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: ☐Yes ☐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

☐Yes ☐No Is your child in good health? Date of last physical exam _____
☐Yes ☐No Has your child ever had a health problem? _____
☐Yes ☐No Is your child current on their vaccinations? If no, please explain _____
_____
☐Yes ☐No Has your child ever been hospitalized? Please give reason and dates _____
_____
☐Yes ☐No Is your child allergic to anything? _____
☐Yes ☐No Is your child currently taking any medications? Please give medication, dose and reason_____
☐Yes ☐No Were there any problems at birth?_____

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

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

Please elaborate on any items circled:_____
_____
_____
_____

Office use only

-over-

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

Was your child: ☐ breast fed At what age stopped_____

☐ bottle fed At what age stopped_____

Dental History

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

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

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

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

☐ Yes ☐ 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:

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

☐ Yes ☐ No Is your home water supply fluoridated?

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

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

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

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** _____

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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 or DISCOVER.
- **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 provide you with a "superbill" with all applicable dental codes to attach to your insurance claim form.
- **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 _____

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 the 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 patient may need to be wrapped in a "hug blanket" or "papoose board" to prevent injury and enable Dr. Elliott or Dr. Molina to ***safely*** provide the necessary treatment.

6. 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.

_____
Parent/Guardian Initials

☺ **OVER PLEASE** ☺

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

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