Northampton Pediatric Dentistry PC

TELL US ABOUT YOUR CHILD

Child's Name:_____

Goes by:_____ Gender: _____

Siblings that we treat:_____

_____

Child's Birthdate: ____/____/_____ Child's Age:_____

Child's Home Address:_____

City:_____ State:_____ Zip:_____

PARENT'S INFORMATION

Name:_____

Mother Father Grandparent Other_____

Parent's Address:_____

City:_____ State:_____ Zip:_____

Cell #:(____)_____Home #:(____)_____

Employer:_____

Occupation:_____

Email Address:_____

PARENT'S INFORMATION

Name:_____

Mother Father Grandparent Other_____

Parent's Address:_____

City:_____ State:_____ Zip:_____

Cell #:(____)_____Home #:(____)_____

Employer:_____

Occupation:_____

Email Address:_____

PRIMARY DENTAL INSURANCE

Insurance Co Name:_____

Insurance Co. Address:_____

_____

Insurance Co Phone #: (_____)_____

Group #:_____Policy #:_____

Subscriber's Name:_____

Relationship to Patient:_____

Employer:_____

Subscriber's Birthdate: _____/_____/_____

Subscriber's SSN:_____-_____-_____

SECONDARY DENTAL INSURANCE

Insurance Co Name:_____

Insurance Co. Address:_____

_____

Insurance Co Phone #: (_____)_____

Group #:_____Policy #:_____

Subscriber's Name:_____

Relationship to Patient:_____

Employer:_____

Subscriber's Birthdate: ____/____/____

Subscriber's SSN:_____-_____-_____

The parent or guardian who brings the child to the appointment is responsible for payment on the day service is rendered, unless prior arrangements have been made.

Please initial_____

264 Elm Street, Suite 5, Northampton, MA 01060 | 413-584-7773
23 Pray Street, Amherst, MA 01002 | 413-835-0310
mail@npdma.com | www.npdma.com

Child's name:_____

DENTAL HISTORY

Is this your child's first visit to the dentist? *YES NO*

If not, how long since the last visit?_____

Previous dentist's name:_____

Were any x-rays taken at previous dental visits? *YES NO*

Have there been any injuries to the teeth, face or mouth?_____

If yes, please explain:_____

_____

_____

Does the child have any of the following habits?

YES NO Lip Sucking/ Biting *YES NO* Nail Biting

YES NO Nursing/Bottle Habits *YES NO* Thumb/Finger Sucking

Has the child ever had a serious or difficult problem with previous dental work? *YES NO*

If yes, please explain:_____

_____

_____

Is the child's water fluoridated? *YES NO*

Is the child taking fluoride supplements? *YES NO*

Please describe any family history of dental treatment:_____

_____

_____

Is your child wearing Orthodontic Braces? *YES NO*

PHARMACY INFORMATION

Pharmacy Name:_____

Pharmacy Address:_____

_____

HEALTH HISTORY

Has the child ever had any of the following conditions?

Y N ADHD	Y N Anxiety Disorder
Y N Asthma	Y N Autism Spectrum
Y N Bleeding Disorder	Y N Cancer
Y N Developmental Delays	Y N Diabetes
Y N Digestive Issues	Y N Epilepsy or Seizures
Y N Hearing Impairment	Y N Heart Condition
Y N Hepatitis	Y N History of Surgery
Y N HIV Positive/AIDS	Y N Respiratory Disorder
Y N Rheumatic Fever	Y N Sensory Disorder
Y N Vision Impairment	Y N Other

If yes to any of the above questions, please provide additional details:_____

_____

_____

_____

Does your child have any allergies to food or medication?

YES NO

If yes, please specify:_____

_____

Please list all medications, over the counter and herbal supplements taken by your child: _____

_____

_____

Child's Physician:_____

Phone #: (_____)_____

PLEASE BE ADVISED THAT WE DO REQUIRE 24-HOUR NOTICE TO CANCEL OR RESCHEDULE APPOINTMENTS. THERE WILL BE A $40 CHARGE IF WE DO NOT RECEIVE 24-HOUR NOTICE

Parent/Guardian Signature:_____ **Relationship:** _____

INFORMED CONSENT FOR PEDIATRIC DENTISTRY

It is your right, as a parent, to understand the risks, benefits, and alternatives of your child's dental treatment, and to accept or refuse treatment offered to your child. Please read this form carefully and ask about anything you do not understand.

EXAMINATION

Every child is a unique individual and thus not every child will require the same treatment to obtain a comprehensive oral examination. Based upon your child's age, teeth present, and tooth position, Dr. Marie Tremblay and Dr. Europa Yang and staff will determine if radiographs (x-rays) are necessary. In general, the examination appointment also includes cleaning of the teeth and application of topical fluoride. If you have any questions or concerns about our examination procedure, please ask one of our staff.

TREATMENT

If your child should need any dental treatment after the dental examination has been completed, Dr. Marie Tremblay and Dr. Europa Yang will review the planned treatment with you. Please read the following information regarding dental treatment at our office.

It is our policy that all treatment options are explained to the parent(s), including treatment alternatives, advantages, and disadvantages of each. Although good results are expected, it is not possible to guarantee success due to the possibility of complications.

Risks that are occasionally associated with dental treatment procedures include: numbness, swelling, bleeding, soreness, tooth discoloration, nausea, vomiting, hyperventilation, fainting, allergic reactions and infection.

If my child requires dental treatment, I will be advised of the benefits, risks, and possible side effects of proposed treatment, and possible consequences of not receiving the treatment. Treatment alternatives, including no treatment, will be presented to me and all of my questions regarding my child's care will be answered satisfactorily. With my signature I authorize Northampton Pediatric Dentistry, PC to perform a dental exam of my child and agreed upon treatment. I acknowledge that I have reviewed the possible risks and complications associated with dental treatment.

Patient Name:_____ DOB:_____

Parent/Guardian Signature:_____ Date:_____

Witness Signature:_____ Date:_____

Email: _____

Northampton Pediatric Dentistry, PC

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient giving consent

Patient's Name: _____

Section B: To the Patient – Please read the following statements carefully.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice is available to you upon request. We encourage you to read it carefully and completely before signing this Consent.

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. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to: Europa Yang, DMD and Marie Tremblay, DMD. Please understand that revocation of this Consent will not affect any action we took in reliance on the Consent before we received your revocation, and we may decline to treat you or to treat you or to continue treating you if you revoke this Consent.

Patient Representative's Name: (Please Print Name)

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Relationship to Patient: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse to Sign This Acknowledgement**

I, _____, have read a copy of this office's Notice of Privacy Practices. (Please Print Name)

Signature: _____ Date: _____