Advantage Dental
Oral Health Center

PEDIATRIC PATIENT INTAKE FORM (AGE UNDER 14)

Date (mm/dd/yyyy)

Welcome, and thank you for selecting our dental healthcare team! We strive to provide the best possible dental care. To help us achieve this goal, please fill out these forms as completely as you can, in ink. If you have any questions or need assistance, please feel free to ask us.

Last Name	First Name	MI	Suffix (circle one) Sr / Jr / I / II / III	Preferred Name
Gender (choose one) ☐ M ☐ F ☐ Other ☐ Choose Not to Disclose				
Race/Ethnicity: ☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Other:				☐ Choose not to disclose
If you require a language interpreter specify language:			Did an interpreter help you with these forms? ☐ YES ☐ NO	
Date of Birth (mm/dd/yyyy)	SSN		School	
Address		City	State	Zip
Mailing Address (if different)		City	State	Zip

Contact Information: Please provide all phone numbers and email.

E-mail _____ Cell _____ Alternative Phone _____

By providing the contact information above you are consenting to receiving electronic communications from Advantage Dental from DentaQuest about your appointments and treatment.

Were you referred to this practice? ☐ YES ☐ NO If yes, who referred you: _____

Parent or Legal Guardian Information: I am the patient's: ☐ Parent ☐ Legal Guardian

Date of Birth (mm/dd/yyyy) _____ SSN ___-___-___ Gender (choose one) ☐ M ☐ F ☐ Other ☐ Choose Not to Disclose

Last Name _____ First Name _____ MI _____

Emergency Contact	Relationship	Home Phone	Cell Phone

Does the patient have Dental Insurance? ☐ YES ☐ NO If yes, who is the insurance carrier?

Primary Carrier	Policy Holder	Group Number	Subscriber I.D.	Policy Holder DOB
Name of Employer	Policy Holder SS# - -		Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐	

Secondary Carrier	Policy Holder	Group Number	Subscriber I.D.	Policy Holder DOB	Policy Holder SS# - -

Communication Agreement

Advantage Dental Oral Health Center practices can communicate with me using the contact information provided above. These communications may include voicemail, text, and/or email. You may opt out at any time by responding appropriately to the messages received.

Signature of Patient, Parent or Legal Guardian: _____ **Date:** _____

You can request a copy of our privacy policy at any time. You can always find a copy of this policy at Advantagedental.com/privacy-policy.

NO CAVITIES CLUB

I, grant my permission for my child's (childs name) _____ picture to be taken for identification purposes and I understand that his/her photo might be displayed for the "No Cavities Club" as well as for any other advertising educational materials that Advantage Dental Oral Health Center and its affiliates may see fit. I waive any compensation, now or in the future, for granting my child's image to be used.

Signature of Patient or parent/guardian/responsible party **Relationship to patient** **Date**

Staff Initials _____

DENTAL AND HEALTH HISTORY

Primary Physician's Name: _____ Phone Number: _____

Primary Physician's Address: _____

Is the child being treated by a physician at this time? ☐ **YES** ☐ **NO** If YES, please describe:

What is the reason for the child's dental visit today? ☐ **EXAMINATION** ☐ **EMERGENCY** ☐ **CONSULTATION** ☐ **PROCEDURE**

What is your main concern about the child's oral health? _____

Date of child's last dental visit (Month/Year): _____ ☐ **EXAM** ☐ **EMERGENCY** ☐ **CONSULTATION** ☐ **PROCEDURE** ☐ **OTHER** _____

Has the child had any problems with previous dental treatment? ☐ **YES** ☐ **NO** If yes, please specify: _____

How would you describe the child's dental health? ☐ **EXCELLENT** ☐ **GOOD** ☐ **FAIR** ☐ **POOR**

How often does the child brush their teeth? ☐ **NEVER** ☐ **SOMETIMES** ☐ **ONCE A DAY** ☐ **TWICE A DAY** ☐ **MORE THAN TWICE A DAY**

How often does the child floss their teeth? ☐ **NEVER** ☐ **SOMETIMES** ☐ **ONCE A DAY** ☐ **ONCE A WEEK** ☐ **MORE THAN ONCE A DAY**

Do the child's gums bleed when they brush or floss? ☐ **NEVER** ☐ **SOMETIMES** ☐ **ALWAYS**

Does anyone help the child brush or floss their teeth? ☐ **YES** ☐ **NO**

Please state any questions or concerns you have about dentistry or your child's dental health: _____

Is the child currently experiencing dental pain or discomfort?	YES	NO	Does the child have loose teeth?	YES	NO
Is the child unhappy with his/her smile or the appearance of their teeth?	YES	NO	Does the child have headaches, earaches, or neck pains?	YES	NO
Does the child have a history of jaw joint problems (popping, etc.)?	YES	NO	Does the child have swelling in or around their mouth, face, or neck?	YES	NO
Does the child have problems with eating (trouble chewing, vomiting, etc.)?	YES	NO	Does the child clench, brux, or grind their teeth?	YES	NO
Does the child have bad breath/ halitosis, metallic taste, or unpleasant taste?	YES	NO	Are the child's teeth sensitive to cold, hot, sweets or pressure?	YES	NO
Does the child have any obstacles to cleaning or caring for their teeth?	YES	NO	Does food or floss catch between the child's teeth?	YES	NO
Has the child ever had a serious injury to their teeth, jaw, head or mouth?	YES	NO	Has the child ever had orthodontic (braces) treatments?	YES	NO

Provide details to all YES answers here:

_____

_____

Does the child have, or have they had any of the following? (Circle yes or no for each) **For each yes, provide details below where indicated**

Acid Reflux	YES	NO	Eating Disorder	YES	NO	Kidney Problems	YES	NO
AIDS/HIV Positive	YES	NO	Epilepsy or Seizures	YES	NO	Learning problems/delays, intellectual disability	YES	NO
Anaphylaxis/Allergic Reaction	YES	NO	Excessive Bleeding	YES	NO	Leukemia	YES	NO
Artificial Heart Valve	YES	NO	Excessive Thirst/Dry Mouth	YES	NO	Liver Disease/ Hepatitis	YES	NO
Asthma/Lung/Breathing problems	YES	NO	Fainting spells/Dizziness	YES	NO	Parathyroid Disease	YES	NO
Attention deficit/hyperactivity disorder (ADHD)	YES	NO	Frequent Cough	YES	NO	Radiation Treatment	YES	NO
Behavior or emotional problems	YES	NO	Frequent Diarrhea	YES	NO	Renal Dialysis (Kidney)	YES	NO
Blood problems, anemia, sickle cell disease	YES	NO	Developmental Disorder	YES	NO	Rheumatic Fever	YES	NO
Brain or nervous system problems	YES	NO	Heart Problems	YES	NO	Scarlet Fever	YES	NO
Cancer/cancer treatment	YES	NO	Hemophilia excessive bleeding, bruising easily	YES	NO	Sexually Transmitted Disease	YES	NO
Chemotherapy	YES	NO	Herpes	YES	NO	Sinus Trouble	YES	NO
Cold Sores/Fever Blisters	YES	NO	High or Low Blood Pressure	YES	NO	Stomach/Intestinal Disease	YES	NO
Cortisone Medicine	YES	NO	Hives or Rash	YES	NO	Thyroid Disease	YES	NO
Diabetes	YES	NO	Hypoglycemia	YES	NO			

Provide details to all YES answers here:

_____

_____

_____

_____

Were there complications before or during birth, prematurity, birth defects, syndromes or inherited conditions? ☐ YES ☐ NO If yes explain:

_____

_____

Staff Initials _____

Are there any other health conditions that you would like to make us aware of to improve our delivery of care and better meet your child's oral health care needs?

_____

_____

Is the child taking, have they recently taken (within the last month), or are they supposed to be taking any medications? ☐ **YES** ☐ **NO**
This includes all prescription, over the counter, diet supplements, vitamins, natural, and/or herbal medications.

If yes, please specify medication(s), dosage, and frequency

Medication Prescription or Over the Counter	**Dosage/Frequency**	**Supplements** Diet supplements, vitamins (natural or herbal)	**Dosage/Frequency**

In the last 2 years, has the child taken or are you now taking steroids (e.g. cortisone)? ☐ **YES** ☐ **NO**

If yes please specify: _____

Has the child taken or is scheduled to begin taking ANY bisphosphonate medications (Examples: Fosamax, Boniva, Actinol, Reclast, Zometa, etc.) ☐ **YES** ☐ **NO**

What drug, dose and frequency? _____ When? _____ What for? _____

Has the child had any serious illness not listed above? ☐ **NO** ☐ **YES:**

If yes please specify: _____

ALLERGIES

Is the child allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetic ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Iodine ☐ Vicodin ☐ Other: _____

Does the child normally take an antibiotic prior to dental treatment? ☐ **YES** ☐ **NO**

TOBACCO

Does the child use or have they used tobacco (smoking, snuff, chew, bidis)? ☐ **NEVER** ☐ **PAST** ☐ **CURRENTLY**

How interested are they in stopping? ☐ **VERY** ☐ **SOMEWHAT** ☐ **NOT INTERESTED**

OTHER

How frequently does the child have the following?

Candy or other sweets ☐ **RARELY** ☐ **1-3 TIMES/DAY** ☐ **3 OR MORE TIMES/DAY**

Snacks between meals ☐ **RARELY** ☐ **1-3 TIMES/DAY** ☐ **3 OR MORE TIMES/DAY**

Sweetened drinks* ☐ **RARELY** ☐ **1-3 TIMES/DAY** ☐ **3 OR MORE TIMES/DAY**

(*such as juice, fruit-flavored drinks, sweetened sodas, colas, or other carbonated drinks, sports drinks, and energy drinks)

Does the child participate in sports or similar activities? ☐ **YES** ☐ **NO** If YES, does the child wear a mouthguard during these activities? ☐ **YES** ☐ **NO**

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient or parent/guardian/responsible party: _____ **Date:** _____

Print Name of parent/guardian/responsible party: _____

OFFICE USE

Blood Pressure: _____ /_____ Pulse: _____ Height: _____ Weight: _____ Temp: _____ Date: _____

HEALTH HISTORY REVIEWED BY _____

PROVIDER'S SIGNATURE **DATE**

AUTHORIZATION TO ACCOMPANY A MINOR

To be completed by the patients authorized representative

We understand the conflict of work schedules and appointments, but we require all children under the age of 14 years to be accompanied by a RESPONSIBLE PARTY or your child will not be treated. This person must be at least 19 years old and must remain on the premises at all times during treatment.

I affirm that I am the parent or legal guardian for the minor child/children named below:

Child	Date of birth
Child	Date of birth
Child	Date of birth

If I am unable to accompany my child, I give permission for the individuals named below to escort my child for dental treatments:

Name	Relationship
Name	Relationship
Name	Relationship

For a child/children 14 and older, please check one:

☐ Since my child/children is/are 14 or older, I also give permission for him/her/them to present for treatment unaccompanied by an adult.

☐ Although my child is/are 14 or over, I wish to be present for all treatments performed.

I certify that I have read and fully understand the above statements and confirm the contents of this form.

Signature of Legal Guardian/Custodial Parent	Date
Print Full Name of Legal Guardian/Custodial Parent	Relationship to Minor(s)

Advantage Dental
From DentaQuest

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES AND NON-DISCRIMINATION NOTICE

Patient Name: _____

* You May Refuse to Sign This Acknowedgement*

I, _____, have been offered a copy of this office's Notice of Privacy Practices and Non-Discrimination Notice.

_____ _____

Please Print Name Relationship to Patient

_____ _____

Signature Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices and Non-Discrimination Notice, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (please specify)

_____

_____

_____

To Improve the Oral Health of All

449FOC_03052020

PATIENT FINANCIAL POLICY

Our goal is to provide you and your family with optimal dental care, and to be a place where patients feel welcomed and valued. Our office strives to provide the highest quality dental care at affordable prices. Our dentist will diagnose treatment based on your dental health and not your insurance coverage. We encourage you to ask questions and to be involved in treatment decision, while we help educate you about your oral health and the importance of prevention.

Kindly remember, you are fully responsible for all fees charged by this office regardless of your insurance coverage.

The purpose of this policy is to eliminate confusion or misunderstandings concerning financial arrangements offered by our office. If you have dental insurance, your portion of the fee is due at the time of service. As a courtesy, this office will file your insurance claim, but we do not guarantee any benefit. Accordingly, to the extent permitted by law, you consent to Advantage Dental Oral Health Center (or its designee's) use and disclosure of your Protected Health Information to carry out payment activities in connection with your insurance claim. This information will be used exclusively for the purpose of evaluating and administering claims for benefits. You further authorize and direct payment to Advantage Dental Oral Health Center of the dental benefits otherwise payable to you. Please understand that the amount to be paid by insurance depends on the benefits of your particular plan. If you have any questions about the amount your plan will pay or the treatments your plan will cover, you should refer these questions to your insurance company. Additionally, there may be a deductible, a co-insurance factor, and/or a yearly maximum to be considered.

1. For our Medicaid patients, Medicaid will be billed for covered services. In the event a service is not covered by Medicaid, you will be informed prior to the service being performed.
2. Payment at the time of service is expected, including the estimated portion of the amount that insurance does notcover. Our office accepts the following payment methods: Cash, Check, Major Credit Cards, and certain third-party financing options (for those who qualify). We do not offer in house payment plans.
3. A statement for services rendered will be mailed to you on a monthly basis. Receipt of payment is expected within 30 days of the billing date on the statement. Payment should be mailed with the specified portion of the statement to establish the proper crediting of the account. If your insurance company hasn't made payment on a claim after 30 days, please contact your insurance company directly.
4. You may choose to pay the amounts due on your statement by phone using an acceptable form of payment. In the event you choose this payment option, we may securely store your payment information for future payments to be made at your direction.
5. Your account is considered delinquent if payment is not received within 30 days of the billing date on the statement. If payment is not received, a late charge of 1½% per month ($1.00 minimum) may be assessed and will appear on the next statement. The annual percentage rate shall be the lesser of 18% or the highest rate allowed under state law.
6. For any check that is returned for any reason, the original amount of the returned item plus a $35.00 charge will be billed to your account. If a check is returned, we may not accept payments by check from you in the future.
7. If you are the parent or legal guardian of a patient that receives treatment when you are not present (either accompanied by an authorized person or unaccompanied), you agree to pay for any services/treatments performed in your absence.

You understand and agree that if you fail to make timely payments, you will be responsible for all costs of collection monies owed, including court costs, collection agency fees, and attorney fees.

By signing below, you acknowledge you have read and understand the financial policy of Advantage Dental Oral Health Center and agree to all the terms described in it.

Signature of Patient (or Person Authorized to Sign for Patient) _____ Print Name _____

Relationship to Patient _____ Date _____

CONSENT TO DENTAL PROCEDURES

Patient: _____ Age: _____ Date: _____

I, the undersigned, for myself or another person for whom I have authority to sign, hereby consent to dental care and treatment while such care and treatment is provided through Advantage Dental Oral Health Center. This consent includes my consent for all treatment performed by a Advantage Dental Oral Health Center dentist and any other dental care provider or other designees under the supervision of the dentist, as deemed reasonable and necessary.

I understand that any current or future treatment may include, but is not limited to examinations, oral prophylaxis (cleanings), fluoride treatments, sealants, restorations (amalgam or composite fillings, crowns and bridges), periodontal (gum) treatments, endodontic (root canal) treatments, extractions, and the use of anesthetics. Such current or future treatment may involve the use of secure electronic communications and technologies to deliver virtual dental health and education services on a remote basis rather than in a traditional dental office setting. Dental treatment is not without potential complications, which may include (but are not limited to) pain, infection, swelling, bleeding, bruising, delayed healing, sinus complications, allergic reactions, stiffness, discomfort and decreased range of motion in the jaw joint(s), loosening of teeth or restoration in teeth, injury to other tissues and need for additional treatment outside scope of treating dentist. I understand topical anesthesia, local anesthesia and/or nitrous oxide inhalation anesthesia may be used if needed during treatment and I consent for their use in my care and that the use of anesthetics may carry a small risk for swelling, bruising, allergic reaction, changes in pain perception, prolonged or in extremely rare instances permanent numbness. I further understand that in the course of any treatment, it may be necessary to modify the intended treatment because of conditions discovered during the ordinary course of dental care and treatment. I further understand and acknowledge that my dental treatment may result in an increased risk of exposure to certain viruses and other pathogens present in the community at the time of my visit (including but not limited to the novel coronavirus/COVID-19, flu, cold virus, etc.). It is possible for such pathogens to be transmitted through respiratory droplets or fine water spray (aerosols) that may be present in a dental practice. I understand that these risks can be mitigated through the dental practice's infection control protocols and other preventative measures designed to reduce the potential for infection, but that these risks cannot be completely eliminated.

I understand that I have the right to discuss and ask questions of any current or future treatment and the purpose, potential risks and benefits of such treatment, as well as any alternative treatments, in order to make an informed decision regarding my care. I further understand that I have the right to refuse treatment and accept any potential consequences of refusing treatment and that I have the right at any time to discontinue treatment.

By signing below, I am indicating that (1) I intend that this consent continue in nature even after a specific diagnosis has been made and treatment recommended; and (2) I consent to treatment at this office or any other Advantage Dental Oral Health Center office. The consent will remain fully effective until it is revoked in writing.

Signed Consent

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ [ ] Patient under 18 years of age _____

Signature of Patient or Legal Guardian — Date

_____ _____

Printed Name of Patient or Legal Guardian — Relationship to Patient

I hereby give my consent to treat the minor child/children below, who is/are under the legal age of eighteen years of age, to receive dental care and/or treatment from a Advantage Dental Oral Health Center dentist. Any care and/or treatment deemed reasonable and necessary may be provided with or without my presence:

_____ _____

Child — Date of birth

_____ _____

Child — Date of birth

_____ _____

Child — Date of birth

RIGHTS AND RESPONSIBILITIES

The patient shall have the following rights:

- To be treated with dignity and respect
- To be treated by providers the same as other people seeking health care benefits
- To have a friend, family member, or advocate present during consultations and at other times as needed for help with treatment decisions
- To be actively involved in decisions about his/her treatment plan
- To be given information about his/her condition and covered and non-covered services to make an informed decision about treatment(s) options
- To consent to treatment or refuse services, and be told the consequences of that decision, except for court ordered services
- To receive written materials describing rights, responsibilities, benefits available, how to access services, and what to do in an emergency
- To have written materials explained in a manner that is understandable
- To receive necessary and reasonable services to treat the condition
- To receive services that meet generally accepted standards of practice and are medically appropriate
- To receive covered preventive services
- To receive a referral to specialty providers for medically appropriate covered services
- To have a clinical record containing documents about conditions, services received, and referrals made
- To have access to one's own clinical record, unless restricted bylaw
- To transfer a copy of his/her clinical record to another provider
- To receive a notice of an appointment cancellation in a timely manner
- To receive a copy of this practices notice of privacy policy

The patient has the following responsibilities:

- To treat the providers and clinic's staff with respect
- To be on time for appointments made with providers and to call in advance to cancel if unable to keep the appointment or if he/she expects to be late
- To seek periodic health exams and preventive services from his/her dentist
- To use his/her dentist for diagnostic and other care except in an Emergency
- To obtain a referral to a specialist from the dentist before seeking care from a specialist unless self-referral to the specialist is allowed
- To use emergency services appropriately
- To give accurate information for inclusion in the clinical record
- To help the provider or clinic obtain clinical records from other providers which may include signing an authorization for release of information
- To ask questions about conditions, treatments and other issues related to his/her care that is not understood
- To use information to make informed decisions about treatment before it is given
- To help in the creation of a treatment plan with the provider
- To follow prescribed agreed upon treatment plans
- To provide the office with any information regarding insurance benefits
- To provide the office with information about address changes, phone number changes, insurance benefit changes
- To pay for non-Covered Services
- To bring issues or complaints to the staff
- To sign an authorization for release of medical information so that the provider can get information which may be needed to respond to a complaint or issue
- To abide by office policies and procedures