pediatric dentistry & orthodontics

No Show and Missed Appointments Policy

When our office schedules your appointment, we reserve a dedicated chair and time slot just for you. Our policy is that if you must reschedule your appointment that you must provide us with at least 24-hours' notice. This courtesy makes it possible to give your reserved time slot to another patient in need.

****** Three (3) cancellations or missed appointments will result in loss of future appointment privileges. You will be charged a $25.00 missed appointment fee pre appointment. If they are multiple children at once they will no longer be able to be booked together. If there are late afternoon appointments, you will only be booked in the morning. Too many missed or canceled appointments may lead to dismissal from our office.***

Every patient in our practice receives this unique reservation. When your appointment is made, a time is reserved, materials ordered, and we make special arrangements to be ready for your visit.

Parent / Guardian Policy

A legally responsible parent or guardian must be present for all dental appointments. If someone other than the parent or legal guardian accompanies your child to their visit, then you must have first signed a non-parental consent form. If we do not have one on file at time of service, we may be obligated to reschedule the appointment. Certain types of visits require the parent or legal guardian including but not limited to dental extractions, sedation and first-time visits

I have read the above Appointment policy and am signing to ensure my understanding of this policy.

Print name Signature Date

1 Lake Street #203
New Britain, CT 06052

860-224-2419
info@kids-dentistry.com

www.kids-dentistry.com

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NEW PATIENT FORMS

Doctor Signature: _____ Date: _____

PATIENT

Date _____ How did you hear about our office? _____

Patient's Last Name _____ First Name _____ Middle Initial _____
Prefers to be called _____ Birth date _____ Sex
□Male □Female
Home address _____ City, State, Zip
_____
Home phone (____)_____-_____ Cell phone (____)_____-_____ Email Address:
_____

RESPONSIBLE PARTY
Custodial parent(s) name(s)
_____
Patient lives with (check all that apply) □Mother □Father □Stepmother □Stepfather □Grandparents □Other
_____
Parent/Guardian's full name _____ Title: □Mr. □Dr. □Other
_____
Address (*if different than patient*) _____
DOB:_____
Home phone (_____) _____-_____ Cell phone (_____) _____-_____
Email Address: _____
Parent/Guardian's full name full name _____ Title: □Mrs. □Ms. □Dr. □Other _____
Address (*if different than patient*) _____
DOB:_____
Home phone (_____) _____-_____ Cell phone (_____) _____-_____
Email Address: _____
Parent's Marital Status: □ Married □ Divorced □ Separated □ Widowed □ Single

DENTAL INSURANCE
Primary policy holder's full name _____ DOB
_____ Relationship to patient _____ Insurance Company
_____ Subscriber / Member ID # _____ Social Security # _____
Group Name _____ Group # _____

Secondary policy holder's full name _____ DOB
_____ Relationship to patient _____ Insurance Company
_____ Subscriber / Member ID # _____ Social

Security # _____
Group Name _____ Group # _____

PHYSICIAN
Patient's primary care physician _____ City, State

Last seen _____ Reason _____ Next appt

Most recent physical exam _____

Please list any specialists your child has seen (i.e. cardiologist, ENT, etc.)
Name _____ City, State

Reason

DENTAL HISTORY
Reason for today's visit

Do you have any concerns about your child's teeth?

Previous/General Dentist: _____
Is this your child's first visit to the dentist? □YES □NO
If no, when was the last visit and what was done? _____
Do you expect your child to be a cooperative patient? □YES □NO If no, please explain:

Has your child bumped any teeth? □YES □NO If so, when?

Has your child has a history of headaches, pain, popping or clicking of the jaws? □YES □NO
Does your child have a nighttime bottle? □YES □NO Does your child have a toothache? □YES □NO

Does your child have or has he/she had any of the following problems/habits?
□ Thumb Sucking How long? _____ Still active? □ YES □ NO
□ Finger Habit How long? _____ Still active? □ YES □ NO
□ Pacifier How long? _____ Still active? □ YES □ NO
How often does your child brush? _____
Is tooth brushing supervised? □YES □NO Is dental floss used? □YES □NO
Does your child receive: □Fluoride tablets/drops □Bottled water □Fluoridated water (tap water) □Well water □Fluoride in vitamins

MEDICAL HISTORY

Is your child in good health? □YES □NO
If no, please explain: _____

Is your child being treated by a physician at this time? □YES □NO

If yes, please explain: _____
Does your child have any allergies? □YES □NO
If yes, please explain: _____
Is your child taking any medications at this time? □YES □NO
If yes, list: _____
Has your child ever been hospitalized or treated in an emergency room for any particular trauma? □YES □NO
If yes, please explain: _____

Has your child ever had any surgeries? □YES □NO
If yes, please explain: _____
Have your child's tonsils and/or adenoids been removed? □YES □NO

Does your child snore? □YES □NO
Does your child breathe through the mouth? □YES □NO If yes: □Seldom □Often

Please indicate if your child has had any of the following:

□Anemia/Sickle Cell	□Bleeding Disorder	□Heart Ailment or Murmer
□Congenital Heart Defect	□Rheumatic Fever	□High Blood Pressure
□Asthma	□Cystic	□Tuberculosis
□Pneumonia	□Diabetes	□Endocrine Disorder
□Gastrointestinal Disorders/GERD	□Bone Disorders	□Arthritis
□Physical	□Malignancies/Leukemia/Tumor	□Radiation/Chemotherapy
□Kidney Problems	□Liver Problems/Hepatitis	□Positive for HIV/AIDS
□Cleft Palate/Lip	□Herpes	□Epilepsy/Seizures
□Speech Delay	□Vision/Hearing Impairment	□Intellectual Disability
□Special Needs	□Hyperactivity/ADD/ADHD	□Autism/Asperger's Syndrome
□Latex Allergy/Sensitivity		

Additional Comments or other medical concerns:

_____

RELEASE AND WAIVER

I attest that the information I have provided on this form is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status.
Parent/Guardian Signature _____ **Date** _____

I authorize release of any information regarding my child's dental treatment to my dental and/or medical insurance company.
Parent/Guardian Signature _____ **Date** _____

I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my dentist/staff of any changes in my child's medical or dental health.
Parent/Guardian Signature _____ **Date** _____

Medical Photography Consent
I consent to digital photographs and x-ray images of my child to be used exclusively within their medical record for the purposes of identification and dental treatment.

Dental Cleaning and Fluoride Treatment
I authorize the Dentist and/or his staff members to clean my child's teeth today. I understand that the application of fluoride is part of the standard of care for children and helps prevents cavities.

Dental Sealants and Restorations
I authorize the Dentist and/or his staff members to perform sealants and restorations including composite fillings, amalgam fillings, stainless steel crowns and space maintainers as part of comprehensive dental care. Any invasive procedures will obtain a separate consent.

pediatric dentistry & orthodontics

A LEGAL GUARDIAN FOR THE CHILD MUST COMPLETE THIS FORM.

REQUEST AND CONSENT FOR DENTAL TREATMENT

Please read this form *carefully*. If you do not understand something to your satisfaction, please ask questions. We will be pleased to explain it.

1. I request and authorize the dental treatment by the doctor(s) and staff at Pediatric Dentistry & Orthodontics.

   Patient Name: _____

2. I am the legal guardian of the child named above. **Initials** _____

3. I request and authorize the following dental procedures to be done for my child:

☐ Comprehensive dental examination ☐ Radiographs (X-Rays), ☐ Prophylaxis (dental cleaning), ☐ Fluoride application, ☐ Restorations (fillings), ☐ Stainless steel crowns, ☐ Extractions, ☐ Nitrous Oxide (Laughing gas) ☐ Space maintainers.
☐ Pulp treatment (root canal treatment, pulpotomy, pulp cap, pulpectomy)
☐ Sealants

4. I further request and authorize the re-taking of dental x-rays if needed and the use of such local anesthetics as may be considered necessary to treat my child's dental need(s).

5. I have had explained to me by the dentists and staff, and have had sufficient opportunity to discuss the patient's dental condition/problem(s), the planned procedures and treatment, and the benefits to be reasonably expected from this treatment plan, compared with alternative approaches and/or no treatment.

6. It is unusual for any of the following risks or complications to occur. These risks or complications include but are not limited to, 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.

7. **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 acknowledge that no guarantees have been made to me concerning the results of the dental treatment that the patient receives in our office.

8. **I understand** it is the goal of this dental office to accomplish dental treatment by the use of warmth, friendliness,

persuasion, humor, charm, gentleness and kindness and understanding. **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.

9. **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) and or doctor to hold the patient's hands, stabilize the head and/or control leg movements for their safety. I also understand the routine use of "tooth pillows" (mouth props) may be necessary to be sure a child does not accidentally close their teeth while an instrument is in their mouth that could harm them. I also understand that mouth props are sometimes necessary if a child refuses to open their mouth.

   Initials _____

10. **I understand** that it is not an uncommon response for children to cry before or during dental treatment or directly afterward when they see their parent. **I understand** the only way I can guarantee my child will not cry or be unhappy during dental treatment is if I elect to have their treatment completed in the operating room under general anesthesia.

11. **I further understand** that should the patient become uncooperative during dental procedures with excessive body movements, or is not able to tolerate the procedure, the treatment would be stopped and alternate treatment plan will be discussed.

12. All of my questions have been answered to my satisfaction and I consent to the treatment and procedures prescribed for the patient on the treatment plan.

13. **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.

14. **I confirm** that I am a legal guardian to the child referenced on the opposite page. **I also 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 Person Consenting to Treatment — Date

_____ _____

Interpreter or Witness — Date

_____ _____

Drugs and Medication
I understand that antibiotics, analgesics and topical compounds can cause allergic reactions even with no prior known history. Allergic reactions can cause redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock. I have informed the dentist, to the best of my knowledge, of any adverse reactions my child has had.

_____ I hereby authorize the dentists and staff at Simply Dental and Orthodontics to perform diagnostic aids including an examination, x-rays, photographs, models, cleaning and fluoride treatment, when necessary, as the standard of care to properly diagnose and record any and all dental conditions.
_____ I understand that by signing below I authorize the following procedures to be performed as deemed necessary by the dentist and have read and understand the possible risks and complications of each procedure. I understand that all of the above treatments are the standard of care in pediatric dentistry. It is my responsibility to inform the staff during the registration process if I choose to decline any of the above treatments.
_____ I authorize the Dentist and/or his staff to release any information including the diagnosis and the records of any treatment or exam rendered to my child during the period of such dental care to third party payors, health practitioners and as required by law.

Patient Name	Date
Patient/Parent Signature	Relationship to Patient

Photography Consent
I consent to having my child's photo taken and displayed in the office as part of contests or bulletin boards. I consent to having my child's photo taken and posted as part of online social media including, but not limited to: the office website and blog, Facebook and Instagram. **Check one:** □ I Consent □ I Do Not Consent

Parent / Guardian Policy
I acknowledge a legally responsible parent or guardian must be present for all dental appointments. If someone other than the parent or legal guardian accompanies your child to their visit we may be obligated to reschedule the appointment. If advance notice is given (at least 48 hours) and we can obtain the necessary paperwork prior to the scheduled visit, we may accommodate your needs on a case by case basis. Certain types of treatment visits (including sedation and dental extractions) always require a parent or legal guardian to be present for the entirety of the visit.

Patient Name	Date
Parent / Guardian Signature	Relationship to Child

Financial Policies

_____ **I understand that payment is expected on the date services are provided.** The parent or guardian who brings the child is responsible for payment, regardless of what a divorce decree may state. **Reimbursements must be made amongst the divorced parties and cannot involve the office.**

_____ I assume financial responsibility for all dental treatment and medications provided for my child. I **understand that I am financially responsible for all charges for services rendered whether or not it is covered by my insurance, all broken appointment fees and all late payment services charges.**

_____ 60 days is the most we can wait for your insurance company to pay your account balances. After this time, we will need you to pay any remaining balances. We will gladly refund you for any overpayments that occur after you have paid your bill.

_____ Insurance plans can vary greatly and some companies select certain services that they will not cover. **I understand that obtaining insurance coverage and benefit information is my responsibility and not the responsibility of Simply Dental and Orthodontics.**

_____ I authorize my insurance company to pay Simply Dental and Orthodontics all insurance benefits otherwise payable to me for services rendered. I also authorize the use of this signature on all insurance submissions.

_____ You give us permission to check your credit and employment history and to answer questions about your credit experience with us. We have the option to report your account status to any credit-reporting agency such as a credit bureau. You understand if this account is submitted to an attorney or collection agency of if we have to litigate in court, of if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

_____ There is a fee (currently $35) for any check returned by the bank. A finance charge will be imposed on each item of your account which has not been paid within ninety (90) days of the time the item was added to the account. The FINANCE CHARGE will be computed at the rate of (1.0%) per month or an ANNUAL PERCENTAGE RATE of twelve (12%) percent. The finance charge on your account is computed by applying the periodic rate (1.0%) to the overdue balance of your account. The "overdue balance" of your account is calculated by taking the balance owed ninety (90) days ago, and then subtracting any payments or credits applied to the account during that time.

This consent is to remain in effect from the date indicated until canceled in writing. **Please contact us if you make any changes to your dental coverage, so that we may keep accurate and current records of your account.**

Patient Name	Date
Parent / Guardian Signature	Relationship to Patient