Welcome to Children's Dental Health Associates, P.C.

Thank You for Selecting Us

Child's Name: _____ DOB: _____

Nickname: _____ Age: _____ Gender: Male Female Other

Ethnicity: Hispanic/Latino Non-Hispanic/Latino Declined

Race: White Black/African American American Indian Asian Native Hawaiian Other Pacific Islander Declined

Social Security #: _____ School: _____ Grade: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Who can we thank for referring you to us? (please check all that apply)

- ○ Primary Care Doctor _____
- ○ General Dentist _____
- ○ Insurance Company _____
- ○ Friend/Family _____
- ○ School/Daycare _____
- ○ Other _____

Where have you seen our advertisement(s)? (please check all that apply)

- ○ Newspaper/Magazine _____
- ○ Internet _____
- ○ Festival/Fair _____
- ○ School/Daycare _____
- ○ Direct Mail _____
- ○ Other _____

PARENT/FOSTER PARENT/LEGAL GUARDIAN INFORMATION (Mother/Guardian)

Name: _____ Relationship: _____

DOB: _____ Social Security #: _____ Email Address:_____

Home Address (if different than child): _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Occupation: _____

PARENT/FOSTER PARENT/LEGAL GUARDIAN INFORMATION (Father/Guardian)

Name: _____ Relationship: _____

DOB: _____ Social Security #: _____ Email Address:_____

Home Address (if different than child): _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Occupation: _____

Primary Dental Insurance

Insured's Name _____

Relationship to Patient _____ Date of Birth _____ Social Security #_____

Subscriber's ID _____

Employer_____Insurance Company_____

Group # _____ Phone # _____

Insurance Company Address _____

City _____ State _____ Zip Code _____

Secondary Dental Insurance

Insured's Name _____

Relationship to Patient _____ Date of Birth _____ Social Security #_____

Subscriber's ID _____

Employer_____Insurance Company_____

Group # _____ Phone # _____

Insurance Company Address _____

City _____ State _____ Zip Code _____

FINANCIAL ARRANGEMENTS

For your convenience we offer the following methods of payment. Please check the option(s) you prefer. Payment in full is due at each appointment: _____Cash _____Personal Check _____Visa _____MasterCard

I authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my dependent's behalf. I agree to be responsible for all fees incurred in attempting to collect these fees.

_____

Signature of Parent or Legal Guardian & Date

Financially responsible person for account □ Self □ Other _____

☐ Child in foster care- Children & Youth and Foster Parents will not sign Staff Initials _____

Children's Dental Health Associates

GUIDELINES REGARDING DENTAL INSURANCE

Our fees for services are the same for all patients whether or not they have a dental insurance program. As a courtesy to our patients we will be happy to complete and submit your insurance carrier forms for dental treatment.

There is a great variety in the types of dental insurances offered. Various programs cover as little as 30% and as much as 80%. Almost every dental plan has a provision for limiting dollar disbursement by the insurance company for covered services. Rarely is it covered 100%.

Please understand that this office does not determine the benefits to be derived under your policy. We cannot be responsible for the structuring of the plan. This is a pre-determined situation agreed upon between your employer and the insurance carrier.

Insurance is a contract between you as the policyholder and the company. We are ***not*** an insurance company, but will do all we can to help you collect legitimate claims. Since our services are rendered for you at your request, in the event your insurance carrier is slow to pay or for some reason disallows the claim, payment of the account is your responsibility. Financial arrangements are to be made with our office prior to commencement of treatment. We will furnish information needed to fill all referrals, but ask that these be submitted by the insured. Our payment is due from the insured at the time of visit.

In order for our office to apply for insurance benefits on your behalf, we ask that you provide us with the following:

1. A signed "Insurance Authorization of Signature" for which we will provide for you. This way you will need to bring only one completed insurance claim form, which will be used as a master.

2. The insured's date of birth, social security number, ID number, name and address of employer, occupation, policy number, plan or group number, whichever is applicable.

FOR YOUR CONVENIENCE THE FOLLOWING PROGRAMS ARE AVAILABLE TO HELP PLAN YOUR DENTAL INVESTMENT:

Plan 1: PAYMENT AT THE TIME OF SERVICE FOR ALL FEES TO DATE: Cash, Check, Mastercard, Visa, and money orders are accepted.

Plan 2: All charges are due and payable at time of service. A finance charge of 1.5% (annual 19% will be applied to any unpaid balance after 60 days).

MOST MAJOR DENTAL PLANS ARE ACCEPTED

Patient's Name: _____ Parent/Legal Guardian's Name: _____

Parent/Legal Guardian's Signature & Date: _____

☐ Child in foster care- Children & Youth and Foster Parents will not sign Staff Initials _____

Children's Dental Health Associates

Financial/Insurance/Appointment Agreement

I authorize the office of CDHA to release any information including the diagnosis and the records of any treatment or examination rendered, to my dependents, or me during the period of such dental care to third party payers. I authorize and request my insurance company to pay directly to CDHA dental insurance benefits otherwise payable to me.

The office of CDHA only submits dental insurance claims and only accepts insurance payments from dental insurance plans and companies. If you believe treatment of diagnosis should be billed to any other type of insurance, we will provide you with copies of the dental insurance forms that you can submit to the insurance of your choice. Payment from these claims will be sent to you. Additionally, payment for these services is to be paid at the time of service. Before submitting any insurance claim, please consult an attorney or insurance professional to avoid committing insurance fraud.

If the patient has two or more dental insurances, your account balance will be due after the primary insurance has been paid. The secondary dental insurance will reimburse the insured subscriber.

According to PA State law, all insurance claims are to be paid within 45 days of receipt of the insurance claim. I understand that any outstanding insurance balance that is due over 60 days will become my financial responsibility.

A parent or legal guardian (as determined by an order of the court) or person/persons with permission from parent or legal guardian, must accompany the patient to all appointments and show proof of identity. Upon arrival, please check in with a receptionist.

A broken appointment is an appointment that is canceled with less than 24 hours notice to the scheduled appointment. Any appointment that the patient and the parent/legal guardian are not present for shall be considered a broken appointment. **I acknowledge there is a fee of $50 for each broken appointment.**

Any unpaid balance due (as listed on a billing statement), not paid within 28 days of the monthly billing date, will be assessed a late charge of 1.5% each month. I realize that failure to keep this account current may result in my children being unable to receive additional dental services except for dental emergencies or when there is pre-payment for additional services. In the default on payment of this account (payment due over 60 days), I agree to pay additional collection cost (33% of the unpaid balance), postage, attorney and court fees incurred in attempting to collect on this amount or any future outstanding balances.

Patient's Name: _____ Parent/Legal Guardian's Name: _____

Parent/Legal Guardian's Signature & Date: _____

☐ Child in foster care- Children & Youth and Foster Parents will not sign Staff Initials _____

Children's Dental Health Associates

MEDICAL ASSESSMENT

CHILD'S NAME: _____ **Nickname:** _____ ☐ **Male** ☐ **Female**

Date of Birth: _____ **Height:** _____**Ft** _____ **in** **Weight:** _____**LBS** (pounds)

Primary Care Physician Name: _____ **Phone Number:** _____

Purpose of Dental Visit: _____

Last Dental Visit: _____ **Previous Dentist:** _____

Do you have any records with you from previous dental office ☐ **Yes** ☐ **No**

Dental Concerns/Other - PLEASE CHECK ALL THAT APPLY

☐ None ☐ Cancer ☐ Recent illness _____
☐ Congenital Anomaly
☐ Breast Fed
☐ Bottle Fed
☐ Thumb sucking/lip sucking/nail biting/finger sucking
☐ Uses a pacifier
☐ Injuries to teeth
☐ Fear of dentist for child/parents
☐ Natural parents have history of decay or crooked teeth
☐ Child has had a toothache recently
☐ Toothache after eating
☐ Toothache that makes the child wake at night
☐ Patient is adopted or in foster care; If yes do you have the proper paperwork with you YES or NO

How will child react to dental visit: Very Poorly _____ Poorly _____ Well _____ Excellent _____ Unsure _____

PLEASE DESCRIBE FURTHER ANY CHECKED:

_____

ALLERGIES ☐ No Known Allergies ☐ Seasonal/Environmental (pollen, etc) ☐ Tape ☐ Latex ☐ Medications Please list allergy and reaction _____ _____

MEDICATIONS ☐ None taken ☐ Takes Medications (List Dosage, Frequency, and why med is taken)- Include any over the counter medication and vitamins)

_____
_____

PREVIOUS SURGERIES HOSPITALIZATIONS (include dates & procedure done if applicable) ☐ No surgery/hospitalization
☐ Had the following completed/was hospitalized for the following

_____
_____
_____

ANESTHESIA PROBLEMS: Has the child or anyone in the family been diagnosed with the following:
☐ Malignant Hyperthermia ☐ Pseudo cholinesterase Disease ☐ Severe Postop Nausea/Vomiting

Does the child have/use any of the following ☐ Glasses ☐ Hearing Aids (please circle) Left Right
☐ Loose/Capped/Missing Teeth (please circle) Upper Lower

Is the child exposed to second hand smoke ☐ yes ☐ no **Is there any illicit drug use in the family** ☐ yes ☐no

Is there any alcohol abuse in the family ☐ yes ☐no **Is there any history of physical abuse in the family** ☐ yes ☐no

Does the child suffer from the following:

Blood/Bleeding Disorders ☐ No Problem with blood diseases ☐ Blood diseases _____ ☐ HIV/AIDS ☐Bleeding tendencies/Factor deficiencies WHICH FACTOR? _____ ☐ Anemia TYPE? _____ ☐ History Transfusions
☐ Other PLEASE **DESCRIBE FURTHER ANY CHECKED: _____**
_____

Respiratory System ☐ No Problems with Lungs ☐ Asthma ☐ Emphysema ☐ Bronchitis ☐ TB ☐ Sleep Apnea ☐ Other
PLEASE DESCRIBE FURTHER ANY CHECKED:
_____

Cardiovascular System ☐ No problem with Heart ☐High blood pressure ☐ problem with heart rhythm ☐ Pacemaker
☐Defibrillator ☐ Stroke ☐ Mitral Valve Prolapse ☐ Murmur ☐Phlebitis ☐ problem with heart valves ☐ congenital heart defect now or at birth
☐ Other **PLEASE DESCRIBE FURTHER ANY CHECKED:_____**

Nervous System ☐ No known Issues ☐ Seizures ☐ Tremors ☐ Vertigo ☐ Other
PLEASE DESCRIBE FURTHER ANY CHECKED:
_____

Endocrine System ☐ No known Issues ☐ Diabetes ☐ Noninsulin Dependent ☐ Insulin Dependent ☐ Thyroid Disease
☐ Other **PLEASE DESCRIBE FURTHER ANY CHECKED:**
_____

Digestive System ☐ No known Issues ☐ Hiatal Hernia ☐ Acid Reflux ☐ Ulcers ☐ Hepatitis ☐ Chronic constipation
☐ Chronic Diarrhea ☐ No bowel control ☐ Other **PLEASE DESCRIBE FURTHER ANY CHECKED: _____**
_____

Genitourinary System ☐ No known Issues ☐ Kidney problems ☐Bladder Issues ☐ Bed Wetter ☐ Other
PLEASE DESCRIBE FURTHER ANY CHECKED: _____

Reproductive System ☐ No known Issues ☐ Last Menstrual Period _____ ☐ Not applicable ☐ Ovarian cysts
☐ Endometriosis ☐ Other PLEASE **DESCRIBE FURTHER ANY CHECKED: _____**

Skeletal System ☐ No known Issues ☐ Arthritis ☐ Neck/Back Problems ☐Limitations in mobility ☐ Wheelchair Bound
☐ Cerebral Palsy ☐Other assistive device _____ ☐ Other **PLEASE DESCRIBE FURTHER ANY CHECKED: _____**
_____

Psychosocial ☐ No known Issues ☐ Mental health disorder ☐ Sleep disorder ☐ recent life changes/stressors ☐ late sleeper
☐Heavy sleeper ☐ Autism ☐ ADHD ☐ parents separated/going through divorce/ widowed ☐other **PLEASE DESCRIBE FURTHER ANY CHECKED: _____**
_____

Skin ☐ No known Issues ☐ Psoriasis ☐Eczema ☐Bruises ☐ Other **PLEASE DESCRIBE FURTHER ANY CHECKED:**
_____

Infection ☐ No known Issues ☐ MRSA ☐ VRE ☐ CDIFF When? _____ Last test performed? _____
When? _____ Where? _____

Parent/Foster Parent/Legal Guardian's Name: _____

Parent/Foster Parent/Legal Guardian's Signature & Date: _____

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE. WE LOOK FORWARD TO CARING FOR YOUR CHILD.

Children's Dental Health Associates

Consent to Perform Exam and Cleaning

1. I hereby authorize and direct the dentists of Children's Dental Health Associates and/or dental auxiliaries of their choice, to perform upon my child (or legal ward) the following dental treatment, radiographs (x-rays), or diagnostic aids:

    A. Cleaning of the teeth
    B. Consult or complete exam by dentist
    C. X-rays
    D. Lap Exam (may need to hold hands down to complete exam)

2. I recognize that during the course of treatment, it may be determined that additional work is necessary to include, but not limited to, fillings, pulpotomies, crowns, extractions, sutures, local anesthetic, sealants, or nitrous oxide. I realize that these procedures are not covered under this consent and, as such, will require a separate treatment consent outlining the specific tooth and work to be completed.

3. If, during any course of my child's care at CDHA, if an employee, dentist, or other provider is exposed to my child's blood via an accidental needle stick or instrument stick, I consent to follow the procedures to get a sample blood withdrawal for HIV and Hepatitis testing. I understand the testing will be done in a manner that protects my child and my privacy and will be done at no cost to me.

4. I hereby state that I have read and understand this consent, and that all questions about the procedure have been answered in a satisfactory manner.

5. I further understand that this consent will remain in effect until such time that I choose to terminate it.

Patient's Name: _____

Parent/Foster Parent/Legal Guardian's Name: _____

Parent/Foster Parent/Legal Guardian's Signature & Date: _____

Children's Dental Health Associates

Consent for Fluoride Treatment

Fluoride is effective in preventing and reversing the early signs of dental caries (tooth decay). Researchers have shown that there are several ways through which fluoride achieves its decay-preventative effects. It makes the tooth structure stronger, so teeth are more resistant to acid attacks. Fluoride also acts to repair, or re-mineralize, areas in which acid attacks have already begun. The re-mineralization effect of fluoride is important because it reverses the early decay process as well as creating a tooth surface that is more resistant to decay.

Most insurance companies cover fluoride treatment twice a year, however some insurance companies are only paid for a once a year application.

I have been informed of all of the alternatives to fluoride.

PLEASE CHOOSE ONE (1) OF THE FOLLOWING:

I, _____ give my consent to apply fluoride treatment TWICE a year. I agree that if my insurance company does not pay for the second application, that I am financially responsible for payment.

I, _____ give my consent to apply fluoride treatment only ONCE a year.

I, _____ do not wish fluoride treatment to be applied to my child at any time.

Patient's Name: _____

Parent/Foster Parent/Legal Guardian's Name: _____

Parent/Foster Parent/Legal Guardian's Signature & Date: _____

Children's Dental Health Associates

Permission for Others to escort child to and from dental appointments

In order to make your visit as prompt and pleasant as possible, please provide the following information:

I, _____ hereby give the following my permission to bring my child/children to Children's Dental Health Associates:

NAME	**Relationship to Child/Children**

*** THERE MAY BE A NEED TO CALL THE PARENT/GUARDIAN PRIOR TO OR DURING TREATMENT

Patient ID# _____ (Office Use Only) Today's Date_____

Patient's Name_____ DOB _____

Parent/Legal Guardian's Name: _____

Parent/Legal Guardian's Signature & Date: _____

Children's Dental Health Associates

Consent for Use and Disclosure of Health Information

Section A: Parent/Legal Guardian giving consent:

Name: _____ **Date**: _____

Address: _____

Telephone: _____ **Email**: _____

Patient: _____ **Social Security #** _____

Section B: PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY:

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protection 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 accompanies this consent. 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.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice, at any time by contacting:

Contact Person: Practice Manager - Brook Murphy

Telephone: (610) 622-1949 Ext 1109 **Fax:** 484-698-7848

Email: brook@childrensdentalhealth.com

Address: 596 Lancaster Ave, Suite 100, Malvern, PA 19335

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of you revocation submitted to the contact person listed above. Please understand the revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation and that we may decline to treat your child if you revoke this consent.

Signature:

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

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

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Children's Dental Health Associates

ACKNOWLEDGEMENT NOTICE OF PRIVACY PRACTICES

I, _____, have been given the opportunity to review the office's Notice of Privacy Practices. I understand that at anytime I may receive a copy of the office's Notice of Privacy Practices.

Please Print:

_____

Name

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices but, acknowledgement could not be obtained for the following reasons:

□ Individual Refused to sign
□ Communication barriers prohibited obtaining the acknowledgement
□ An emergency situation prevented us from obtaining acknowledgement
□ Other (please specify below)

_____
_____
_____

Children's Dental Health Associates

PRIVACY PRACTICES AND INTENT TO KEEP YOUR INFORMATION PRIVATE

We make every attempt to ensure we have the proper information on file including contact information and individuals that we may have discussions about your child's health information with by any means including, but not limited to phone, email, etc. Please complete the following contact sheet as well as list any and all individuals and relationships to those individuals that we may disclose this information to. If the information you would prefer to disclose is limited, please document that next to their relationship.

Updated Contact Information

I hereby authorize the office to contact the designated phone numbers and/or email address listed below. With this authorization, a message may be left indicating my appointment time and date, balances due and/or estimated co-pays for future visits.

Signature _____

Phone #1 _____

Phone #2 _____

Email _____

List of individuals to release information to, relationship, and information allowed:

Name	Relationship	Information, if other than all