Welcome

25 Town Center Blvd.
Suite 202
Crestview Hills, KY 41017
Phone: 859 344-6200
Fax: 859 344-0980

Health History Form

Today's Date: ______________

NOTE: The parent or Guardian who accompanies the child is responsible for payment at the time of service.

1. Tell Us About Your Child

Child's Name ______________________________________
Last First MI

Goes by: ______________________ ☐ Male ☐ Female

Siblings that we treat ______________________________

Child's Birthdate _____/_____/_____ Child's Age __________

School____________________________Grade__________

Child's Home # (__________)_________________________

SS#____

Child's Home Address:______________________________

____
City State Zip

Email Address:____________________________________

2. Who may we thank for referring you to our office?

____

3. Mother's Information

Name ____

Mother Stepmother Guardian Birthdate _____/_____/_____

Employer ____

Work # (_________)__________________ Ext. __________

Home # (_________)_________________________________

Cellular Phone # (_________)_________________________

SS # ____________________ DL# ____________________

4. Father's Information

Name ____

Father Stepfather Guardian Birthdate _____/_____/_____

Employer ____

Work # (_________)__________________ Ext. __________

Home # (_________)_________________________________

Cellular Phone # (_________)_________________________

SS # ____________________ DL# ____________________

5. Who is Accompanying the Child Today?

Name ____

Relationship_______________________________________

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

6. Person Responsible for Account

Name____

Relationship_______________________________________

Billing Address _____________________________________

____
City State Zip

Home # (___________)_______________________________

Work # (___________)_______________________________

Cellular # (___________)_____________________________

E-mail ____

7. Primary Dental Insurance

Insurance Co. Name __________________________________

Insurance Co. Address ________________________________

____

Insurance Co. Phone # (___________)___________________

Group # (Plan, Local, or Policy #) _____________________

Policy Owner's Name ________________________________

Relationship to Patient_______________________________

Policy Owner's Birthdate ______/ ______/ ______

Social Security # ____________________________________

Policy Owner's Employer _____________________________

8. Secondary Dental Insurance

Insurance Co. Name __________________________________

Insurance Co. Address ________________________________

____

Insurance Co. Phone # (___________)___________________

Group # (Plan, Local, or Policy #) _____________________

Policy Owner's Name ________________________________

Relationship to Patient_______________________________

Policy Owner's Birthdate ______/ ______/ ______

Social Security # ____________________________________

Policy Owner's Employer _____________________________

9. Dental History

Is this your child's first visit to the dentist? ________________

If not, how long since the last visit to the dentist? ____________

Previous Dentist's Name______________________________

Were any x-rays taken at previous dental visits? ____________

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

If yes, please explain ________________________________

____

____

Why did you bring the child to the dentist today? ____________

____

____

Does the child have any of the following habits?

Y N Lip Sucking / Biting   Y N Nail Biting

Y N Nursing / Bottle Habits   Y N Thumb / Finger Sucking

Has the child ever had a serious or difficult problem associated 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

Has the child ever had any pain or tenderness in his/her jaw/ joint? (TMJ/TMD)? Yes No

Does the child brush his/her teeth daily? Yes No

Floss his / her teeth daily? Yes No

10. Health History

Has the child ever had any of the following conditions?

Y N Abnormal Bleeding

Y N Allergies to any Drugs

Y N Any Hospital Stays

Y N Any Operations

Y N Asthma

Y N Cancer

Y N Congenital Birth Defects

Y N Convulsions/Epilepsy

Y N Pregnancy

Y N Tuberculosis

Y N Handicaps/Disabilities

Y N Hearing Impairment

Y N Heart Disease/Murmur

Y N Hemophilia/Blood Disorders

Y N Hepatitis

Y N HIV + / AIDS

Y N Kidney/Liver Conditions

Y N Rheumatic/Scarlet Fever

Y N Allergies to Latex Product

Y N Diabetes

Please discuss any serious medical conditions the child has had

____

____

Please list all drugs the child is currently taking _______________

____

Please list all drugs the child is allergic to ___________________

____

Child's Physician _____________________________________

Phone (_____________)_______________________________

Is the child currently under the care of a physician? Yes No

Please describe the child's current physical health...

Good   **Fair**   **Poor**

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA the CDC, and the ADA.

11.

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

____   ______________________________

Signature of Parent or Guardian   Date   Relationship to Patient

For Office Use Only

I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein.

Initials _____________ Date _______________

Doctor's Comments _________________________________

____

____

____

Sophie Duval-Austin, D.M.D.
Board Certified Pediatric Dentist

25 Town Center Blvd., Suite 202
Crestview Hills KY 41017

PH (859) 344-6200
FX (859) 344-0980

DentalBuds.com

INFORMED CONSENT

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 happy to further explain it to you.

1. I hereby authorize and direct Dr. Sophie Duval-Austin, assisted by other dentists and/or dental auxiliaries of their choice, to perform upon my child (or legal ward) the following dental treatment or oral surgery procedures.
   - Examination and radiographs (x-rays) as determined by the dentist
   - Cleaning of the teeth and application of topical fluoride
   - Application of plastic "sealants" to the fissures or grooves of the teeth
   - Administration of local anesthetics
   - Treatment of diseased or injured teeth with dental restorations (fillings, crowns and pulpotomies)
   - Removal (extractions) of one or more teeth
   - Treatment of diseased or injured oral tissues (had and/or soft)
   - Replacement of missing teeth with space maintainers and /or dental prosthesis
   - Use of nitrous oxide sedation
   - Use of general anesthesia with an anesthesiologist to accomplish the necessary treatment
   - Postponing or delaying treatment at this time

2. This treatment has been explained to me. Alternate methods of treatment, if any, have also been explained to me, as have the advantages, disadvantages and risks of each. These include pain and/or sensitivity to temperature changes, spontaneous pain, abscess, fracture of the tooth away from the restoration, partial or complete loss of the restoration, amalgam toxicity, failure and/or loss of the porcelain and/or composite restoration, loosening of the crowns necessitating their replacement or re-cementation. I am advised that though good results are expected, the possibility and nature of complications can not be accurately anticipated and that, therefore, there can be no guarantee either expressed or implied, as to the result of the treatment or as to the cure.

3. I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request the performance of any additional procedures that are deemed necessary or desirable to my child's oral health and well being in the professional judgements of Dr. Sophie Duval-Austin and/or any of her associates of her choice.

4. I understand and have been informed that there are possible risks and complications associated with administration of local anesthesia, sedation and drugs. The most common of these being welling, bleeding, pain, nausea, vomiting, bruising, tingling and/or prolonged numbness of the lips, gums, face and tongue, allergic reactions, hematoma (swelling), fainting, lip and cheek biting resulting in ulcerations and infection of the mucosa. I also understand that there are rare and potential risks such as unfavorable reactions to medications, like respiratory and cardiovascular collapse (stopping of breathing and heart function) and lack of oxygen to the brain that could result in coma or death.

5. I have also been made aware that after the 1st appointment, the decision to stay with my child during his/her dental treatment appointment will be left at the discretion of the dentist. My presence at subsequent follow-up examinations will be subject to my child's age, maturity, behavior and cooperation.

I hereby state and knowledge that I have read and understand this consent, and that all questions about the procedures and treatment plan have been answered in a satisfactory manner. I further understand that I have the right to be provided with answers to questions that may arise during the course of my child's treatment.

PATIENT NAME ______________________ SIGNATURE OF PARENT OR LEGAL GUARDIAN ______________________

RELATIONSHIP TO PATIENT ______________________

Patient Financial Rights & Responsibilities

Dr. Austin & her Staff are committed to provide our Patients the optimum in dental care! Payment for dental services provided is part of that process. We want to ensure that you are informed of our Financial Policy and your Patient Rights & Responsibilities. Please review the statements below and initial beside each statement and sign at the bottom of the form. Our Staff is available for any questions you may have and thank you for choosing our Office to care for your Family's Dental needs.

______Visa, MasterCard, Discover, CareCredit, Cash, and Check w/ proper ID are accepted forms of payment.
**Our banking institution will assess a $25.00 fee on any returned check s which will be added to your account.*

______ Co-Payments are due at the time dental services are provided unless alternate payment arrangements have been confirmed with our Office 48 hours in advance of your appointment. This is applicable for estimated co-payments if the patient has Dental Insurance Coverage, and Patients without Dental Insurance Coverage.

______ An estimate of Dental Insurance Coverage (*if applicable)* obtained by our Staff does not guarantee payment of your dental claim. This information is an estimate only based on information provided by your Insurance Carrier and you are responsible for knowing the detailed coverage of your dental insurance policy.

_______ Your Insurance Carrier (*if applicable)* has the final determination of the specific dental benefits and materials covered under your policy when the claim is processed. Patients share the responsibility to be informed of their specific dental benefits.

______ Any amount not paid by your Dental Insurance Carrier (*if applicable)* or any dental claim not resolved by your Dental Insurance carrier 15 days after the dental service was rendered will be the responsibility of the patient.

______ Balances over 30 days will acquire finance charge periodic rate of 1.25% not to exceed 15% APR.

______ Late Charges are assessed if the minimum payment requested on your statement is not received by the due date. The late charge will be $5.00 or 5% of the amount requested, whichever is greater, not to exceed $20.00.

______ Delinquent Accounts of any unpaid balances over 150 days will be reported to a Collection Agency. Additional charges to your account may occur and will be added to the original unpaid balance.

______ We required a 24 hour notice for any appointment cancellation. Failure to give the 24 hour courtesy cancellation will result in a $50.00 cancellation fee applied to your account.

Our Office adheres to the Patient Rights under **The Fair Credit Billing Act.** If you think you have been billed incorrectly, submit in writing to our office within 60 days of your first statement from our office in which the error or problem appeared. Please provide your name, account number, dollar amount of the suspected error, and describe the error, and if you can, explain why you believe there is an error. If you need more information, describe the item you are not sure about on your statement. You may call our office at 791-0030 to speak to our Staff but we will require written documentation of your concern if we are unable to resolve the matter via phone.
After we receive the written notice, we will acknowledge receipt of your written concern within 30 days unless we have already corrected the error.
Our Office will provide an explanation or correction of these charges within 90 days of receipt of your written concern. No attempt will be made to collect the amount you question or report you as delinquent during the investigation. We can continue to bill you this amount while we are investigating and you are responsible to pay any amount of your bill that is not in question. If there was no mistake on our part, you will be responsible for payment of the account, including any finance charges. If you fail to pay this amount we can report you as delinquent.

I agree to be responsible for all charges rendered for dental services and materials. If I have Dental Insurance Coverage, I assume all responsibility for charges and materials not paid by my policy.

____

Patient Name Parent Guardian Name

____ ______________________

Signature of Parent Guardian completing form Date

Pediatric Dental Garden Center, Inc.

Notice of Privacy Practices

Acknowledgement of Receipt Form

Patient Name:________________________________ Date of birth:______________
(Please Print)

Personal representative (if applicable):________________________________
(Please Print)

I hereby acknowledge I have received a copy of the Notice of Privacy Practices for Pediatric Dental Garden Center, Inc.

Personal representatives signature__________________________ Today's date__________

TO BE COMPLETED BY MEDICAL FACILITY IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGEMENT FROM THE PATIENT.

On______________, I made a good faith effort to obtain written acknowledgement of receipt of the Notice of Privacy Practices from the above named patient, but was unable to do so because of the following reason(s):

- Patient (or personal representative) declined to sign the Written acknowledgement form
- Patient (or personal representative) did not understand the request to sign the written acknowledgement form.
- Other(specify)____

  ____

Employee signature:____Date:______________

Employee job title:____