Thank you for completing our forms online.

When complete, click Submit (green arrow)
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Scroll Down to Continue.

Robert D. Elliott, DMD, MS

Cary Pediatric Dentistry

Julie R. Molina, DDS, MS

540 New Waverly Place • Suite 300 • Cary, NC 27518 • Telephone: (919) 852-1322 • FAX: (919) 852-1230

Demographic Information

Patient_____ Today's Date_____

Preferred Name_____ Guardian's Email _____

Birthday_____ Age_____ Sex_____ Ethnicity_____

Home Phone_____Cell Phone_____ Secondary Cell Phone _____

Home Address_____

street *town* *state* *zip code*

Names *and ages* of other children in family_____

School_____Grade _____

Parent/Legal Guardian: _____Relation to patient _____

Employer_____Phone_____

Parent/Legal Guardian: _____Relation to patient _____

Employer _____Phone_____

Who has legal custody of patient? _____Dental Insurance: o Yes o No

Person responsible for payment of account_____SS#_____DOB _____

Name of child's physician/group_____ City/St_____Ph #_____

Whom may we thank for referring you to us? _____

What is the reason for your child's dental visit? _____

Health History

o Yes o No Is your child in good health? Date of last physical exam _____

o Yes o No Has your child ever had a health problem? _____

o Yes o No Is your child current on their vaccinations? If no, please explain _____

_____

o Yes o No Has your child ever been hospitalized? Please give reason and dates _____

_____

o Yes o No Is your child allergic to anything? _____

o Yes o No Is your child currently taking any medications? Please give medication, dose and reason_____

o Yes o No Were there any problems at birth? _____

o Yes o No Has your child had any change in family emotional history (i.e., divorce, loss of a pet)?

_____

Please circle if your child has been treated for any of the following:

o Heart disease	o Bleeding/transfusions	o Asthma/breathing	o Blood dyscrasias
o Liver/GI disease	o Anemia	o Diabetes	o AIDS
o Kidney disease	o Rheumatic fever	o Hepatitis	o Developmental delays
o Speech/hearing	o Seizures	o Cleft lip/palate	o Physical delays
o Eyesight	o Congenital birth defects	o Personality/social	o Other problems
o Cancer/tumors	o Recurrent headaches	o Frequent infections	o Adverse Drug reactions
o Cerebral palsy	o Significant injuries	o Endocrine/growth	o Autism
o Down Syndrome			o Verbal
			o Non Verbal

Please elaborate on any items circled:_____

_____

_____

_____

Office use only

-over-

Do you consider your child to be: o advanced in the learning process
o progressing normally
o slow in the learning process

Was your child: o breast fed At what age stopped_____
o bottle fed At what age stopped_____

Dental History

o Yes o No Has your child ever been to the dentist? Date of last xrays (if taken) _____
Name of dentist and date_____

o Yes o No Has your child experienced any unfavorable reaction from previous dental care? Explain _____

o Yes o No Does your child suck a finger, thumb or pacifier?

o Yes o No Does your child have pain with chewing, yawning, or wide opening?

o Yes o No Does your child's jaw make noise and is pain associated with the sounds?

Please check if your child is having problems with any of the following:

o Cavities	o Toothache	o Sensitive Teeth
o Trauma	o Gum Infections	o Color of teeth
o Orthodontics	o Jaw Sounds	o Other

Comments: _____

Please estimate your child's daily exposure to the following items:

Soda: _____ Cereal bars/granola bars: _____
Juice:_____ Gummies/gummy vitamins:_____
Sports drinks: _____ Fruit snacks/fruit roll-ups: _____
Cookies/crackers: _____ Dried fruit: _____

Office Use Only
☐ Fl- City Water
☐ Pvt. Well
☐ Public Well _____ppm
☐ H_2O test kit given

Fluoride History

o Yes o No Is your home water supply fluoridated?

o Yes o No Does your child use a fluoride toothpaste?

o Yes o No Does your child participate in a school fluoride rinse program?

o Yes o No Do you give your child any other form of fluoride? What?_____

I understand that gummy vitamins, fruit snacks, fruit leathers, raisins, craisins and similar sticky/gooey food will absolutely 100% increase my child's risk for cavities.

Consent for Dental Treatment

I request and authorize Dr. Elliott or Dr. Molina to examine, clean, and provide dental treatment on my child's teeth. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Elliott or Dr. Molina to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or child's teeth for diagnostic or educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr. Elliott or Dr. Molina will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone. I will be responsible for any charges incurred on this child for dental treatment.

Signature _____ **Date** _____

Request and Consent for Pediatric Dental Treatment
Cary Pediatric Dentistry

Please read this form carefully! If you do not understand something to your satisfaction, please ask questions. We will be pleased to explain it. ☺

1. I request and authorize dental treatment and associated procedures for:

   Patient Name: _____ Today's Date: _____

2. **I understand** that treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Behavior will be guided using praise, explanation and demonstration of procedures and instruments, using variable voice tone and loudness.

3. I further request and authorize the taking of oral dental x-rays and the use of such anesthetics as may be considered necessary to treat the patient's dental problem(s).

4. **I understand** that should the patient become uncooperative during dental procedures with movement of the head, arms and/or legs, dental treatment cannot be ***safely*** provided. During such disruptive behavior, it may be necessary for the assistant(s) to hold the patient's hands, stabilize the head and/or control leg movements.

5. **I further understand** that should the patient become uncooperative during dental procedures with excessive body movements, the team may discuss a technique to stabilize your child to provide dental care in a safe environment. The patient may need to be wrapped in a "hug blanket" or "papoose board", verbal consent would be obtained prior to use. This is for their safety and to prevent injury and enable Dr. Elliott or Dr. Molina to ***safely*** provide the necessary treatment.

6. Both Drs. Elliott and Molina are faculty members at UNC Dental School and enjoy teaching dental students and residents. For the purpose of advancing medical-dental education, I give permission for the use of clinical photographs of the patient for diagnostic, scientific, educational or research purposes. *Please note only the teeth or oral structures would be included, we would never use photos of your child's face or identifying markers.*

In order for us to see your child initially, we require your signature on the bottom right line of this page

_____

Parent/Guardian Signature

☺ **OVER PLEASE** ☺

Guardians: Y*ou may wait to complete this section until the end of the appointment.*

7. I have had explained to me by Dr. Elliott, Dr. Molina or their associates, and have had sufficient opportunity to discuss the patient's dental condition/problem(s), the planned procedures and treatment, and the benefits to be reasonably expected from this treatment plan, compared with alternative approaches and/or no treatment.

8. The usual and most frequent risks or complications occurring from the planned treatment and procedures also have been explained to me. These risks include but are not limited to, the possibility of pain or discomfort during the treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of a temporomandibular joint disorder, temporary or permanent numbness, and allergic reactions.

9. **I understand** that during the course of the patient's dental treatment, something unexpected may arise that may necessitate procedures in addition to or different from those listed on the patient's PLAN OF CARE and that I will be consulted *prior to initiation of treatment procedures* not listed. I am aware that the practice of dentistry is not an exact science and acknowledge that no guarantees have been made to me concerning the results of the dental treatment that the patient receives in the office.

10. All of my questions have been answered to my satisfaction and I consent to the treatment and procedures prescribed for the patient on the PLAN OF CARE.

11. **I understand** that I may revoke this consent to treatment at any time and that no further action based on this consent will be initiated except to the extent that treatment and procedures have already been performed or initiated.

12. I request and authorize the dental treatment and associated procedures outlined on the PLAN OF CARE.

13. **I confirm** that I have read and understand this form or it was read to me, and that all blanks were filled in and all inapplicable paragraphs, if any, were stricken before I signed below.

_____	_____
Signature of Person Consenting to Treatment	Date
_____	_____
Signature of Dr. Elliott or Dr. Molina	Date
_____	_____
Witness Certification	Date

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FINANCIAL POLICY

Thank you for choosing our office for your child's dental treatment. We are committed to their successful treatment! Please understand that *payment of your bill is considered a part of your child's treatment.* The following is a supplement to our **Payment Policy** which you received in the New Patient Information Folder.

- Please be aware that the parent bringing the child to Cary Pediatric Dentistry is *legally responsible for payment of all charges*. We cannot send statements to other persons.

- **Payment is expected in full for each appointment as services are rendered.** For the convenience of our patients, we accept cash, personal checks (which CANNOT be post-dated), MasterCard, Visa, Discover or American Express.

- **Dental Insurance** – there is NO direct relationship between our office and your insurance company. The type of plan chosen by you, and/or your employer determines your insurance benefits. As such, we have no say in the selection of your insurance company, no control over the terms of your contract, the methods of reimbursement or the determination of your insurance benefits. Therefore*, we do not accept assignment of benefits from any insurance company.* Any reimbursement by your insurance company should be made directly to you according to the terms of your contract with them. Cary Pediatric Dentistry will electronically file your insurance claim for you if allowed by your insurance carrier the day services are rendered. If your insurance carrier is not able to receive electronic submissions we will provide you with a "superbill" with all applicable dental codes and you will mail that to your insurance company.

- **Emergency Treatment** – all emergency treatment must be paid in full at the time the service is rendered.

We recognize that under unusual circumstances an account balance may be incurred. Cary Pediatric Dentistry requires that all outstanding balances *be paid in full within thirty (30) days* unless other arrangements have been made. Also note, if we have not received payment or you have not contacted us within thirty (30) days, further action may be taken with a collection agency or with Small Claims Court. We reserve the right to apply an interest rate of eighteen (18%) from the date of service. Thank you in advance for your understanding of our financial policy!

_____ _____
Parent/Legal Guardian Date

_____ _____
Witness Date

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APPOINTMENT POLICY

The scheduled appointment is reserved specifically for your child. Any change in this appointment affects many patients. If a cancellation is unavoidable, please call the office **at least 24 hours** in advance so that we may give that time to another patient.

- *All restorative (fillings, extractions, etc.) procedures are scheduled in the morning.* Children, as well as adults, are more prepared and do better in the morning for these types of procedures.
- *Our most requested appointment times are 8:*20am – 9:10am and 3:00pm – 4:00pm. As a result, we will alternate your cleaning appointment time every 6 months. For example, if you had an 8:20am – 9:10am appt or a 3:00pm - 4:00pm appt we would ask you to schedule your next appointment between 9:10am and 2:40pm. We do understand that sometimes this can be an inconvenience but we do appreciate your understanding and cooperation.
- *We strive to see all patients on time* for their scheduled appointment. There are times when our schedule is delayed in order to accommodate an injured child or an emergency. Please accept our apology in advance should this occur during your appointment. We will do the exact same if your child is in need of emergency treatment.
- *Please plan to arrive 10 minutes or more before your scheduled appointment*. **This will allow time for parking** and to complete any additional paperwork and see your child on time.
- *If you arrive 10-15 minutes late for your appointment, you may be asked to reschedule for the next available appointment time.*
- Again, *please call at least 24 hours in advance if a cancellation is unavoidable* so that we may give it to another patient.
- *Broken or missed appointments affect many people*. If two (2) broken/missed appoint-ments occur or two (2) cancellations without 24-hour notice, our office reserves the right to NOT schedule any subsequent appointments and/or charge a $40.00 broken appointment fee.
- *A parent or legal guardian (with official documentation) must be present during all appointments that the child patient is in the office.*

If at any time you have questions, please feel free to ask our staff or call our office. We are here to help in any way we can. We appreciate you entrusting your child's dental health to us.

Thank you!

_____ _____

Signature (Parent/Guardian) Date

Cary Pediatric Dentistry

Acknowledgement of Receipt

Of Notice of Privacy Practices

I have received a copy of this office's Notice of Privacy Practices. If I am a minor unaccompanied by a parent or guardian, I will accept this Notice and provide it to my parent or guardian.

Please print name

Signature

Date

FOR OFFICE USE ONLY

The patient was offered a copy of the Notice of Privacy Practices. An attempt was made to obtain a signature on this Acknowledgement of Receipt for the notice. It could not be obtained because:

- ☐ Individual refused to sign.
- ☐ Parent stated that a copy was received previously prior to treatment of sibling.
- ☐ Communications or language barrier.
- ☐ Emergency situation prevented obtaining acknowledgement.
- ☐ Other (Specify below).

Received by _____ Date _____

Staff Member

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How would you like us to communicate with you?

Our dental office sends appointment reminders, information about treatment, payment and insurance, and other communications. Please tell us how you would like us to communicate with you.

Your name: _____ Child/Children's name (s):_____Today's Date: _____
_____
_____

How would you like us to communicate with you regarding your child/children's health and insurance information? Please check or complete **ALL** that apply (please print clearly):

- ☐ Contact me by U.S. Mail or e-mail at the following address or e-mail address:
  _____
  _____
  E-mail: _____
- ☐ Contact me by email **ONLY** at the following email address (we cannot scan and e-mail forms, those can only be received by mail):
  _____

For Phone and Text Communications:

You are not required to sign this form, and you do not need to sign it to receive care in our dental office.

Phone Number: _____ Please circle what type of number this is: ☐CELL ☐HOME or ☐WORK

- ☐ **By checking this box, I consent to the following:** The dental practice or its service provider may contact me to provide health care information such as appointment reminders and information about treatment, payment, my account or insurance, using artificial or prerecorded voice or telephone equipment that may be capable of automatic dialing. The dental practice may:
  - ☐ Call me
  - ☐ Text me – appointment reminders only
  - ☐ Call me and text me – text is for appointment reminders only

Signature: _____ Date: _____

Please call the dental office right away if you get a new telephone number!

For Office Use Only:

- ○ Consent revoked. Date/Initials: _____/_____
- ○ Possible reassigned number: Date/Initials: _____/_____
- ○ Confirmed accurate: Date/Initials: _____/_____
  Date/Initials: _____/_____

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Patient Insurance Information

Our office is considered out of network for all insurance companies. Therefore, we request payment on the day of the appointment in full. We in turn will give you (the parent) a general claim form, with an itemized statement attached, to send into their insurance company for reimbursement. In order to complete this general claim form we will need to import your insurance information or any insurance changes into our computer system. Please fill out your insurance information below.

Primary Insurance

Insurance Company/plan name:_____

Insurance Company Address:_____
(P.O Box/Street #) (City) (State) (Zip Code)

Insurance phone #: _____

Policyholder/Subscriber Information

Policyholder's Name:_____
(Last) (First) (Middle Initial)

Policyholder Date of Birth:_____ **Gender:** ☐ M ☐ F
(MM/DD/CCYY)

Policyholder/Subscriber ID: (SSN or ID#):_____ **EDI #:**_____

Plan/Group Number:_____ **Employer Name:**_____

Scheduled Patient(s) Information

Patient Name:_____
(Last) (First) (Middle Initial)

Patient Name:_____
(Last) (First) (Middle Initial)

Patient Name:_____
(Last) (First) (Middle Initial)

Secondary Insurance (If not applicable leave blank)

Insurance Company/plan name:_____

Insurance Company Address:_____
(P.O Box/Street #) (City) (State) (Zip Code)

Insurance phone #:_____

Policyholder/Subscriber Information

Policyholder's Name:_____
(Last) (First) (Middle Initial)

Policyholder Date of Birth:_____ **Gender:** ☐ M ☐ F
(MM/DD/CCYY)

EDI #:_____

Policyholder/Subscriber ID: (SSN or ID#):_____

Plan/Group Number:_____ **Employer Name:**_____

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