Child's Name: ____ DOB: ____________________

Preferred Name: _________________________ Gender: __________________

Address: ________________________________ City: ______________ State: _____ Zip: ____________

Home Phone: ____________________________ Cell Phone: _______________________

Who can we thank for referring you to our practice? ____

Where have you seen our advertisements? ____

PARENT/GUARDIAN INFORMATION I (Mother/Father)

Name: ____ Relationship: _____________________

DOB: ___________ SSN:___________________ E-mail: _______________________________________

Address (if different): ____

Home Phone: ____________________________ Cell Phone: __________________________

Employer: ______________________________ Occupation: _________________________

PARENT/GUARDIAN INFORMATION II (Mother/Father)

Name: ____ Relationship: _____________________

DOB: ____________ SSN: __________________ E-mail: _______________________________________

Address (if different): ____

Home Phone: ____________________________ Cell Phone: __________________________

Employer: ______________________________ Occupation: __________________________

PRIMARY DENTAL INSURANCE

Policy Holder's Name: ______________________________ Relationship to Patient: ___________________

DOB: ______________________________ SSN: _________________________

Insurance Company: ___________________ Subscriber ID: _______________ Group #: _______________

Insurance Company Phone Number: ___________________________

Employer: ___________________________ Occupation: _____________________________

***** PLEASE INFORM THE OFFICE IF YOU HAVE SECONDARY INSURANCE*****

Although our office primarily treats the area in and around your child's mouth, the mouth is a part of the entire body. Health problems that your child may have, or medication that your child may be taking, could affect the dentistry your child will receive. Thank you for answering the following questions so that your child receives the best care!

Patient's name: ____ Date of birth: ________________________

What is the name of your child's pediatrician/group practice? ____

Has your child ever had major surgery or been hospitalized? **Y / N If yes**:_________________________________

Has your child ever had a mouth, head or neck injury? **Y / N If yes:** _____________________________________

Does your child currently take any medications, pills, or drugs? **Y / N If yes**:________________________________

Has your child taken any prescription medications, pills, or drugs in the past? **Y / N If yes**:_____________________

____

Is your child on a special diet**? Y / N If yes:** ____

Have you ever been told that your child needs antibiotics prior to dental treatment? **Y/ N**

Does your child have any allergies? Yes (please circle below) / No

Penicillin (or other antibiotic)	Latex	Local anesthetics
	Seasonal	Adhesive / Tape
Codeine (or other pain medicine)	Sulfa drugs	Other: _________________

Does your child have any of the following? Yes (please circle below) / No

ADD / ADHD	Connective tissue / joint problem	Hemophilia / bleeding problem	Radiation/ chemotherapy
AIDS / HIV	Diabetes	Hepatitis A / B / C	Rheumatic / scarlet fever
Anemia	Eczema	High / low blood pressure	Sickle cell disease
Artificial joint / valve	Epilepsy / seizures	Hypoglycemia	Sinus problem
Asthma / breathing problem	Eye / vision problem	Kidney problem	Spina bifida
Autism spectrum disorder	Fainting spells / dizziness	Liver problem	Syndrome
Blood transfusion	Frequent headaches	Lung problem	Stomach / intestinal problem
Bruise easily	Heart problem	Mental/Physical delay	Thyroid / parathyroid problem
Cancer/tumor/growth	Herpes / cold sores / fever blisters	Pregnancy	
Cleft lip / palate			

Does your child have (or ever had) any serious illness not listed above? Please explain:

____

Has your child been to the dentist previously? **Y / N** **If yes:**

Name of previous dentist: ____

Date of last visit: ________________________________ Date of last x-rays: __________________________________

Do you have any dental concerns? ____

Does your child currently suck his/her thumb/finger? **Y/ N** Use a pacifier? **Y / N** Have another other oral habit? **Y/N**

Has your child ever complained of a toothache? **Y / N** **If yes:**

Was the pain recent? **Y /N**

Is your child sensitive to pressure/biting? **Y / N**

Has your child had any facial swelling/abscess? **Y / N**

Is dental pain waking your child up in the middle of the night? **Y / N**

Are your child's teeth sensitive to hot/cold temperatures? **Y / N**

How do you think your child will react to today's appointment: **Positively** **Negatively** **Unsure** **(please circle)**

To the best of my knowledge, the questions on this form have been accurately answered. 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 medical status.

Signature of Parent/Guardian: ____________________________________ Date: _____________________

Name of Parent/Guardian: ____

Consent to Perform Basic Treatment

1. I authorize the dentist(s) of Pooler Pediatric Dentistry (PPD) and her/his auxiliaries to perform the following treatment and diagnostic procedures on my child:
   a. Cleaning of the teeth (prophylaxis)
   b. Consultation or complete examination by the dentist in the treatment chair or in the parents lap (the child may need to have hands held to complete)
   c. Fluoride varnish application

2. I understand that dental x-rays may be needed to diagnose and confirm decay and I authorize that they be taken when the doctor believes it is appropriate. I understand that my insurance company may not cover these if they have been taken previously and I have not obtained them from my previous dentist as requested. I understand that I will be financially responsible for these x-rays if my insurance company does not reimburse the doctor for them. I understand that the doctor reserves the right to not examine my child if I refuse to let her/him practice according to the standard of care by refusing x-rays.

3. I recognize that, during the course of treatment, it may be determined that additional work is necessary. This may include (but is not limited to) fillings (restorations), nerve treatments (pulpotomies), crowns, extractions, sutures, local anesthetic, sealants, and/or nitrous oxide. I realize that these procedures are not covered under this consent form and will require a separate treatment consent form specifying the procedures to be performed.

4. If, during the course of care at PPD, a dentist or other employee is exposed to my child's blood via an accidental needle or other instrument prick, I consent to follow the procedures for a blood sample withdrawal for HIV and Hepatitis testing. I understand that every effort will be made to protect the privacy of all parties involved and that it will be completed at no charge to me.

5. I hereby state that I have read and understand this consent and that all questions have been answered in a satisfactory manner.

6. I further understand that this consent will remain in effect until such time that I terminate it in writing.

____
Patient's Name

____
Parent/Guardian's Name

____
Patient/Guardian's Signature & Date

Patient Privacy Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize Pooler Pediatric Dentistry to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g., my insurance company)
- The day-to-day healthcare operations of your practice

I have also been informed of and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions in how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurs prior to the date I revoke this will not be affected.

Patient's Name: ____

Parent or Guardian's Name: ___________________________________

Signature: ____ Date: _________________

Pooler Pediatric Dentistry
120 Towne Center Drive, Suite 500
Pooler, GA 31322
912.376.9296
charles@poolerpd.com

Thank you for selecting us as your dental health care provider. Our goal is to provide your family with optimal dental care. We encourage you to ask questions and to be involved in treatment decisions. This includes understanding your treatment plan as well as our financial policy.

FINANCIAL AGREEMENT

Patients are expected to pay for our services at the time they are rendered. Our patients who have dental insurance are expected to pay the amount of their ESTIMATED co-pay and deductible at the time of service. Payments may be made using cash, check, Visa, MasterCard, AMEX or Discover. We also offer CARECREDIT, a financing option that is available only for healthcare expenses. We will mail monthly statements to all patients with outstanding balances. After 90 days, a finance charge of 18% per annum will be added to these accounts.

Optional payment terms:

> Term loan: Through our arrangement with CARECREDIT, we can offer, upon approval, an interest free term loan (up to 12 months) with no down payment, no annual fee and no prepayment penalty. Ask for an application at the front desk.

Insurance:

As a courtesy to our insured patients, we submit claims to your insurance company free of charge. We will help you to receive your maximum allowable benefits. In order to do this, we need to see your insurance card/policy on your first visit every calendar year (not all insurances run on a January to December schedule). ***HOWEVER, ALL CHARGES ARE ULTIMATELY YOUR RESPONSIBILITY*** and any charges for treatment not paid in full by your insurance will be due immediately. Our doctor diagnoses based on optimal dental health, not based on your insurance coverage. If your insurance has not paid within 90 days of service, you will need to make payment to this office and be reimbursed when your insurance company releases payment. All current documentation will be provided to you in order to assist you with your inquiries.

Appointments:

In order to serve you better and keep the cost of dental care down, we try to maintain an efficient appointment system. However, our cost of providing care increases when people fail to keep scheduled appointments or cancel at the last minute. We require at least 24 hours' notice for any canceled appointment. Failed appointments –or those that are canceled with fewer than 24 hours' notice - **will be subject to a $25 fee**.

Please indicate your understanding of these policies by signing below and thank you for trusting us with your child's smile!

Patient's Name: ____

Parent/Guardian's Name: ____

Parent/Guardian's Signature: ____

Photography Release

I hereby authorize Pooler Pediatric Dentistry (Carla G. Stappenbeck DDS LLC) to publish photographs taken of my child during his/her dental office visits, and his/her name and likeness, for use in its print, online and video-based marketing materials, as well as other office publications.

I hereby release and hold harmless Pooler Pediatric Dentistry from and reasonable expectation of privacy or confidentiality associated with the images specified above.

I further acknowledge that participation is voluntary and that I will not receive financial compensation of any type associated with the taking or publication of these photographs or participation in company marketing materials or other dental office publications. I acknowledge and agree that publication of photographs confers no rights of ownership or royalties whatsoever.

I hereby release Pooler Pediatric Dentistry its contractors, its employees, and any third parties involved in the creation or publication of marketing materials, from liability for any claims by me, my child or any third party in connection with my participation.

Patient's Name: ___________________________________

Parent/Guardian's Name: ___________________________

Parent/Guardian's Signature: _________________________ Date: __________

Pooler Pediatric Dentistry
120 Towne Center Drive, Suite 500
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