Welcome to Oak Tree Pediatric Dentistry

Child's Information

Child's Name(Last, First, Middle Initial):_____

Child's DOB: ____/____/_____Child's Age_____ Nickname: _____ ( ) Male ( ) Female

School : _____ Grade: _____ Child's Home Phone : (____)_____-_____

SS# :____-___-_____ Child's Address: _____

Apt #:_____ City: _____ State:_____ Zip Code: _____

Would you like to receive text message reminder? ( ) Yes ( ) No Cell Phone:(____)_____-_____

Whom may we thank for referring you? _____

Other siblings seen by us: _____

Previous Dentist: _____ Last Visit Date: ___/___/_____

Parent's Information

Mother's Name: _____ DOB: ___/___/_____

Work Phone: (____)_____-_____ Ext: _____ Home Phone: (____)_____-_____

Employer: _____ SS#: _____- ____-_____

Email Address:_____

Father's Name: _____ DOB: ___/___/_____

Work Phone: (____)_____-_____ Ext: _____ Home Phone: (____)_____-_____

Employer: _____ SS#: _____- ____-_____

Email Address:_____

Person Responsible for Account

Name: _____

Relationship to patient:_____

Billing Address: _____Apt#:_____

City:_____State:_____Zip Code:_____

Who is Accompanying the Child Today?

Name:_____ Relation:_____

Primary Dental Insurance

Insurance Co Name: _____

Insurance Co Address: _____

Insurance Co Phone Number: (____)_____-_____ Group #: _____

Policy Owner's Name: _____

Relationship to Patient: _____ Policy Owner's DOB: ___/____/_____

Policy Owner's SS#: _____-_____-_____ Policy/Member ID# _____

Policy Owner's Employer: _____

Secondary Dental Insurance

Insurance Co Name: _____

Insurance Co Address: _____

Insurance Co Phone Number: (____)_____-_____ Group #: _____

Policy Owner's Name: _____

Relationship to Patient: _____ Policy Owner's DOB: ___/____/_____

Policy Owner's SS#: _____-_____-_____ Policy/Member ID# _____

Policy Owner's Employer: _____

Medical Problems

Has your child ever had any of the following medical Problems? PLEASE CIRCLE YES OR NO

YES	NO	ABNORMAL BLEEDING	YES	NO	CHICKEN POX
YES	NO	ANEMIA	YES	NO	EPILEPSY
YES	NO	CANCER	YES	NO	HANDICAPS OR DISABILITES
YES	NO	CONGENITAL HEART DEFECTS	YES	NO	HIVES
YES	NO	HEART MURMOR	YES	NO	KIDNEY OR LIVER PROBLES
YES	NO	EXPOSED TO HIV,BUT NEGATIVE	YES	NO	MONONUCLEOSIS
YES	NO	HEARING IMPAIRMENTS	YES	NO	SKIN RASH-CAUSE=
YES	NO	HEMOPHILIA	YES	NO	PENICILLIN ALLERGY
YES	NO	HIV/AIDS	YES	NO	RED DYE ALLERGY
YES	NO	MEASLES	YES	NO	PEANUT ALLERGY
YES	NO	RHEUMATIC/SCARLET FEVER	YES	NO	EGG ALLERGY
YES	NO	TUBERCULOSIS (TB)	YES	NO	LATEX
YES	NO	ANY HOSPITAL STAYS	YES	NO	THUMB HABIT
YES	NO	DIABETES	YES	NO	PACIFIER
YES	NO	ASTHMA	YES	NO	OTHER ALLEREGIES
YES	NO	CONVULSIONS	YES	NO	CHILD'S IMMUNIZATIONS CURRENT

Please discuss any serious allergies to medications and or medical problems below:_____

_____

_____

_____

Please list any medications the patient is currently taking:_____

_____
_____
_____

If there is any other information you feel we need to know about the patient, please list below:_____

_____
_____
_____
_____

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest 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: ____/_____/_____ I certify that my child is covered by _____ Insurance Co and I assign directly to Dr _____ all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary for the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature of Parent or Guardian: _____ Date:____/____/_____

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY I verbally reviewed the medical / dental information above with the parent / guardian named herein.

Staff Name: _____ Date: _____/_____/_____

Doctor's Initials: _____ Date: _____/_____/_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT OF INFORMATION

*You may refuse to sign this acknowledgement and consent form.

* I, _____, have received a copy of this office's notice of privacy practices. By this signature, I also consent that this office can use or disclose my health information to a physician or other healthcare provider, providing treatment for me. It also authorizes this office to use and disclose my health information for the purpose of filing insurance claims. It further authorizes this office to contact me via mail, and/or telephone (cell phone or pager) to advise me of appointment times, payment and/or questions regarding treatment. If there is any part of this consent you do not wish to agree to, please strike through that portion and advise our staff.

Print Name: _____

Signature: _____ Date: _____/_____/_____

Office use only

We attempted to obtain written acknowledgement and consent of our notice of privacy practices, but acknowledgement and consent could not be obtained because:

___Individual refused to sign ___Communication barrier prohibited obtaining the acknowledgement and consent

___An emergency situation prevented us from obtaining acknowledgement ___Other (Please Specify)

Oak Tree Pediatric Dentistry
410-A Pelham Rd.
Greenville, SC 296155
864-232-3333

I understand and consent (for dental treatment)

For: _____

Great improvements have been made in relation to the health, appearance and diction of dental patients. However, like any other medical treatment, dental procedures (restorative, periodontic, orthodontic, or prosthodontics) have certain risks and limitations. Despite the seriousness of these procedures, contraindications for the performance of recommended dental treatment are rarely present; however, they must be considered before treatment. Therefore, we urge you to read the following information and ask questions that may arise in your mind, so that (after being completely satisfied with our explanations), authorize your treatment or that of your family member, by signing this form. This is a common procedure in our office.

1. I have discussed my* medical and dental history with the doctor, I have informed you about allergies or other serious problems that afflict me. The doctor has informed me about the current state of my dental health.
2. I understand what the existing problems are in my mouth.
3. I understand the doctor's treatment plan, the consequences that complete, partial treatment or absence of one could have, as well as the risks involved in that procedure, and the risk that exists if such procedure were rejected.
4. I have been explained about the most beneficial treatment plan as well as alternative procedures.
5. I understand the purpose of treatment, and the benefits that are expected to be obtained. I also understand that it cannot be predicted with certainty what the outcome of the treatment will be, I recognize that I might feel unhappy with it and even consider it a failure, because the condition could worsen and not even meet the expectations of my dentist, although our goal is to achieve success, it cannot be guaranteed.
6. I was informed of payments in relation to each of the treatment options, and payment systems were discussed. Important: If the patient has coverage from a private insurance company, he or she will be considered a private patient during any of his visits, (not as a Medicaid patient). This has also been explained to me verbally and I understand that I will be responsible for the full payment of the amounts not paid by the insurance company, unless a prior arrangement has been made, the how much it should be signed by the doctor.
7. Within my responsibilities as a patient is to fulfill my appointments on time, care for my teeth and gums – before, during and after treatment, following the instructions given to me, and fulfilling the financial obligations incurred.
8. I also understand that during the treatment process any unforeseen events or circumstances may arise; so, if necessary, I consent to the dentist practicing the treatment that I deem necessary, although there is no previously specified roast.
9. I understand that I have the right to accept or not the proposed treatment, and all my questions have been answered to my satisfaction, before signing this formula.
10. I have had the opportunity to ask questions about the proposed treatment, and all my questions have been answered to my satisfaction, before signing this formula.

If you are the parent or patient's caregiver, the words "my" or "I" should be replaced by "the patient" respectively***

Logically, the risks depend on the dental procedures used. These procedures could include restorative, periodontal treatment, orthodontic therapy, surgery, endodontic and prosthetic treatment, as well as minimal x-ray exposure, for the purpose of diagnosis.
These risks may include: bad breath, food impact, sensitivity to cold and hotness, unwanted tooth movements, inflammation in tissue infection, gum problems and bone loss; pain, inflammation, bleeding, premature loss of the tooth, deterioration of the journalistic condition, difficulty speaking and chewing, impediments to opening the mouth, joint pain, and the weakening/wear of the tooth making necessary a nerve treatment with all the risks that this would entail; unforeseen surgery along with all its risks as well as some unforeseen procedure required by local or general, with all the risks that this entails.
I reiterate that our intention is to inform you about possible problems that may arise, although most of them occur very rarely. There may also be other risks that have not been mentioned. You should be aware that these situations may happen. In the event that any of these conditions occur, we will make every effort to give the patient the correct treatment or refer it to the appropriate dentist or physician. The treatment of a human biological condition will never achieve a state of perfection, despite technological advances. Your treatment depends on a close working relationship. Patients and their families should feel confident to ask about any aspect of treatment. Understanding, as well as cooperation, are essential to achieving the results that both sides seek.

I attest that I have read or have read the contents of this form I also agree to sign the authorization related to the proposed treatment, medications or surgery that I have indicated. I know and accept the risks consent for the dentist to make your treatment plan.

Date_____

Signature_____

Witness Signature_____

Our Financial Policy

Thank you for choosing us for your dental care provider. We are committed to your being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy which we require you read and sign prior to any treatment. All patients must complete our information and insurance form before seeing the doctor.

-Full Payment is due at time of service unless otherwise arranged prior to appointment.

- We accept Cash, Checks, Visa, Master card, American Express, and Care Credit

Regarding Insurance: We cannot bill your insurance unless you give us your insurance information or insurance card. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We do require and appropriate co-payment to be paid at the time of services. The balance is your responsibility whether your insurance company pays or not. In the event we do accept assignment of benefits, you must provide a credit card with authorization to bill the account for the balance. To “accept assignment of benefits” means to accept that portion of your responsibility directly from the insurance company. It does not imply that any insurance company that has not paid your account in full within 45days, the balance will automatically be transferred to your credit card, unless other arrangements are made. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not portion of the family account with this office is unpaid, the responsible party and/or insurance policy holder does herby assign any and all insurance benefits directly to the provider.

Usual and Customary Rates: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company’s arbitrary determination of usual and customary rates.

Minor Patients: The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan.

Appointment Cancellations: Please help us serve you better by keeping scheduled appointments in timely fashion. At least 48 hours advanced notice in canceling appreciated. If proper notice is not given, an office fee will be charged. Thank you for understanding our Financial Policy. Please let us know if you have any questions of concerns. I have read the Financial Policy. I understand and agree to this Financial Policy, which includes direct payment of benefits to the provider.

Signature of Patient or responsible party :_____

Patient's Name:_____

Witness: _____

Date: _____/_____/_____

Oak Tree Pediatric Dentistry

NON-PARENTAL/GUARDIAN PERMISSION CONSENT FORM FOR TREATMENT

Date: _____

I _____(relation to patient_____) give consent/permission/authority to let (list below) bring my child to his/her dental visits.

Child's Name_____

_____

_____

_____

I give permission to the above-named people to sign any forms necessary the day of the procedure, including treatment consent forms and/or for a change in treatment. I have previously been given information regarding dental treatment and understand that treatment may change the day of service and I give permission for any and all treatment to be performed in my absence, according to the needs of the child. I give permission and understand that my child depending on the cooperation or lack thereof, may need to be papoosed. I have been told this is a method used to protect my child and staff.

Photograph & Video Release Form

We love capturing smiles at Oak Tree Pediatric Dentistry and having fun with our patients. We regularly update our social media and office bulletin boards and want to make sure you say YES before posting them. Our staff members LOVE selfies and silly faces…… so don't hesitate to snap a photo for social media while you're here.
I hereby grant permission to the rights of my child's image, likeness and sound of my voice as recorded on audio or video without payment or any other consideration. I understand that my image may be enhanced and published online.
Photographic, audio or video recordings may be used for the following purposes

- Social media/website
- Educational videos
- Advertising for Children's Dentistry of Greenville
- Educational presentations or courses

By signing this release, I understand this permission signifies that photographic or video recordings of me may be electronically displayed via the Internet or in the public educational settings.
By signing this form, I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby.
Full Name of Patient: _____

Signature:_____Date:_____

If this release is obtained from a presenter under the age of 18, then the signature of that presenter's parent or legal guardian is also required.

Parent's Signature_____ Date:_____