# Dental Specialty Group of Pinellas

## PATIENT INFORMATION

Patient: ____________________________________________________________
Today's Date: ______________________
Nickname/Preferred Name: _________________________________ Date of Birth : ___________ Age: _______ Sex: M F
School: __________________________________________________________________
Grade: _______________________
Home Address: ______________________________________________ City: ________________________
Zip: __________
PhoneNumber: ______________________________________
Social Security Number: ____________________________
Who has legal custody of this patient? ___________________________________________________________
How did you hear about our office? _______________________________________________________________
Reason for today's visit: ______________________________________________________________________________

**MOTHER'S INFORMATION**:
Name: _______________________________________________________________
Date of Birth:______________________
Employer: __________________________________________________
Social Security Number: ______________________
Work Phone #: _____________________ Home Phone #: _____________________
Cell Phone #: _____________________

**FATHER'S INFORMATION**:
Name: _______________________________________________________________
Date of Birth: ______________________
Employer: __________________________________________________
Social Security Number: ______________________
Work Phone #: _____________________ Home Phone #: _____________________
Cell Phone #: _____________________

**PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT:**
Name: ______________________________________________________
Relationship to Patient: ______________________
Billing Address: _____________________________________________ City: ______________________
Zip: ______________
Work Phone #: _____________________ Home Phone #: _____________________
Cell Phone #: _____________________
E-mail address: ______________________________________________________________________
**INSURANCE INFORMATION**
Dental Insurance Company: _______________________________________
Group #: _______________________________
Phone #: _______________________________________
Name of Insured: ________________________________________

## HEALTH INFORMATION

Physician's Name: _______________________________________________
Phone #: ____________________________
Date of last physical: _______________
Please list any known allergies: ________________________________________
Please list all current medications this patient is taking, including the reason for taking the medication:
________________________________________________________________________________________________________________
________________________________________________________________________________________

Y N Does your child need pre-medication with antibiotics before dental appointments?
Y N Has your child ever been hospitalized?
If yes, please describe when and why: _____________________________________________________
Y N Has your child ever been treated in the emergency room?
If yes, please describe when and why: _____________________________________________________
Y N Has your child ever had surgery?
If yes, please describe when and why: ______________________________________________________

Has your child ever been diagnosed with or treated for the following?

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Y N | ADHD/hyperactivity | Y N | breathing problems | Y N | heart murmur | Y N | premature birth |
| Y N | allergies | Y N | cancer/tumor | Y N | hepatitis | Y N | rheumatic fever |
| Y N | anaphylactic reaction | Y N | cerebral palsy | Y N | high blood pressure | Y N | seizures/epilepsy |
| Y N | anemia | Y N | cleft lip/palate | Y N | HIV/AIDS | Y N | sleep apnea |
| Y N | arthritis | Y N | delayed speech | Y N | kidney disease | Y N | sickle cell disease |
| Y N | artificial joints | Y N | developmental delay | Y N | latex sensitivity | Y N | sinus problems |
| Y N | asthma | Y N | diabetes | Y N | liver disease | Y N | STD |
| Y N | birth defects | Y N | fainting spells | Y N | low birth weight | Y N | tonsillectomy |
| Y N | bladder disease | Y N | head/neck injury | Y N | mental/nervous disorder | Y N | tuberculosis |
| Y N | bleeding problems | Y N | hearing impairment | Y N | pacemaker | Y N | vision problems |
| Y N | blood disorder | Y N | heart condition | Y N | pregnancy | Y N | other |

If other, please specify: ___________________________________________________________________________
Please elaborate on any of the above marked yes: ________________________________________________
___________________________________________________________________________________________________

## DENTAL INFORMATION

When was your child's last dental visit? ____________________________________________________________
Previous dentist's name and address: ______________________________________________________________
Why did your child leave his/her previous dentist? __________________________________________________
When were X-rays last taken of your child's teeth? __________________________________________________

Y N Do you have any concerns regarding his/her teeth?
Y N Does your child clench or grind his/her teeth?
Y N Does your child have any tooth, jaw, or muscle discomfort?
Y N Does your child have frequent headaches?
Y N Does your child have a click, pop, or other noise in the jaw joint?
Y N Are your child's teeth sensitive to hot or cold?
Y N Are any of your child's teeth uncomfortable for him/her when he/she bites?
Y N Do your child's gums bleed when brushing or flossing?
Y N Does your child have any concerns about the appearance of his/her teeth?
Y N Does your child have a history of an accident or injury involving the teeth/jaws?
Y N Does your child get cold sores or canker sores?
Y N Does your child have a habit of snoring or mouth breathing?
Y N Does your child have a current or previous habit involving a pacifier or thumb/finger sucking?
Y N Does your child have a history of going to sleep with a baby bottle or on demand breast feeding?
Y N Does your child frequently eat sweets and/or drink juices or sodas?

Y N Does your child only drink bottled, highly-filtered, or well water?
Y N Do you supervise or assist your child in brushing his/her teeth?
Y N Does your child use toothpaste with fluoride?
Y N Does your child use fluoride tablets or rinses?
Y N Does your child use dental floss?

How has your child reacted to previous medical or dental procedures? ____________________________

How do you expect your child to react in the dental chair? ________________________________________

What are your child's interests and hobbies? _______________________________________________________

Please list any conditions or concerns regarding your child's health that have not been covered in this questionnaire: ________________________________________________________________________________

I, the undersigned parent/legal guardian of this child, certify that the above is accurate and complete to the best of my knowledge. I will notify the dentist and/or the staff of ***any*** change in the above prior to ***any*** appointment.

Signature: _____________________________________ Name: ____________________________________________

Date: ___________________ Relationship to Patient: ___________________________________

## CONSENT FOR DENTAL TREATMENT

I, the undersigned parent/legal guardian, hereby give consent for the dentist and/or clinical staff to examine this child, clean his/her teeth, perform all necessary dental treatment, administer local anesthetics, administer medications, apply topical fluoride, take diagnostic radiographs (X-rays), take clinical photographs, obtain study models and other records necessary for an accurate diagnosis for my child. I understand that dental treatment for children involves behavior guidance, which may include the use of praise, explanation and demonstration of procedures and instruments, variable voice tone, mouth props, nitrous oxide (laughing gas), or protective stabilization when necessary to promote cooperative behavior and a positive experience and to protect my child from potential injury.

Signature: ____________________________________ Name: ____________________________________________

Date: ________________ Relationship to Patient: _______________________________________________________

Dental Specialty Group of Pinellas
4326 Park Boulevard, Suite C-East
Pinellas Park, FL  33781
(727) 544-5345

# CANCELLATION / MISSED APPOINTMENT POLICY

Our office strives to provide optimum treatment and convenience for our patients by offering several specialties in one location. This means however, that each specialist is available only certain days.

Therefore, we ask that you help us by keeping your scheduled appointments, and by notifying our office in advance if you are unable to do so.

We have a waiting list for appointments and when given advance notice we are often able to accommodate other patients.

**ALL PATIENTS WHO FAIL TO ARRIVE FOR THEIR SCHEDULED APPOINTMENTS OR WHO CANCEL WITH LESS THAN 24 HOURS ADVANCE NOTICE WILL BE CHARGED A MISSED APPOINTMENT FEE**

- Missed appointment fees are **NOT** covered by insurance plans and are your responsibility to pay
- If you need to cancel or reschedule an appointment, please give at least **24 hours** notice to avoid a charge
- If you fail your appointment and have not notified the office 24 hours in advance you will be charged a missed appointment fee
- If you miss two consecutive appointments, any remaining appointments scheduled will be cancelled and referring dentist will be notified.

Thank you for your cooperation.

Patient Name (please print): ___________________________________

Signature below indicates I have read and understand this policy.

Patient(18 or older) or Legal Guardian Signature: ___________________________________

**Dental Specialty Group of Pinellas**
4326 Park Boulevard, Suite C-East
Pinellas Park, FL 33781
727-544-5345

# INSURANCE BENEFIT ACKNOWLEDGEMENT

Your insurance is a method for you to receive reimbursement for the fees you have paid. Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on the contract you have with them, not with our office. It is your responsibility to pay deductible, coinsurance, and any other balances not paid by your insurance company.

In determining the amount of benefits payable, your insurance company may give consideration to an alternate procedure that may accomplish a professional satisfactory result. If an alternate benefit provision is applied to a procedure performed by your dentist and submitted to your insurance company as a claim, the amount of money you owe your dentist may be more than the amount specified on the Explanation of Benefits (EOB).

Estimates of coverage are not a guarantee as eligibility, policy provisions and possible charges from other offices affect payment. Your insurance company may not pay their full estimated portion. YOU ARE RESPONSIBLE FOR ALL TREATMENT CHARGES NOT PAID BY YOUR INSURANCE COMPANY.

I agree to pay the fees, including any deductible, co-insurance, and any other balances not paid by my insurance company, to Dental Specialty Group of Pinellas.

_______________________________________________ ___________________
Signature of Patient/ Legal Guardian if patient is minor Date

_______________________________________
Patient's Name

## *Dental Specialty Group of Pinellas*

Acknowledgement of Receipt of Notice of Privacy Practices

**Purpose**: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You May Refuse to Sign This Acknowledgement****

I have been given copy of this office's Notice of Privacy Practices to review and I am aware that the office has a copy of the Notice available to take with me if I request one.

________________________________________
{Please Print Patient's Name}

________________________________________
{Signature of Patient or Legal Guardian}

________________________________________
{Date}

Dental Specialty Group of Pinellas may use or disclose protected health information for the purpose(s) of treatment, payment, collections, or health care operations. We may disclose your personal health care information to other dental and/or medical professionals relating to your treatment, payment, or health care. If you wish to authorize Dental Specialty Group of Pinellas to release your personal health care information to anyone other than for the reasons above, please list below.

1. _______________________________

2. _______________________________

3. _______________________________

## For Office Use Only

We attempted to obtain written proof of Informed Acknowledgement of Notice of Privacy Practices, but acknowledgement could not be obtained because:

- o Individual refused to sign
- o Communications barriers prohibited obtaining the acknowledgement
- o An emergency situation prevented us from obtaining acknowledgement
- o Other (Please Specify)

________________________________________________________________
________________________________________________________________
________________________________________________________________

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