MOBILE PREMIER PEDIATRIC DENTISTRY

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251-342-3323 www.MobileKidsDentist.com

Welcome!

We would like to welcome you to our practice. Our goal is to make every child's visit to Mobile Premier Pediatric Dentistry a pleasant and enjoyable experience. Please take a moment to complete each section of this form to help us provide the best possible treatment for your child.

Tell us about your child

Child's Name: _____

Childs' Preferred Name: _____

Date of Birth: _____ SSN: _____

School: _____

Hobbies: _____

Whom may we thank for referring you? _____

Is this your child's first visit to a dentist? Yes/No

If not, who is their previous dentist? _____

Date of last cleaning: _____ Date of last x-rays: _____

Are there any injuries to your child's teeth or jaws? Yes/No

If yes, please explain: _____

_____

How often does your child brush? _____

Is tooth brushing supervised? Yes/No Is dental floss used? Yes/No

Does your child receive any of the following?

- ○ fluoride in vitamins
- ○ fluoride in tablets or drops
- ○ fluoridated water
- ○ bottled water
- ○ well water

Does your child have a history of any of the following?

- ○ Bottle habits
- ○ Pacifier
- ○ Dental Grinding
- ○ Pain in any of their teeth
- ○ Breast feeding
- ○ Thumb Sucking
- ○ Tongue Thrust
- ○ Excessive Gagging
- ○ Prolonged bleeding after an extraction
- ○ Bleeding gums bleed while flossing or brushing
- ○ Oral hygiene instruction regarding the care of their teeth and gums

Does your child require premedication antibiotics? Yes/No

Responsible Party *(must be present at first appointment)*

Name: _____

Relationship to the child:_____

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

Are you married to the parent of this child? Yes/No

Are any other family members current patients? Yes/No

Address: _____

_____

Home #: _____ Work #: _____

Cell #: _____ Email: _____

Date of Birth: _____ SSN: _____

Primary Dental Insurance

Policy Holders Name: _____

Date of Birth: _____ SSN: _____

Employer: _____

Insurance Company Name: _____

Group Number: _____ Member ID: _____

Secondary Dental Insurance

Policy Holders Name: _____

Date of Birth: _____ SSN: _____

Employer: _____

Insurance Company Name: _____

Group Number: _____ Member ID: _____

Mother's Information

Name: _____

Relationship to the child: Mother/Stepmother/Grandmother

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

Are you married to the parent of this child? Yes/No

Are any other family members current patients? Yes/No

Address: _____

_____

Home #: _____ Work #: _____

Cell #: _____ Email: _____

Date of Birth: _____ SSN: _____

Father's Information

Name: _____

Relationship to the child: Father/Stepfather/Grandfather

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

Are you married to the parent of this child? Yes/No

Are any other family members current patients? Yes/No

Address: _____

_____

Home #: _____ Work #: _____

Cell #: _____ Email: _____

Date of Birth: _____ SSN: _____

Signature of Responsible Party

Mobile Premier Pediatric Dentistry strives to provide each patient individual treatment that will promote excellent oral care. As a result there may be certain routine services that we feel are necessary to maintain proper oral health that your insurance company may not cover. As a courtesy we will file your dental insurance. In the event that your dental insurance company does not remit payment to Mobile Premier Pediatric Dentistry within 60 days, you agree to pay the pending insurance balance in full and contact your dental insurance company directly for reimbursement of payment. Payment of the patient's portion is due at the time of the appointment. If your insurance company does not accept assignment of benefits from our office, you will be required to pay your full balance at the time of service and your insurance company will reimburse you directly. By signing below you authorize Dr. Maureen T. Baldy to file and assign benefits, if any, otherwise payable to you for services rendered. In additions, you authorize the use of this signature for submission of any insurance claims whether manual or electronic.

Mobile Premier Pediatric Dentistry does not offer payment plans. We accept cash, check, Visa, Master Card, Discover, American Express, and Care Credit as forms of payment. There is a returned check fee of $30 per transaction. Any balance unpaid after 90 days will be turned over to a collection agency. At that time you will be liable for your past due balance, collections fees, and any other fees necessary to collect your past due balance.

I/we agree that if our balance becomes delinquent, defined as 90 days past due, and is referred to a collection agency or attorney, we shall be responsible for collection fees equal to 33 1/3% of the balance due in addition to the balance. We further understand and agree that if legal action is taken to collect the balance, we shall also be responsible for all court costs. We hereby waive our rights under the laws and constitution of Alabama to exempt our personal property from executions. _____ (initials)
_____ (initials)

In the event my account becomes more than sixty days past due, I authorize Mobile Premier Pediatric Dentistry, and any of its officers, agents or employees, to request a credit report on me. I also understand any past due balances may be reported to one or all of the national credit bureaus. I also authorize Mobile Premier Pediatric Dentistry, and any of its officers, agents, or employees to contact me by phone, cell phone, text message, email, or any other universally used modes of communication as needed to confirm appointments, provide essential treatment information or secure payment of outstanding past due balances.

Signature: _____ Date: _____

I have read and understand the above policy regarding insurance and payment requirements and agree to comply as the responsible party.

Consent for Treatment

The information that I have provided is true and correct to the best of my knowledge and will be held in the strictest of confidence. It is my responsibility to inform this office of any changes in my child's medical status. By signing below, I authorize the dental staff at Mobile Premier Pediatric Dentistry to perform dental services on my child. I understand that all fees are due at the time of service. I also understand that any appointment that is not cancelled within 24 business hours will be considered broken. After the second broken appointment I may be charge a broken appointment fee.

Signature: _____ Date: _____

Thank you for choosing us. We appreciate your confidence in our practice.

Patient Medical Questionnaire

Patient's Name: _____ **Date of Birth:** _____ **Gender: Male/Female**

Primary Physician's Name: _____ **Phone:** _____

Is the patient being treated by a physician at this time? ..... Yes/No

Is the patient currently taking any medication (prescription or over the counter)? If yes, please list ..... Yes/No

_____

Has the patient had any illness, allergic reaction, or medical emergency within the past year? If yes, please list ..... Yes/No

_____

Has the patient ever had a reaction to any type of anesthetic? ..... Yes/No

Has the patient ever had a reaction or allergy to an antibiotic, sedative, or other medication? If yes, please explain ..... Yes/No

_____

Is the patient allergic to latex, metals, acrylic, or dyes? ..... Yes/No

Has the patient ever been hospitalized, had surgery or a significant injury, or been treated in an emergency room? ..... Yes/No

Is the patient current on immunizations against childhood disease? ..... Yes/No

Please check any conditions that apply and explain.

- ◊ Premature Birth
- ◊ Birth Defects
- ◊ Syndromes
- ◊ Inherited Condition
- ◊ Sinusitis
- ◊ Chronic Tonsil/Adenoid Infections
- ◊ Sleep Apnea
- ◊ Mouth Breather
- ◊ Excessive Gagging
- ◊ Heart Defects/Disease
- ◊ Heart Murmur
- ◊ Rheumatic Fever
- ◊ High Blood Pressure
- ◊ Asthma
- ◊ Reactive Airway Disease
- ◊ Wheezing/Breathing Problems
- ◊ Cystic Fibrosis
- ◊ Pneumonia
- ◊ Frequent Colds
- ◊ Exposure to Tobacco Smoke
- ◊ Jaundice
- ◊ Hepatitis
- ◊ Liver Problems
- ◊ Reflux
- ◊ Stomach Ulcers
- ◊ Intestinal Problems
- ◊ Lactose Intolerant
- ◊ Food Allergies
- ◊ Dietary Restrictions
- ◊ Prolonged Diarrhea
- ◊ Unexplained Weight Loss
- ◊ Eating Disorder
- ◊ Bladder or Kidney Problems
- ◊ Arthritis
- ◊ Scoliosis
- ◊ Rash, Hives, or Eczema
- ◊ Impaired Vision
- ◊ Impaired Hearing
- ◊ Impaired Speech
- ◊ Developmental Disorder
- ◊ Learning Problems
- ◊ Mental Retardation
- ◊ Cerebral Palsy
- ◊ Epilepsy
- ◊ Autism
- ◊ Frequent Headaches or Migraines
- ◊ ADD/ADHD
- ◊ Behavioral or Emotional Problems
- ◊ Abuse or Neglect
- ◊ Diabetes
- ◊ Hypoglycemia
- ◊ Hormone Problems
- ◊ Thyroid Problems
- ◊ Anemia
- ◊ Sickle Cell Disease
- ◊ Blood Disorder
- ◊ Hemophilia
- ◊ Bruises Easily
- ◊ Excessive Bleeding
- ◊ Blood Transfusions
- ◊ Cancer
- ◊ Tumors
- ◊ Chemotherapy
- ◊ Radiation Treatments
- ◊ Bone Marrow Transplant
- ◊ AIDS/HIV

Medical Questionnaire Continued

What is your primary concern for the patient's oral health?_____

How would you describe the patient's oral health? Excellent Good Fair Poor

Is there a family history of cavities? Yes/ No

Does the patient have a history of any of the following? If yes, please describe.

Inherited dental characteristics	Yes/No	Mouth sores or fever blisters	Yes/No
Bad Breath	Yes/No	Bleeding Gums	Yes/No
Cavities/decayed teeth	Yes/No	Toothaches	Yes/No
Injury to teeth/ mouth/Jaw	Yes/No	Clinching/Grinding	Yes/No
Jaw joint problems	Yes/No	Excessive Gagging	Yes/No
Sucking Habit after 1 year of age	Yes/No		

Does the patient eat regularly 3 times per day? Yes/No

Is the patient on a special or restricted diet? Yes/No

Is patient a picky eater? Yes/No

Does the patient have a diet high in sugars or starches? Yes/No

Do you have any concerns about the patients weight? Yes/No

How frequently does the patient have the following?

Candy or other sweets	Rarely	1-2 times daily	3 or more daily	Product: _____
Chewing gum	Rarely	1-2 times daily	3 or more daily	Product: _____
Snacks between meals	Rarely	1-2 times daily	3 or more daily	Product: _____
Soft drinks	Rarely	1-2 times daily	3 or more daily	Product: _____
Juice or flavored drinks	Rarely	1-2 times daily	3 or more daily	Product: _____

Please note other significant dietary habits: _____

Doe the patient participate in sports activities? Yes/No If so, what type: _____

Does the patient wear a mouth guard during these activities? Yes/No If yes, what type? _____

Has the patient been treated for orthodontic care? Yes/No If so, by whom and when? _____

Does the patient become anxious at dental appointments? Yes/No

Has the patient been given sedation medication for dental appointments before? Yes/No If so, what type? _____

How do you anticipate the patient will respond to their dental visit? Very Well Fairly Well Somewhat poorly Very poorly

Is there anything else we should know before treating this patient? _____

_____

_____

_____

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HIPPA PATIENT ACKNOWLEDGMENT AND CONSENT

I have received the Notice of Privacy Practices containing a complete description of the uses and disclosures of my health information and have had an opportunity to read and review all contents of said document.

By signing this form, you will consent to our use and disclosure of you protected health information to carry our treatment, payment activities, and health care operations.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. These changes may apply to any of your protected health information that we may obtain.

You have the right to revoke this consent at any time by giving us written notice of your revocation. Please understand that revocation of this consent will not affect the action we have or will take in reliance to this consent before we received your revocation, and that not signing this consent or by revoking such consent in the future, we may reserve the right to refuse treatment.

Patient Name:_____

Parent or Guardian Signature: _____

Date: _____

If a personal representative on behalf of this patient signs this consent, or is appointed by you as the patient to have shared knowledge of treatment, payment activities, and health care options, please fill out the following information.

Personal Representative's Name:_____

Relationship to patient:_____

Mobile Premier Pediatric Dentistry Informed Consent for Patient Management Techniques and Acknowledgement Receipt of Information

State law requires health professionals to provide their prospective patients with information regarding the treatment or procedures they are contemplating. State law also requires us to obtain your consent for any specific dental treatment, procedures or techniques, which might be considered to be of concern to the patient or parent. Informed consent indicates your awareness of sufficient information to allow you to make an informed personal choice concerning your child's dental treatment after considering the risks, benefits, and alternatives.

Please read this form carefully and ask about anything you do not understand. We will be pleased to explain it.

It is our intent that all professional care delivered in our dental operatories shall be of the best possible quality we can provide for each child. Providing a high quality care can sometimes be made very difficult or even impossible, because of the lack of cooperation of some child patients. Among the behaviors that can interfere with the proper provision of quality dental care are: hyperactivity, resistive movements, refusing to open the mouth or keep it open long enough to perform the necessary dental treatment, and even aggressive or physical resistance to treatment, such as kicking, screaming, and grabbing the dentist's hands or the sharp dental instruments.

There are several behavior management techniques that are used by pediatric dentists to gain the cooperation of child patients to eliminate disruptive behavior or prevent patients from causing injury to themselves due to uncontrollable movement. The more frequently used pediatric dentistry behavior management techniques are as follows:

1. Tell-Show-Do: The dentist or assistant explains to the child what is to be done using simple terminology and repetition and then shows the child what is to be done by demonstrating with instruments on a model or the child's or dentist's finger. Then the procedure is performed in the child's mouth as described. Praise is used to reinforce cooperative behavior.

2. Positive reinforcement: This technique rewards the child who displays any behavior, which is desirable. Rewards include compli ments, praise, a pat on the back, a hug or a prize.

3. Voice control: The attention of a disruptive child is gained by changing the tone or volume of the dentist's voice.

4. Mouth props: A rubber or plastic device is placed in the child's mouth to prevent closing when a child refuses or has difficulty main taining an open mouth.

5. Papoose Boards and Pedi-Wraps: These are restraining devices for limiting the disruptive child's movements to prevent injury and to enable the dentist to provide the necessary treatment. The child is wrapped in these devices and sits in a reclined dental chair.

6. General anesthesia: The dentist performs the dental treatment with the child anesthetized in the hospital operating room. Your child will not be given general anesthesia without you being further informed and obtaining your specific consent for such procedure.

7. Nitrous Oxide: Nitrous Oxide may be provided for your child. The patient does not become unconscious.

Mobile Premier Pediatric Dentistry Informed Consent for Patient

Management Techniques and Acknowledgement Receipt of Information

The listed pediatric dentistry behavior management techniques have been explained to me. Alternative techniques for treatment, if any, have also been explained to me. Alternative techniques for treatment, if any, have also been explained to me, as have the advantages and disadvantages of each.

I hereby authorize and direct Dr. Maureen T. Baldy, to utilize the behavior management techniques listed on the reverse side of this form to assist in the provision of the necessary dental treatment for:

_____, my child/ren or legal ward, with the exception of: (If none, so state) _____

_____

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 my child's treatment. **I further understand that this consent shall remain in effect until terminated by me.**

Date: _____/_____/_____ Time: _____:_____ a.m. / p.m.

Patient's Names:

_____

Signature of Parent or Guardian:

_____

Relationship to Patients:

_____

Witness:_____