PAPILLION®
Pediatric Dentistry
Specialized Care for Infants, Children, and Teens

Dr. Jane Bennett, DDS • Pediatric Dentist

545 Fortune Drive • Suite 400 • Papillion, NE 68046
Phone: 402-502-1256 • Fax: 402-504-3322
email: drjane@janebennettdds.com

Patient Information, Office and Privacy Policies, Medical/Dental History Questionnaire, and Consent Forms

To provide the safest and most comprehensive dental care for your child, we ask for your cooperation in completing our detailed questionnaire.

Date:_____ Child's Name:_____ _____ ___
Last First MI

Nickname/Preferred Name :_____ Birth date: Mo:____ Day:____ Year:_____

Age:_____ SSN:_____ Gender (M/F): ____ Home Phone: _____

Address:_____ Apt No.: _____

City:_____ State:_____ Zip:_____ Primary Language Spoken:_____

Child Primarily Lives With: _____

Is your child presently under the care of a physician for any reason? ❑Yes ❑No

Explain: _____

Physician's Name: _____ Date of last exam: _____

Physician's Address: _____ City:_____ State: ____ Zip: _____

Phone Number: _____

Is your child taking any medications? ❑Yes ❑No

List: _____

Has your child ever been hospitalized, sedated, or had surgery? ❑Yes ❑No

Explain: _____

Does your child have any allergies to medicines, latex, foods, or metals? ❑Yes ❑No

List: _____

Are antibiotics necessary for dental work because of a heart murmur, defect, prosthesis, shunt, organ transplant or other medical reasons? ❑Yes ❑No

Explain:_____

Has any member of the family, including your child, had a problem with sedation or general anesthesia?
❑Yes ❑No

Explain:_____

Are your child's immunizations up to date? ❑Yes ❑No

Medical History

If your child has or ever had any of the following conditions please check yes below.
Please explain any yes's to the Doctor.

		Condition			Condition
❑ Yes	❑ No	ADD/ADHD—Attention Deficit Disorder/ Attention Hyperactivity Disorder	❑ Yes	❑ No	Hearing Impairment
❑ Yes	❑ No	AIDS/HIV	❑ Yes	❑ No	Heart Disease
❑ Yes	❑ No	Asthma	❑ Yes	❑ No	Heart Murmur
❑ Yes	❑ No	Autism	❑ Yes	❑ No	Hemophilia
❑ Yes	❑ No	Behavioral Problems	❑ Yes	❑ No	Hepatitis/Liver Disease
❑ Yes	❑ No	Birth defects	❑ Yes	❑ No	High Blood Pressure
❑ Yes	❑ No	Bleeding gums	❑ Yes	❑ No	Injury to Front Teeth
❑ Yes	❑ No	Blood Transfusions	❑ Yes	❑ No	Kidney Disease
❑ Yes	❑ No	Bone or Joint Problems	❑ Yes	❑ No	Mentally Handicapped
❑ Yes	❑ No	Brain Injury	❑ Yes	❑ No	Metallic Implant, Shunts, Pins/Rods
❑ Yes	❑ No	Cerebral Palsy	❑ Yes	❑ No	Premature Birth
❑ Yes	❑ No	Cancer/Tumor	❑ Yes	❑ No	Prolonged bleeding When Cut
❑ Yes	❑ No	Chemical Dependency	❑ Yes	❑ No	Psychiatric Care
❑ Yes	❑ No	Chemotherapy/Radiation	❑ Yes	❑ No	Rheumatic Fever
❑ Yes	❑ No	Chicken Pox	❑ Yes	❑ No	Sickle Cell Disease
❑ Yes	❑ No	Child Abuse	❑ Yes	❑ No	Sore Throats
❑ Yes	❑ No	Cleft Palate/Lip	❑ Yes	❑ No	Speech Impairment
❑ Yes	❑ No	Cold Sore/Canker Sores	❑ Yes	❑ No	Thyroid Disease
❑ Yes	❑ No	Developmentally Delayed Age level is __	❑ Yes	❑ No	Tonsillitis
❑ Yes	❑ No	Earaches/Ear Infections	❑ Yes	❑ No	Transplants, Organ Specify _____
❑ Yes	❑ No	Epilepsy/Seizure Disorder	❑ Yes	❑ No	Tuberculosis
❑ Yes	❑ No	Eye Conditions	❑ Yes	❑ No	Other Please Specify
❑ Yes	❑ No	Females: Are you Pregnant?			_____
❑ Yes	❑ No	Females: Are you taking Birth Control medication?			_____

Is there any other health information that should be known? ❑Yes ❑No

Explain: _____

Staff Medical History Review (for internal use only)

Signed: _____	Date: _____	Signed: _____	Date: _____
Signed: _____	Date: _____	Signed: _____	Date: _____
Signed: _____	Date: _____	Signed: _____	Date: _____
Signed: _____	Date: _____	Signed: _____	Date: _____
Signed: _____	Date: _____	Signed: _____	Date: _____

Dental History

Is this your child's first dental visit? ❑Yes ❑No

Previous Dentist:_____ Date of Last Visit: _____

Date of Last X-rays: _____

Has your child experienced any unfavorable reaction from previous dental or medical care? ❑Yes ❑No

Explain:_____

How often does your child brush?_____

Is tooth brushing supervised? ❑Yes ❑No Is dental floss used? ❑Yes ❑No

Does your child receive (check all that apply):

❑Fluoride in vitamins ❑Bottled water ❑Fluoridated water ❑Fluoride tablets/drops ❑Well water

Has there been any injuries to your child's teeth or jaws? ❑Yes ❑No

Explain :_____

History of (check all that apply):

❑Breast feeding ❑Thumb sucking ❑Bottle habits ❑Pacifier ❑Sippy cup ❑Teeth grinding/clinching

How do you think your child will act toward the dentist?

Explain:_____

Has your child had recent dental pain? ❑Yes ❑No

Explain: _____

Does your child have a specific dental problem that needs attention? ❑Yes ❑No

Explain: _____

How Did You Hear About Us?

❑Family ❑Friend ❑Doctor ❑Other: _____

Referer's Name: _____ Address:_____

City: _____ State: _____ Zip: _____ Phone: _____

Primary Responsible Party Information

Resident Parent's Name: _____ _____ ___ Gender (M/F): ____
Last First MI

Marital Status: _____ SS#: _____ Birth Date: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Email:_____ Cell Phone: _____

Home Phone: _____ Work Phone: _____ Ext: _____

Secondary Responsible Party Information

Secondary Name: _____ _____ ___ Gender (M/F): ____
Last First MI

Marital Status: _____ SS#: _____ Birth Date: _____

Address:_____ Apt #:_____

City:_____ State:_____ Zip Code:_____

Email: _____ Cell Phone: _____

Home Phone: _____ Work Phone: _____ Ext: _____

Primary Dental Insurance

Insured's Name: _____ _____ ___
Last First MI

Insurance Company Group Plan: _____

Employer: _____

Insurance Company Address: _____

City: _____ State: _____ Zip: Code: _____

Insurance Company's Phone #: _____

Group #: _____ Local Group #: _____

Secondary Dental Insurance

Insured's Name: _____ _____ ___
Last First MI

Insurance Company Group Plan: _____

Employer: _____

Insurance Company Address: _____

City: _____ State: _____ Zip: Code: _____

Insurance Company's Phone #: _____

Group #: _____ Local Group #: _____

Emergency Contact Information

Name: _____

Relationship to child: _____

Address: _____

City: _____ State: _____ Zip: Code: _____

Phone: _____ Cell Phone: _____ Work Phone: _____

Treatment Consent

The permission of a parent or legal guardian is necessary for dental treatment of a minor.
As a minor child, it is necessary that signed permission be obtained from a parent or legal guardian before any dental care can begin. As a parent or legal guardian of the above patient, I acknowledge that the above information is correct and grant Papillion Pediatric Dentistry permission to provide my child's dental and related medical/surgical treatment as deemed necessary, including digital radiographs (x-rays), diagnostic, restorative, oral surgery, and patient management techniques that are reasonable, necessary and advisable. Protective restraints are used when a child might harm themselves or when certain procedures may jeopardize their health and welfare without such restraints. I also authorize the administration of anesthetics or analgesics that are advisable by Dr. Bennett, such as nitrous oxide (laughing gas).

I have given an accurate report of this patient's physical and mental health history. I have also reported any prior allergic or unusual reactions to medications, latex, foods, or metals, and any other disease or condition, including pregnancy.

I agree to inform Dr. Bennett and the staff of Papillion Pediatric Dentistry of any changes in the medical history. This authorization is valid until revoked by me in writing.

_____ _____ _____

Signature | Relationship to Child | Date

Financial Consent

The Financial responsibility of a parent or legal guardian is necessary for dental treatment of a minor.
I accept financial responsibility for this child.
I authorize the release of any dental information necessary to process this claim and all future claims.
I authorize insurance payments directly to Dr. Jane Bennett/Papillion Pediatric Dentistry.
I will be responsible for reporting any changes in my child's dental insurance coverage,
I will be responsible for any late fees due on my account.

I agree to inform Dr. Bennett and the staff of Papillion Pediatric Dentistry of any changes in the Financial arrangements prior to treatment. This authorization is valid until revoked by me in writing.

_____ _____ _____

Signature | Relationship to Child | Date

Office Policies

No-show Policy

Missed appointments without 24 hour prior notification are considered 'NO SHOW' appointments and will result in a $55.00 fee. This fee must be paid before being scheduled again.

Missed Appointments

After **THREE** 'No Show' appointments (missed appointments without 24 hour prior notification) you will be dismissed from our practice.

Late Arrivals

Late arrival for a scheduled appointment leads to inadequate time to accommodate the remaining patients on the schedule. As such, late arrivals of greater than 10 minutes may not be seen depending on the time available. In addition, those patients who are on the schedule and here at the assigned time will be seen first. We will try to accommodate late appointments if time permits.

Payment Policies

For patients without insurance, payment in full is expected for services rendered on that day of service. Major credit cards , checks, and cash are accepted.

For those patients with dental insurance, the office will send claims to the insurance carrier, provided that the insurance card is presented to the office at the time of the visit. Dental insurance may not cover all of the costs of your child's dental care. **Most plans include coinsurance provisions, a deductible, and certain other expenses which must be paid by the responsible party at the time of services.**

Any portion of services not covered by dental insurance along with your deductible is due on the day services are rendered. Based on the information from your insurance, we give you an **estimate of** the total cost to you, however if there is a balance due after insurance pays, it will become your responsibility, and is due within 30 days.

Payment plans are available through the Citi Health card program. Please ask for details.

By my signature, I acknowledge and understand the office policies at Papillion Pediatric Dentistry.

Signature	**Relationship to child**	**Date**

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.
MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITYS IN THE FUTURE.

_____ _____
Please ***print*** your child's name Please ***print*** your child's name

_____ _____
Please ***print*** your child's name Please ***print*** your child's name

_____ _____
Please ***print*** your child's name Please ***print*** your child's name

_____ _____
Legal Representative (sign here) Description of Authority

Your comments regarding Acknowledgements or Consents:

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA?

☐ First Name Only ☐ Proper Sir Name ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message
☐ Text Message
☐ **Any of the Above**
☐ **None of the above** (opt out) ☐ Email

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

☐ It was emergency treatment

☐ I could not communicate with the patient

☐ The patient refused to sign

☐ The patient was unable to sign because

☐ Other (please describe) _____

Jane Bennett DDS

_____
Signature of Privacy Officer

Office Name: Papillion Pediatric Dentistry
HIPAA Privacy Officer: Dr. Jane Bennett
Phone Number: 402-502-1256
Email Address: drjane@janebennettdds.com