SWEET TOOTH PEDIATRIC DENTISTRY

HEALTH HISTORY AND PATIENT INFORMATION

Today's Date: _____ ☐ **I am the legal parent or legal guardian of this child**
(A legal guardian MUST be present for a new patient appointment)

Patient's Name: _____ _____ Age: _____ DOB: _____ Sex: _____
First Middle Last Nickname

Name(s) of Parent(s) or Legal Guardian(s) _____DOB:_____

Best Contact Number _____ Email Address _____

Address _____
City State Zip

Name of Child's Physician _____Date last seen:_____ Previous Dental Office_____

Reason for bringing child to the dentist:_____ **How did you hear about us?** _____

HISTORY	**Yes**	**No**
Is your child being treated by a physician at this time?	☐	☐
Has your child ever been a patient in a hospital?	☐	☐
Or had a serious illness?	☐	☐
Has your child ever received general anesthesia?	☐	☐
Is your child allergic to anything?	☐	☐
If yes, what? _____		
Is your child taking any medications at this time?	☐	☐
If yes, what? _____		

	Yes	**No**
Has your child ever been seen by a dentist before?	☐	☐
Has your child ever received fluoride in any form?	☐	☐
If yes, what?_____		
Does your child suck his/her thumb or fingers?	☐	☐
Are your child's teeth brushed once a day?	☐	☐
How many times daily? _____		
What kind of toothpaste does your child use? _____		
What age did your child stop bottle/breastfeeding? _____		

Do you have well water or city water? _____

ILLNESS

Has this child ever been diagnosed as having any of the following conditions? Please check yes or no:

	Yes	No		Yes	No		Yes	No
Anemia	☐	☐	Epilepsy	☐	☐	Nutritional Deficiency	☐	☐
Allergy	☐	☐	Eye Problems	☐	☐	Orthopedic Problems	☐	☐
Arthritis	☐	☐	Excessive Bleeding	☐	☐	Pneumonia	☐	☐
Asthma	☐	☐	Fainting	☐	☐	Polio	☐	☐
Autism	☐	☐	Hearing Loss	☐	☐	Rheumatic Fever	☐	☐
Brain Injury	☐	☐	Heart Disease/Problems	☐	☐	Scarlet Fever	☐	☐
Cancer	☐	☐	Hemophilia	☐	☐	Scoliosis	☐	☐
Cerebral Palsy	☐	☐	Hepatitis - Type ____	☐	☐	Sickle Cell Anemia	☐	☐
Chicken Pox	☐	☐	HIV Positive/AIDS	☐	☐	Spina Bifida	☐	☐
Cleft Lip/Palate	☐	☐	Jaundice	☐	☐	Tetanus	☐	☐
Convulsions/Seizures	☐	☐	Leukemia	☐	☐	Whooping Cough	☐	☐
Diabetes	☐	☐	Measles	☐	☐	Other	☐	☐
Diphtheria	☐	☐	Mental Delay	☐	☐	_____		
Emotional Disturbance	☐	☐	Mumps	☐	☐			

ORGANS & SYSTEMS

Has this child ever had any treatment for any of the following? Please check yes or no:

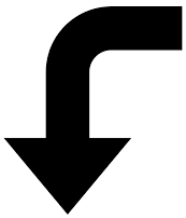
	Yes	No		Yes	No
Blood - Circulatory	☐	☐	Heart	☐	☐
Bones	☐	☐	Liver	☐	☐
Endocrine Glands	☐	☐	Muscles	☐	☐
Eyes, Ears, Nose, Throat	☐	☐	Nervous System	☐	☐
Specify: _____			Skin	☐	☐
Gastrointestinal (stomach)	☐	☐	Tonsils/Adenoids	☐	☐
Kidney - Bladder	☐	☐			

Is there anything else we should know about your child?

_____

_____

_____



Signature of Person Completing Form | Printed Name | Date

_____

Dr. Signature | Date Reviewed

SWEET TOOTH PEDIATRIC DENTISTRY

FINANCIAL POLICIES

At Sweet Tooth Pediatric Dentistry, we strive to offer convenient payment options while also maintaining a high standard, 5 star quality level of dental care that our patients deserve.
At the onset of your treatment, we will provide you with an estimate of your treatment costs.

Please take a moment to review the financial options offered at our office, and check which box is most applicable for your family.

Please note we are NOT contracted providers with Medicaid/Badgercare/Forward Health.

☐ **No Dental Insurance -** Payment in full on the day of treatment. Courtesy of 10% is given for payment in full by cash or check at the start of treatment, or 5% for payment by card.

☐ **Dental Insurance -** Bill your provided dental insurance policy - patient portion paid at the time of service with cash, check, Visa, MasterCard or Debit Card.*

*If for any reason the estimated amount is not paid by your insurance company, it becomes your obligation. Please remember that the contract itemizing your dental benefits is between you, your employer and your insurance carrier. Regardless of coverage, your estimated co-payment is due in full the day of treatment. If your dental plan does not pay within 60 days of treatment, you must pay any outstanding balance and seek reimbursement from your dental plan. If your dental plan pays more than expected, you will receive a refund check.

Please fill out the following information OR provide a copy of your dental insurance card to ensure accurate billing.

PRIMARY DENTAL POLICY	SECONDARY DENTAL POLICY
Policy Holder Name:_____	**Policy Holder Name:**_____
Policy Holder DOB:_____	**Policy Holder DOB:**_____
Employer:_____	**Employer:**_____
Insurance Company:_____	**Insurance Company:**_____
Member ID or Policy Holder SSN:_____	**Member ID or Policy Holder SSN:**_____
Group Number:_____	**Group Number:**_____

I accept full financial responsibility for this account and for all dental costs for my dependents in this dental office. I understand it is my responsibility to confirm insurance eligibility, waiting periods, and benefits. I also understand this office cannot guarantee insurance status in any of these areas. Any insurance estimate or information given to me by this office is not a guarantee of actual insurance payment. I also understand that any insurance claim not paid in full will become my responsibility. I understand that if I do not remit payment in a timely manner, my account may be subject to an outside collections agency.

_____

Printed Name Signature Date

SWEET TOOTH PEDIATRIC DENTISTRY

OFFICE POLICIES

***By checking each box**, you are confirming that you understand and agree to abide by each policy.*

☐ Radiographs (x-rays) are an important diagnostic tool used during a dental examination. All radiographs are diagnosed and taken at the sole discretion of the doctor. Refusal of necessary radiographs will lead to patient dismissal.

☐ Appointments that are no-showed or canceled with less than 24 hours notice may be subject to a $50 fee. This charge does not apply to cancellations due to illness or injury. More than 3 missed appointments may lead to dismissal from the practice.

☐ I agree to receive appointment confirmations and reminders via email and/or text message. It is my responsibility to notify the front desk if I do not wish to receive appointment confirmations or reminders.

☐ One parent or guardian may accompany or escort a child into the treatment room **(treatment room is used for completing restorative dentistry such as fillings, crowns, etc.)**. It may become necessary that all parents be asked to stay in the waiting area. This decision will be at the discretion of the doctor to aid in creating a positive experience for your child. Absolutely no siblings or other children will be allowed in the **treatment room.**.

☐ Disrespectful behavior of any type, including physical or verbal abuse, by or to patients, parents, or staff will not be tolerated. This includes interactions over the phone, and disrespectful treatment of Sweet Tooth property. Disrespectful behavior includes and is not limited to profanity, yelling, or derogatory remarks relating to gender, age, race or sexual orientation.

☐ After-hours calls are reserved for patients of record only.

☐ All dental emergencies will be screened for urgency. It is the discretion of the doctor to decide if a patient should be seen immediately or if the patient can be regularly scheduled.

☐ Creating a positive experience is of utmost importance. Refrain from using words such as “shot”, “hurt”, “needle”, “scary” or “drill”.

☐ Dentistry is not an exact science. Clinical success relies mainly on creating good habits at home. No warranties or guarantees are made as a result of dental procedures.

☐ I understand that Sweet Tooth Pediatric Dentistry, LLC (“STPD”) considers the safety and security of their employees and patients of the utmost importance. This form acknowledges that you understand and agree to STPD’s policies on closed-circuit video surveillance, including 24/7 video monitoring of common areas (waiting rooms and open bays). My signature on this form acknowledges consent and agreement to STPD’s recording and monitoring of video.

☐ Supervise your children while in the office. The office is not liable for injuries occurring in the play areas or if your children climb or play on objects such as dentist chairs or cabinets.

☐ Treatment plans are updated with an exam and radiographs every six months. Uncompleted treatment plans may lead to swelling, pain or hospitalization. Every effort will be made to get your child's treatment completed in a timely manner. Treatment that is left incomplete due to patient or parent compliance will be subject to review and possible dismissal.

☐ Patients referred for treatment will need an exam, and in some cases, radiographs. Treatment plans may differ from what was referred based on professional opinion or patient behavior. Same-day treatment may not be possible and should not be expected.

☐ Parent or guardian is required to be at the patient's initial visit. For all other visits, written permission by the guardian for another adult to bring the patient must be given. The guardian must be available by phone during the duration of the appointment.

☐ In efforts to reduce its exposure in the environment, amalgam ("silver fillings" or "mercury fillings") is not used in this office. As a superior material, composite ("white fillings") is used in all cases. Please do keep in mind that your insurance may downgrade compensation for this and you may be responsible for the balance.

☐ All patients are seen on an appointment basis. Please call to reserve appointment times. We make every effort to stay on time for our scheduled patients and ask for the same courtesy in making and arriving at appointments. Patients who arrive more than 10 minutes late to an appointment may need to be rescheduled.

☐ The specialty of pediatric dentistry has a scope that limits the procedures that can be completed. Procedures outside the scope of pediatric dentistry include endodontics ("root canals"), deep cleanings, surgical extractions, adult crowns, extensive treatment on adult teeth, and dentures. If your child requires these types of procedures, or if the dentist feels necessary, they will be graduated from this office to be seen by the appropriate provider.

☐ No food, drinks or gum allowed in treatment areas.

☐ No photos or video recording in **treatment** areas. Ask for permission before taking photos with any staff member.

Printed Name Signature Date

SWEET TOOTH PEDIATRIC DENTISTRY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

By signing below I am acknowledging that I have received a copy of this office's Notice of Privacy Practices.

_____

Printed Name

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please specify below)

_____