YOUR CHILD

Child's name

Nickname | Sex

Birthdate | Age

SS# / SIN

School | Grade

Child's home address

City | State/Province | ZIP

Phone

Patient ID#

RESPONSIBLE PARTY

Name

Relationship

Address

SS# / SIN

DL#

Email

WHO IS RESPONSIBLE FOR MAKING APPOINTMENTS?

Name

Home phone

Work phone

Cell phone

Best time to call ☐ AM ☐ PM

☐ **MOTHER** ☐ Stepmother ☐ Guardian

Name

Home phone | Work phone

Cell phone

SS# / SIN

Employer

Birthdate | Occupation

☐ **FATHER** ☐ Stepfather ☐ Guardian

Name

Home phone | Work phone

Cell phone

SS# / SIN

Employer

Birthdate | Occupation

PARENT IS:

- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed

WELCOME TO NAPLES PEDIATRIC DENTISTRY!

We strive to make each of your child's visits pleasant and comfortable. Our goal is to teach your children oral habits which will help keep their smiles beautiful for a lifetime.

How did you hear about us?

PRIMARY DENTAL INSURANCE

Insured's name

Relationship

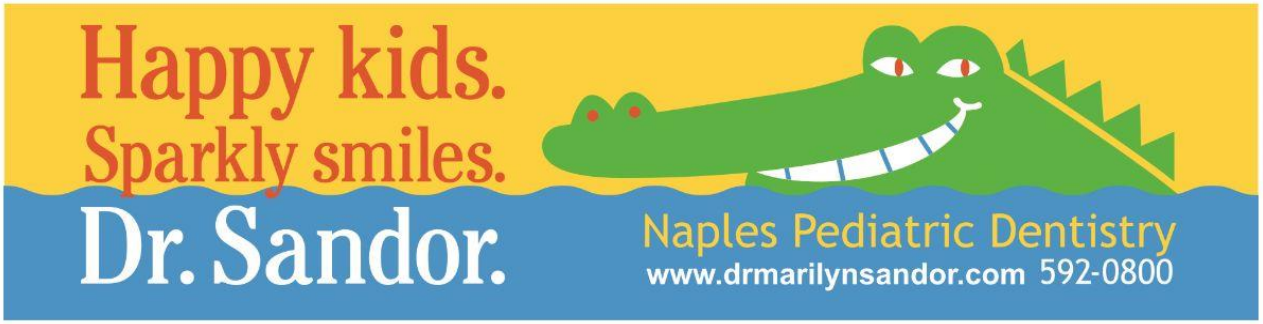
Birthdate | SS# / SIN

Employer | Date employed

Occupation

Insurance company | Group # | Employee #

Insurance company address



MEDICAL HISTORY

Patient's Name: _____ Date of Birth: _____

Your child's overall health, as well as any medications which your child takes, could have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely.

Name of your child's primary care physician and/or specialists?

_____

_____

_____

Has your child ever been hospitalized or had a major operation? Yes ☐ No ☐

Has your child ever had a serious head or neck injury? Yes ☐ No ☐

Is your child taking any medications, pills, or drugs? Yes ☐ No ☐

If yes, please list: _____

Is your child on a special diet? Yes ☐ No ☐

If yes, please describe: _____

Does your child use tobacco? Yes ☐ No ☐

Is your child allergic to any of the following? Yes ☐ No ☐

☐ Aspirin	☐ Penicillin	☐ Amoxicillin
☐ Codeine	☐ Latex	☐ Tree-nuts
☐ Other: _____		

Does your child have or has your child had any of the following?

☐ ADD/ADHD	☐ Cold/Fever sore	☐ Heart murmur	☐ Respiratory problems
☐ AIDS/HIV	☐ Diabetes	☐ Heart conditions	☐ Recurrent ear infections
☐ Anaphylaxis	☐ Digestive disorder	☐ High blood pressure	☐ Rheumatic Fever
☐ Anemia	☐ Disabilities	☐ Immunologic	☐ Thyroid diseases
☐ Asthma	☐ Eating disorder	☐ Kidney disease	☐ Tonsillitis
☐ Bronchiolitis	☐ Epilepsy/seizures	☐ Leukemia	☐ Tuberculosis
☐ Cancer	☐ Headaches	☐ Liver disease/Hepatitis	☐ Vesicoureteral reflux
☐ Cleft lip/palate	☐ Hearing problems	☐ Neurological problems	☐ Vision problems

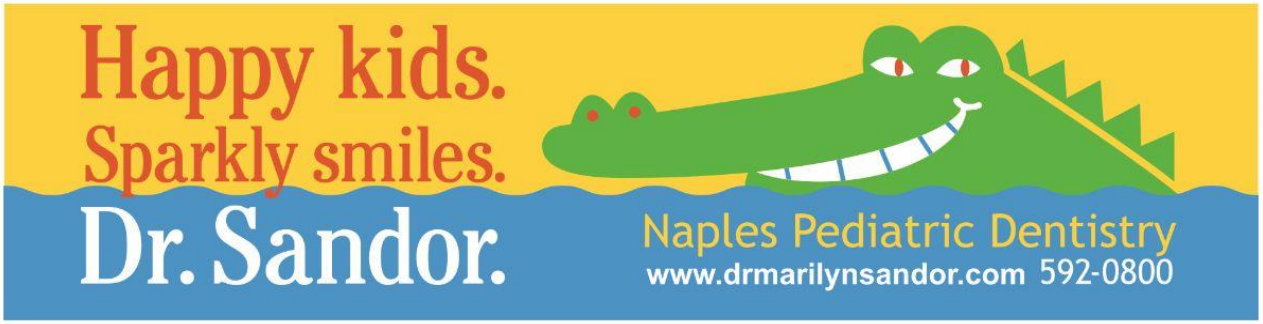
If your child had any serious illness not listed above, please describe here:

_____

_____

Print Name: _____ Signature: _____

Relationship to Patient: _____ Date: _____



DENTAL HISTORY

Patient's Name: _____ Date of Birth: _____

Age until bottle-fed? _____
Age until breast-fed? _____

Is this your child's first visit to the dentist?	Yes ☐	No ☐
Is your child experiencing dental pain right now?	Yes ☐	No ☐
Has your child had dental pain/toothaches in the past?	Yes ☐	No ☐
Does your child grind his/her teeth?	Yes ☐	No ☐
Does your child bite or suck his/her cheek, lips, or thumb?	Yes ☐	No ☐
Do you think there is anything wrong with your child's teeth right now?	Yes ☐	No ☐
Is your child nervous about this appointment?	Yes ☐	No ☐
Do your child's gums bleed when they are brushed or flossed?	Yes ☐	No ☐
Do you assist your child with brushing and flossing?	Yes ☐	No ☐
Does your child use fluoride products: Rinse, drops, tablets? (Please circle)	Yes ☐	No ☐
Is your child's water fluoridated?	Yes ☐	No ☐
Does your child eat well-balanced meals?	Yes ☐	No ☐

How often does your child brush? _____
How often does your child floss? _____

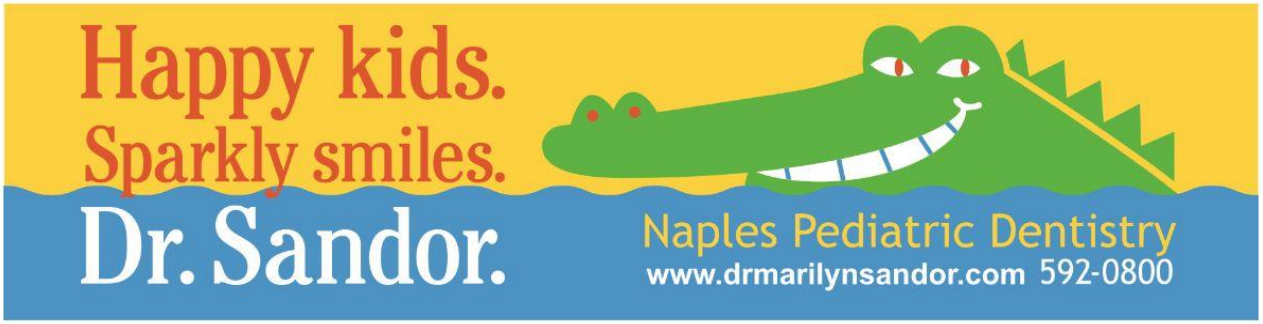
AUTHORIZATION AND RELEASE

I authorize Dr. Sandor to examine the above-named patient and perform the dental procedures explained to me, including the taking of any necessary dental radiographs to evaluate the oral health of my child. To the best of my knowledge, the questions of this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status.

I authorize Dr. Sandor to release the records of any treatment or examination rendered to my child during the period of such dental care to other health practitioners as required for the purposes of caring for my child's health. I understand that this office may not accept assignment of benefits. I understand that I am directly responsible for the payment of all services rendered on behalf of my child. My insurance company may reimburse me directly according to the terms of my policy. I understand that if it is necessary for Naples Pediatric Dentistry to seek legal consultation for collection actions, I am financially responsible for the unpaid debt and any necessary attorney and court fees required to collect that debt.

Print Name: _____ Signature: _____

Relationship to Patient: _____ Date: _____



CONSENT FOR RELEASE OF MEDICAL RECORDS AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

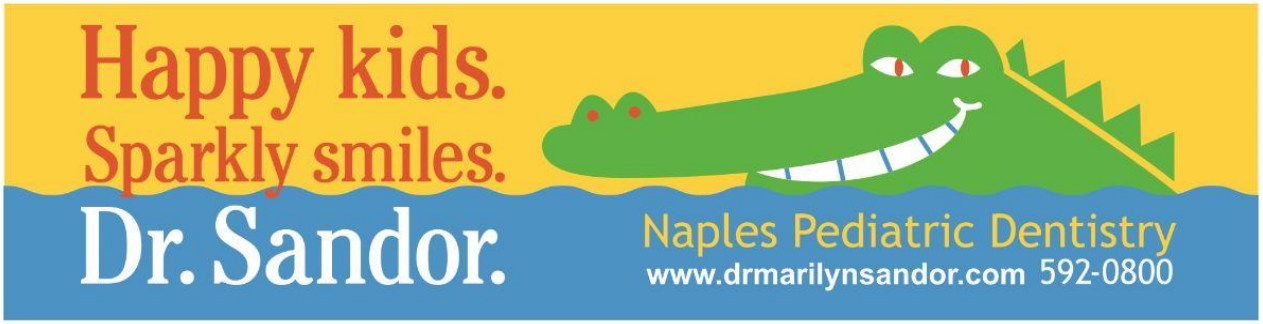
I, _____ (parent or guardian), hereby authorize Naples Pediatric Dentistry (Marilyn C. Sandor, D.D.S., M.S., P.A.) to disclose medical information contained in my child's pediatric dental record in accordance with the Notice of Privacy Practices. I have been given the opportunity to review the Notice of Privacy Practices, to ask questions about it, and do hereby agree to its terms. A copy of this signed, dated consent shall be as effective as the original. I release, hold harmless, and agree to indemnify Naples Pediatric Dentistry (Marilyn C. Sandor, D.D.S., M.S., P.A.), and its employees and agents for any and all liability. This includes, but is not limited to, negligence arising from or occurring as a result of this consent. I specifically authorize Naples Pediatric Dentistry (Marilyn C. Sandor, D.D.S., M.S., P.A.) to disclose verbally, by mail, fax, or unencrypted e-mail the contents of my child's medical records.

Complete as Applicable:

- Please send a copy of my child's records (including information from other health-care providers that it may contain) to _____ at _____. I understand that my child's records may be subject to re-disclosure by recipient(s) and unprotected by federal and state law.
- Please allow _____ to pick up a copy of my child's records (including information from other healthcare providers that it may contain).
- I acknowledge there will be a charge for duplication of records as allowed for by Florida law.

Print Name: _____ Signature: _____

Relationship to Patient: _____ Date: _____



AUTHORIZATION FOR MINOR CHILD ACCOMPANY

Patient's Name: _____ Date of Birth: _____

I, _____ give _____
(Parent or Legal Guardian's Name) (Authorized Person's Full Name)

my permission to accompany my child to Naples Pediatric Dentistry for his/her appointment and to consent and make necessary dental and health care for my child including, but not limited to:

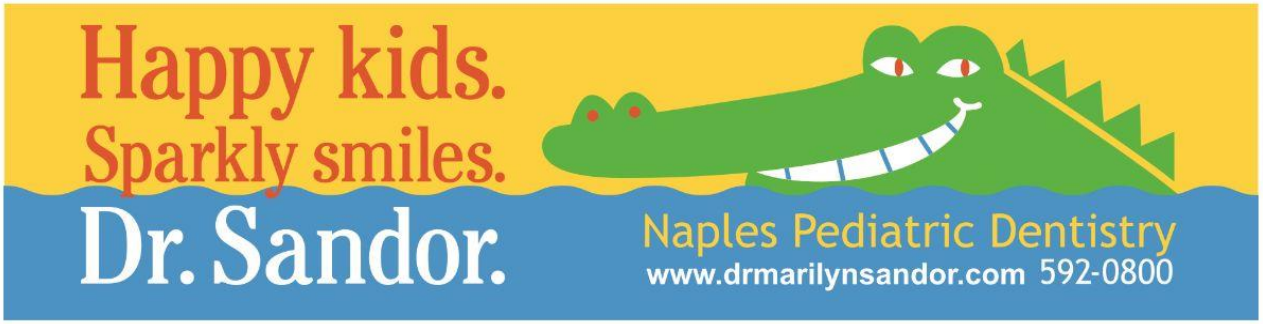
- Sign informed consents for preventative appointments
- Discuss post-operative instructions
- Discuss finances, treatment charges, insurance estimations, account balances and next visit charges
- Discuss dental findings, future dental treatment needs and any pertinent personal health information

As the parent or legal guardian, I understand that I must sign any treatment plans and or informed consents before any restorative procedures or invasive dental treatment can be performed for my child. I further understand that it is my responsibility to provide payment or a source of payment on the day that services are rendered, even when this authorized person brings my child.

I understand that, despite this Authorization, Naples Pediatric Dentistry, its employees and staff, in its/their sole discretion, may decide not to treat minor child, and instead require my presence during my minor child's treatment or care.

Signature of Parent/Legal Guardian: _____ Date: _____

Witness: _____ Date: _____



FINANCIAL POLICY

Payment for your child's dental treatment is due at the time the services are performed. The parent or guardian who accompanies the patient to an appointment is responsible at that time for all costs associated with services rendered, unless prior written arrangements have been made with our office.

For your convenience, we accept cash, checks, and all major credit cards. We also participate in a financial payment program called Care Credit. Please call or ask at the reception desk for details.

Insurance benefits are determined by your employer and not your dentist. Any deductible or estimated co-payment amount will be due at the time of treatment. Insurance is not a guarantee of payment; insurance companies may not pay for all your costs. Your insurance policy is a contract between you and your insurer. As a courtesy we will be glad to file your claim for you provided you have submitted complete and accurate insurance information.

Unpaid accounts will become eligible for submission to our collection agency after ninety (90) days. If your account must be turned over to our agency to our collection agency, there will be a forty percent (40%) collection fee added to the balance of the account.

Service charges for returned checks will apply. Please refer to the 2020 Florida Statutes for the fees applicable by Florida State Law Statute chapter 68.065 section 832.062 and 832.085.

For patients scheduled for IV anesthesia, a $200 deposit is required. This deposit will be credited toward the dental treatment fee.

I have read and understand this financial policy.

Print Name: _____ Signature: _____

Relationship to Patient: _____ Date: _____