Northampton Pediatric Dentistry New Patient Information

To be filled in ONLY by a custodial parent or guardian of the child.
We require these forms to be completed and returned 24 hours ahead of appointment.
Please completely fill in all fields. If a field is not applicable, please enter "N/A". In accordance with HIPAA and our office policy, all information provided is kept completely confidential and can only be shared with a signed release. Please see our administrative team if you have any questions.

PATIENT

Full Name: _____ Date of Birth: _____ Current Age: _____

Legal Gender: _____ Preferred Pronouns: _____ Preferred Name: _____

Street Address: _____ City/State/Zip: _____

PRIMARY RESPONSIBLE PARTY

Please check all that apply: ☐ *Primary Caregiver* ☐ *Legal Guardian* ☐ *Non-Custodial Parent*
(Must check one) ☐ *Non-Custodial Caregiver* ☐ *Guarantor* ☐ *State Agency*

Full Name: _____ Date of Birth: _____

Relationship to patient: _____ Legal Gender: _____ Preferred Pronouns: _____
(If other than custodial biological parent, court documentation is required)

Street Address: _____ City/State/Zip: _____

Mailing Address: _____ City/State/Zip: _____

Primary Daytime Phone: _____ □*Mobile* □*Work* □*Other* Can we text this line? Y N

Secondary Phone: _____ □*Mobile* □*Work* □*Other* Can we text this line? Y N

Email: _____ Employer: _____

Occupation: _____ SSN: _____Primary Language: _____

SECONDARY RESPONSIBLE PARTY

Please check all that apply: ☐ *Primary Caregiver* ☐ *Legal Guardian* ☐ *Non-Custodial Parent*
(Must check one) ☐*N/A* ☐ *Non-Custodial Caregiver* ☐ *Guarantor* ☐ *State Agency*

Full Name: _____ Date of Birth: _____

Relationship to patient: _____ Legal Gender: _____ Preferred Pronouns: _____
(If other than custodial biological parent, court documentation is required)

Street Address: _____ City/State/Zip: _____

Mailing Address: _____ City/State/Zip: _____

Primary Daytime Phone: _____ □*Mobile* □*Work* □*Other* Can we text this line? Y N

Secondary Phone: _____ □*Mobile* □*Work* □*Other* Can we text this line? Y N

Email: _____ Employer: _____

Occupation: _____ SSN: _____Primary Language: _____

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PRIMARY DENTAL INSURANCE

Subscriber's Name: _____ ☐ *Check if patient has an individual policy*

Insurance Company: _____ Phone #: _____

Subscriber Date of Birth: _____Member ID#:_____Group #:_____

Subscriber SSN: _____Employer: _____

SECONDARY DENTAL INSURANCE ☐ *Check if not applicable*

Subscriber's Name: _____ ☐ *Check if patient has an individual policy*

Insurance Company: _____ Phone #: _____

Subscriber Date of Birth: _____Member ID#:_____Group #:_____

Subscriber SSN: _____Employer: _____

PRIMARY MEDICAL INSURANCE

Subscriber's Name: _____ ☐ *Check if patient has an individual policy*

Insurance Company: _____ Phone #: _____

Subscriber Date of Birth: _____Member ID#:_____Group #:_____

Subscriber SSN: _____Employer: _____

***We make every effort to check patient's eligibility and benefit level prior to treatment, however it is your responsibility to inform us of treatment rendered elsewhere and if there has been a change of benefit BEFORE each appointment.**

***Failure to do so may result in higher than expected out of pocket payments.**

PRIMARY MEDICAL CARE PROVIDER

Practice Name: _____ Phone: _____

Provider Name: _____ Years at practice: _____

Date of last physical exam: _____

PHARMACY

Pharmacy Name: _____ Phone: _____

Address: _____ Have you filled RXs here before? ☐ YES ☐NO

DENTAL HISTORY

Has your child ever seen a dentist before? □ **YES** □**NO**

If YES complete both sections, if NO complete <u>just</u> section B

A)

Previous dentist's name: _____ Date of last visit: _____

Were any x-rays taken? □ **YES** □**NO** Was treatment rendered? □ **YES** □**NO**

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

If yes, please explain: _____

_____

Has the patient ever visited an oral surgeon? □ **YES** □**NO** If yes, who? _____

Is the patient in the care of an orthodontist? □ **YES** □**NO** If yes, who? _____

B)

Have there been any injuries to the teeth, face, or mouth? □ **YES** □**NO**

If yes, please explain: _____

_____

Does the patient have any of the following habits? Thumb/Finger Sucking □ **YES** □**NO**

Lip Sucking/Biting □ **YES** □**NO** Nail Biting □ **YES** □**NO** Nursing/Bottle Habits □ **YES** □**NO**

Is the patient's water fluoridated? Is the patient taking fluoride supplements? □ **YES** □**NO**

Please describe any family history of significant dental treatment: _____

_____

MEDICAL HISTORY

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: _____

_____

(Medical History Cont.)

Has your child ever had any of the following conditions?

ADHD	□ **YES** □**NO**	Hearing Impairment	□ **YES** □**NO**
Anxiety Disorder	□ **YES** □**NO**	Heart Condition	□ **YES** □**NO**
Asthma	□ **YES** □**NO**	Hepatitis	□ **YES** □**NO**
Autism Spectrum	□ **YES** □**NO**	History of Surgery	□ **YES** □**NO**
Bleeding Disorder	□ **YES** □**NO**	HIV Positive/AIDS	□ **YES** □**NO**
Cancer	□ **YES** □**NO**	Respiratory Disorder	□ **YES** □**NO**
Developmental Delays	□ **YES** □**NO**	Rheumatic Fever	□ **YES** □**NO**
Diabetes	□ **YES** □**NO**	Sensory Disorder	□ **YES** □**NO**
Digestive Issues	□ ***YES*** □***NO***	Vision Impairment	□ **YES** □**NO**
Epilepsy or Seizures	□ **YES** □**NO**	Other	□ **YES** □**NO**

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

_____

AGREEMENTS

Please initial next to each statement to indicate that you have read and agree.

_____ We are a total care practice. This means we will not see your child solely for treatment appointments. Any attempt at using our practice as a specialist office will result in termination of care.

_____ The adult who accompanies the patient to the appointment is responsible for any and all co-pays due at the time of the visit. We do not accept custody arrangements in lieu of payment.

_____ Our practice reserves the right to charge a $40 broken appointment fee for missed or cancelled appointments without 24 hours' notice.

_____ If one family unit has three or more missed appointments in a 2-year window, we reserve the right to dismiss said family from our practice.

_____ It is the primary responsible party's duty to inform our practice of any change to contact, insurance, or treatment information PRIOR to the scheduled appointment time.

_____I understand that this dental practice makes every effort to keep its patients, parents, and staff safe from COVID-19 and other viruses. I understand the risks associated with bringing my child into a dental office setting and will not hold the office accountable for any infections.

_____ I hereby allow the following authorized individuals to accompany my child to all routine dental appointments (excluding initial new patient visit). I understand that by authorizing these individuals to accompany my child I am allowing them to make routine dental care decisions for my child on my behalf and that I have advised them of the above stated agreements.

(Name)	(Phone)	(Relationship to child)
(Name)	(Phone)	(Relationship to child)
(Name)	(Phone)	(Relationship to child)
(Name)	(Phone)	(Relationship to child)

This information can be changed or altered at any time by a custodial parent or guardian.

(Continued….)

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, Dr. Europa Yang and Dr. Brianna Muñoz 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, Dr. Europa Yang or Dr. Brianna Muñoz 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 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: _____Date of Birth: _____

Parent/Guardian Signature: _____Date Signed: _____

Witness Signature: _____Date Signed: _____

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, Marie Tremblay, DMD and Brianna Muñoz, DMD, MPH. 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: _____