and that all questions about the behavior management techniques described have been answered in a satisfactory manner, and I further understand that I have the right to be provided with answers to questions which may arise during the course of the patient's treatment.

Responsible Party's Signature _____ Date _____/_____/_____

Staff Signature _____ Date _____/_____/_____

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Patient HIPPA Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out:

Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)

Obtaining payment from third party payers (e.g., my insurance company)

The day-to-day healthcare operations of your practice

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoked this consent is not affected.

Signature _____ Date _____/_____/_____

Patient Name _____ Relationship to Patient _____