Angel Smile
PEDIATRIC DENTISTRY

1. TELL US ABOUT YOUR CHILD

Child's Name: ______________________________

Preferred Name or Nickname: ______________________________

Gender: ☐ Male ☐ Female

Childs Birthdate: ________/______ /______ Age:______

Home Phone #: ______________________________

Home Address: ______________________________

City: ______________ State:______ Zip: ______

Child's SS#: ______________________________

Referred By: ______________________________

2. WHO IS ACCOMPANYING THE CHILD TODAY?

Name: ______________________________

Relationship to the Child: ______________________________

Do you have legal custody of the child? ☐Y ☐N

Is the child adopted? ☐Y ☐N

Is the child in a foster home? ☐Y ☐N

3. MOTHER'S INFORMATION

Name: ______________________________

☐Mother ☐Stepmother ☐Guardian Birth date:____ /____ /____

SS#: ______________ DL#: ______________

Home Address: ______________________________

City: ______________ State:______ Zip: ______

Main #: ______________ Work #: ______________

Email Address: ______________________________

Preferred Contact method ☐Main# ☐Email

4. FATHER'S INFORMATION

Name: ______________________________

☐Father ☐Stepfather ☐Guardian Birth date:____ /____ /____

SS#: ______________ DL#: ______________

Home Address: ______________________________

City: ______________ State:______ Zip: ______

Main #: ______________ Work #: ______________

Email Address: ______________________________

Preferred Contact method ☐Main# ☐Email

5. PERSON RESPONSIBLE FOR ACCOUNT

Name: ______________________________

Birth date:____ /____ /____

SS#: ______________ DL#: ______________

Billing Address: ______________________________

City: ______________ State:______ Zip: ______

Main #: ______________ Work #: ______________

Employer: ______________________________

6. DENTAL INSURANCE INFORMATION

Insurance Company: ______________________________

Claims Address: ______________________________

City: ______________ State:______ Zip: ______

Ins Co Phone #: ______________

Group #: ______________ ID #: ______________

Name of Insured: ______________________________

Relationship to Patient: ______________________________

SS# of Insured: ______________________________

Birth Date of Insured: ______________________________

Insured's Employer: ______________________________

7. PLEASE READ AND SIGN BELOW

All payments are due at time of service. However, most insurance plan benefits can be used for treatment in our office. Please check with your insurance plan administrator for more details. **During your visit, we will collect what we estimate your insurance will not pay. Actual insurance reimbursement may vary from our estimate. You are responsible for the full balance on your account.** In the case of divorce or separation the parent that brings the child in for the visit is responsible for payment at the time of the visit. Please see our insurance specialist or business manager with any questions.

I have read and understand this insurance policy and hereby authorize my insurance company to send payments directly to Angel Smiles and understand that I am responsible for all remaining balances.

Signature: ______________________________ Date: ___/____ /____

Angel Smile
PEDIATRIC DENTISTRY

8. MEDICAL HISTORY

Child's Name: ____________________

Child's Physician: ____________________

Address: ____________________

Phone Number: ____________________

Date of Last Visit: ____________________

Does your child take any medications? ☐Y ☐N
If yes, please list medications and include dosage:

____

Are immunizations up to date? ☐Y ☐N
Has your child been treated in an emergency room? ☐Y ☐N
If yes, please explain: ____________________

Has your child been hospitalized or had surgery? ☐Y ☐N
If yes, please explain: ____________________

Has your child ever had any of the following conditions?

☐Y ☐N Heart Murmur
☐Y ☐N Rheumatic Fever
☐Y ☐N Artificial Heart Valves
☐Y ☐N Congenital Heart Defect
☐Y ☐N Scarlet Fever
☐Y ☐N Cancer/Tumors
☐Y ☐N Chemotherapy
☐Y ☐N Jaw Problems (TMJ/TMD)
☐Y ☐N Hearing/Visual Problems
☐Y ☐N Heart Problems
☐Y ☐N Seizures/Epilepsy
☐Y ☐N Tonsillitis
☐Y ☐N Respiratory Problems
☐Y ☐N Asthma/Difficulty Breathing
☐Y ☐N Seasonal Allergies
☐Y ☐N Blood Transfusion
☐Y ☐N Leukemia
☐Y ☐N Anemia
☐Y ☐N Diabetes
☐Y ☐N Hypoglycemia
☐Y ☐N Hemophilia
☐Y ☐N Abnormal Bleeding
☐Y ☐N Cleft Lip/Palate
☐Y ☐N Birth Defects
☐Y ☐N High Blood Pressure
☐Y ☐N Low Blood Pressure
☐Y ☐N Thyroid Problems
☐Y ☐N Sickle Cell
☐Y ☐N Hepatitis
☐Y ☐N Artificial Bones/Joints
☐Y ☐N Liver/Kidney Problem
☐Y ☐N HIV/AIDS
☐Y ☐N Tuberculosis (TB)
☐Y ☐N Hyperactive/ADD
☐Y ☐N Autism
☐Y ☐N Behavioral Problems
☐Y ☐N Mental/Physical Delay
☐Y ☐N Pregnancy

Allergic to:

☐Y ☐N Latex
☐Y ☐N Tetracycline
☐Y ☐N Penicillin/Amoxicillin
☐Y ☐N Food Allergies
☐Y ☐N Aspirin

Other: ____________________

9. DENTAL HISTORY

Is this your child's first visit to the dentist? ☐Y ☐N

Previous Dentist: ____________________

Date of last visit:____ /____ /____

Date of last exam:____ /____ /____ Date of last x-rays:____/____ /____

Reason for today's visit: ☐Exam ☐Consultation ☐Emergency

How often does your child floss? ____________________

How often does your child brush? ____________________

Who brushes your child's teeth? ____________________

Is your child bottle or breast fed? ____________________

Does your child take fluoride supplements? ☐Y ☐N

Is your child's water fluoridated? ☐Y ☐N

Has your child had difficulty with previous dental visits? ☐Y ☐N

Are you aware of any problems with your child's mouth? ☐Y ☐N

Has your child ever been sedated for dental treatments? ☐Y ☐N

Please check any of the following that apply to your child:

☐ Bad Breath
☐ Bleeding Gums
☐ Clicking or Popping Jaw
☐ Food Collection Between Teeth
☐ Grinding Teeth
☐ Loose Teeth or Broken Fillings
☐ Injury to Face or Mouth
☐ Sensitivity to Cold/Heat
☐ Sensitivity to Sweets
☐ Sores or Growth in Mouth
☐ Mouth Breathing
☐ Thumb/Finger Sucking
☐ Pacifier Sucking
☐ Lip Biting
☐ Nail Biting

10. PLEASE READ AND SIGN BELOW

I affirm that the information I have given on this form is correct to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes in my child's medical status.

Signature: ____________________ Date:____/____ /____

Dr. Signature: ____________________ Date:____/____ /____

GENERAL CONSENT FOR TREATMENT

Our office specializes in the dental health of children. We strongly believe in the establishment of a dental home for your child for preventive dental care in a safe and comfortable environment. In order to provide the best dental care, we are required to obtain your consent before preforming any dental services for your child. Please read this form carefully and we encourage you to ask us about anything that you do not understand, we will be happy to explain it to you.

I hereby authorize and direct Angel Smile Pediatric Dentistry with the support of licensed dentists and/or dental auxiliaries to preform upon my child the following dental treatment or oral surgery procedures including the necessary or advisable local anesthesia, radiographs (x-rays), photographs or diagnostic aids.
In general terms, the dental procedures may include one, or a number of, the following:

1. **Cleaning of the teeth and application of fluoride**
2. **Application of sealants to the grooves of teeth**
3. **Treatment of diseased or injured teeth with dental restorations**
4. **Stainless steel crowns**
5. **Extraction (removal) of one or more teeth**
6. **Treatment of diseased or injured oral tissues (hard and/or soft)**
7. **Treatment of malposed (crooked) teeth and/or developmental abnormalities with fixed or removable orthodontic appliances**
8. **Behavior guidance through the use of mouth prop, tell-show-do method, and/or voice control**
9. **Use of sedation medications and/or nitrous oxide to control apprehension**
10. **Space maintainer(s) to prevent shifting of teeth**

The treatment has been explained to me and I understand that none of the above procedures will be performed without discussing the necessity with me and obtaining my consent to proceed. Alternative methods of treatment, if any have been explained to me, along with their advantages, disadvantages, and risks. I am advised that good results are expected; however, the possibility and nature of complication cannot be accurately anticipated. Therefore, no guarantee, expressed or implied, can be given to me regarding this treatment. I further understand and authorize the doctor to perform any necessary treatment that in his/her judgment will be in the best interest of my child's health, once treatment has been initiated.

Although their occurrence is rare and unpredictable, some risks are known to be associated with dental or oral surgery procedures, medication and/or anesthetics. We are required to disclose the known risk of numbness, infection, aspiration (swallowing), swelling, bleeding, discoloration, nausea, vomiting, allergic reaction, the loss of function of organs, or scarring. I understand and accept that complications may require medical assistance, hospitalization and in very rare cases death.

I hereby state that I have read and fully understand this consent. I have been given an opportunity to ask questions regarding this consent and proposed treatment and understand that treatment and available options will always be discussed with me in detail prior to commencing work. I also understand that this consent will remain in effect until such time that I choose to terminate. Such termination of consent must be in writing.

Patient Name:_______________________ Date:_______________________

Signature of Parent or Guardian:_______________________ Date:_______________________

Witness:_______________________ Date:_______________________

GENERAL OFFICE POLICIES

A parent/legal guardian must accompany each child to all dental visits. Only a parent/legal guardian can consent to treatment or fill out a child's medical history.

PARENT PARTICIPATION

Parents are welcome to accompany their child for exam and cleaning appointments. **Parents are encouraged to wait in the waiting room while their child is receiving treatment.** At subsequent visits we encourage that you allow our staff to accompany your child through the dental experience. We can usually establish a closer rapport with your child when you are not present. Our purpose is to gain your child's confidence and overcome apprehension. There are instances when a parents presence is needed during treatment. This will be evaluated on an individual patient basis.

SCHEDULED APPOINTMENTS

We attempt to schedule appointments at your convenience and whenever time is available. Preschool children and school children requiring extensive dental treatment are best seen in the morning when they are fresher and well rested because they tend to be more cooperative, which allows for a more comfortable experience for the child. In order to allow the best possible care for our patients, we reserve a specific time for your child and make every effort to see him/her as scheduled. We appreciate your promptness and your consideration in not changing your scheduled time. **However, if you need to change your child's appointment, it is required that a 48-hour notification is made to our office.**

PAYMENT RESPONSIBILITY

All payments are due at the time of service. However, most insurance plan benefits can be used for treatment in our office. Please check with your insurance plan administrator for more details. **During your visit we will collect what we estimate your insurance will not pay. Actual insurance reimbursement may vary from our estimate. You are responsible for the full balance on your account. In the case of divorce or separation, the parent that brings the child in for the visit is responsible for payment at the time of the visit. Please see our insurance specialist or business manager with any questions.**

X-RAY RECORDS

By law, x-rays taken here are the property of this office.

THANK YOU FOR CHOOSING ANGEL SMILE PEDIATRIC DENTISTRY AS YOUR CHILD'S ORAL HEALTHCARE PROVIDER.

I have read and understand these policies and hereby authorize my insurance company to send payments directly to Angel Smile Pediatric Dentistry and understand that I am responsible for all remaining balances.

Patient's Name: ______________________________

Parent/Guardian Signature: ______________________________

Date: ____________________ Witness: ______________________________

NOTICE OF PRIVACY FORM

Acknowledgment of Receipt of HIPAA Notice of Privacy Practices

I acknowledge that I have received a copy of Angel Smile Pediatric Dentistry HIPAA Notice of Privacy Practices.

____
Print Patient's Name

_______________________________________ _______________________________________
Signature of Patient Date

OR

____
Signature of Personal Representative

☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Other _______________________________

Please Note: It is your right to refuse to sign this acknowledgment.

I tried to obtain written acknowledgment by the individual noted above of receipt of our Notice of Privacy Practices, but it could not be obtained because:

☐ *An emergency prevented us from obtaining acknowledgment*

☐ *A communication barrier prevented us from obtaining acknowledgment*

☐ *The individual was unwilling to sign*

Other: ____

____

_______________________________________ _______________________________________
Staff Member Signature *Date*

FINANCIAL AGREEMENT

Thank you for choosing our office. Following you will find information that clarifies our office policies.

The person who accompanies the patient is responsible for payment of services at the completion of that day's treatment regardless of who carries the dental insurance. Outstanding balances on a patient's account must be settled prior to the initiation of additional treatment.

We accept cash, VISA, Master Card, and Discover. On extensive treatment, we ask that you use the services of an outside financing company such as CareCredit should you need financial assistance.

IF YOU DO NOT HAVE DENTAL INSURANCE

We will provide you a treatment plan that outlines your anticipated expenses. Full payment is expected at each visit for the completed treatment.

IF YOU HAVE DENTAL INSURANCE

- **We file insurance claims as a courtesy.** However, remember that your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a part of that contract-you are! So, please review your benefits with your insurance company so that you are familiar with the specifics of your policy.
- We work very hard to help you receive all the benefits under your plan but **we are not responsible nor guarantee how your insurance company handles claims or the benefits they pay.**
- We ask that you pay the estimated difference between what your insurance company will probably pay and the allowed benefit on the day of treatment.
- We are not responsible for any discrepancies in the estimated benefits because **insurance providers do not guarantee their information until claim submission.**
- **You are responsible for any remaining balance on your account after your insurance company has paid its portion.** If we do not receive payment from your insurance company within 30 business days of claim submission regardless of the reason, you will be expected to pay the balance in full within 10 calendar days. Angel Smile Pediatric Dentistry will reimburse you if a duplicate payment is made.

If you have TWO dental plans, we'll file a claim with your primary carrier and provide you the paperwork to submit to the other insurance. You will be responsible to pay the balance remaining and will receive your reimbursement directly from the second insurance carrier.

I hereby authorize assignment of payment of my dental insurance benefits to Valeria Kresevic, DDS.
This Assignment of Benefits shall be deemed ongoing until my dental insurance carrier receives written notice from me that I have revoked this agreement .

COLLECTION POLICY

Accounts unpaid after 45 days from the date of service are subject to a 1.5% finance charge per month.

We will take necessary steps to collect outstanding balances for accounts greater than 90 days past due. You agree to pay all the incurred collection costs, court costs, and attorney fees if your account is referred to a collection agency or small claims court.

I have read this document in its entirety and understand the payment policies for Angel Smile Pediatric Dentistry. All of my questions have been answered. This agreement cannot be amended or altered without the direct written approval of Dr. Valeria Kresevic. Without any reservation, I agree to abide by the policies outlined herein.

Print Patient's Name	Patient's Age	Print Your Name	Relationship

Doctor's Signature	Today's Date

NOTICE AND ACKNOWLEDGMENT OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PROTECTED MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. Angel Smile Pediatric Dentistry is permitted to make use and disclosure of protected health information for treatment, payment, and health care operations, as described in the following examples:
   a. For treatment-consultation, lab work
   b. For payment- claims, collections
   c. For health care operation-chart maintenance, regulatory requirements, accounting, HIPAA compliance
2. Angel Smile Pediatric Dentistry is permitted or required, under specific circumstances, to use or disclose protected health information without the individual's written authorization. Other uses and disclosures will only be made with the individual's written authorization, and the individual may revoke such authorization.
3. Angel Smile Pediatric Dentistry may engage in the following:
   Angel Smile Pediatric Dentistry may contact the individual to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to the individual or patient.
4. The individual has rights regarding protected health information:
   a. The right to request restrictions on certain uses and disclosures of protected health information. Angel Smile Pediatric Dentistry is not required to agree to requested restrictions.
   b. The right to receive confidential communications of protected health information, as applicable.
   c. The right to amend protected health information, as provided in the privacy regulation.
   d. The right to obtain a paper copy of the Notice from the covered entity upon request.
5. Angel Smile Pediatric Dentistry is required by law to maintain the privacy of protected health information and to provide individuals with the Notice of its legal duties and Privacy practices with respect to protected health information.
6. Angel Smile Pediatric Dentistry is required to abide by the terms of the Notice currently in effect.
7. Angel Smile Pediatric Dentistry will provide individuals or patients with a revised Notice as requested.
8. Angel Smile Pediatric Dentistry reserves the right to change the terms of this Notice. The new Notice provisions will be effective for all protected health information that it maintains.
9. Individuals may complain to Angel Smile Pediatric Dentistry and to the Secretary of the Department of Health and Human Services, without fear of retaliation by the organization, if they believe their privacy rights have been violated.

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for Angel Smile Pediatric Dentistry.

Print Name	*Signature*	*Date*
Patient's Printed Name	*DOB*	*Your Relationship to patient*

Are you legally responsible for this child? ☐ *Y* ☐ *N*

FOR OFFICE USE ONLY

I verbally reviewed the information above with the parent/legal guardian/patient named herein. *Initials* ________ *Date* ______________