florence pediatric dentistry

Kimberly Elvington, DMD
680 Senior Way
Florence, SC 29505
843.661.5700 ~ 843.661.5710 fax

We are so excited to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we will be glad to assist you. We look forward to working with you in maintaining your child's dental health.

PATIENT INFORMATION

Child's Name:_____
Last First Middle Preferred Name

( ) Male ( ) Female Date of Birth_____ Hobbies: _____

Address:_____ City /State:_____ Zip:_____

Home Phone #:_____ Cell #:_____ SSN:_____

Email Address:_____

How would you prefer us to contact you for confirming your child's appointments?

( ) Phone ( ) Email ( ) Mail ( )Phone and Email

**Whom may we thank for referring you to our office (how did you hear about us)?_____

PARENTS' INFORMATION

( ) Mother ( ) Stepmother ( ) Guardian Name:_____

Address (if different from above):_____

Home # (if different from above):_____ Work #: _____ Employer:_____

( ) Father ( ) Stepfather ( ) Guardian Name: _____

Address (if different from above): _____

Home # (if different from above): _____ Work #: _____ Employer: _____

DENTAL INSURANCE INFORMATION

Policy Holder:_____ Relationship to Patient:_____

Policy Holder Social Security #:_____ Date of Birth:_____

Insurance Co:_____ Employer:_____

Policy #:_____ Group #:_____ ID#:_____

USE SPACE BELOW FOR SECONDARY INSURANCE INFORMATION

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Patient Name:_____ Date of Birth:_____

MEDICAL HISTORY

Child's Pediatrician:_____City/State:_____

Name of Practice:_____Date of last physical exam:_____

Were there any difficulties during the pregnancy or delivery of your child? ( )Yes ( )No

If yes, please describe:_____

Has he/she ever been hospitalized or had surgery? ( )Yes ( )No

If yes, please describe:_____

Does your child have any history of the following medical concerns (Please check all that apply):

General Conditions
_____Arthritis
_____Asthma
_____Diabetes
_____Gastrointestinal Disorder
_____GERD/Acid Reflux
_____Heart Disease
_____Heart Murmur
_____Kidney Disease
_____Rheumatic Fever

Behavior/Learning
_____ADD/ADHD
_____Anxiousness/Nervousness
_____Autism
_____Asperger Syndrome
_____Behavioral Issues
_____Learning Disabilities
_____Psychiatric Disorder

Developmental
_____Blindness
_____Visual Impairment
_____Brain Injury
_____Cerebral Palsy
_____Cleft Lip/Palate
_____Developmental Delay
_____Down Syndrome
_____Feeding/Eating Problems
_____Growth Problems
_____Hearing Loss/Deafness
_____Neuromuscular Defect
_____Orthopedic Problems
_____Seizures: Type _____
_____Speech Delay
_____Spina Bifida

Hematological (Blood-related)
_____Anemia
_____Bleeding Issues
_____Hemophilia
_____Sickle Cell Trait
_____Sickle Cell Disease
_____Blood Transfusion

Infectious
_____Hepatitis
_____HIV Infection
_____AIDS
_____Tuberculosis

Other
_____Adenoids
_____Allergies (seasonal)
_____Cancer/Tumors
_____Fainting
_____Headaches
_____Leukemia
_____Skin Disorder
_____Sleep Apnea
_____Snoring
_____Thyroid Disorder
_____Tonsils
_____Tubes in ears
_____Other
_____

If any checked, please describe further: _____

MEDICATIONS

Please list any medications your child is currently taking and the correlating diagnosis: _____

_____

_____

Patient Name:_____

ALLERGIES

Has your child had any allergic reactions to the following:

( ) Penicillin/Amoxicillin ( ) Latex ( ) Aspirin ( ) Sulfa drugs ( ) Local Anesthetic

( ) Foods (Please list): _____

( ) Other (Please list): _____

Have you ever been told your child requires antibiotic prophylaxis for dental treatment due to a medical condition (e.g., heart condition, shunt, etc)? ( ) Yes ( ) No

Physician following medical condition?_____

City/State: _____ Phone #: _____

DENTAL HISTORY

Previous Dentist: _____ Last Dental Visit:_____

My child brushes his/her teeth _____ times a day. Do you help your child brush his/her teeth? ( ) Yes ( ) No

Does your child floss every day? ( ) Yes ( ) No Is fluoride taken in any form? ( ) Yes( ) No

Is there a history of bad dental experiences? ( ) Yes ( ) No Is your child experiencing any dental pain? ( ) Yes ( ) No

Any injuries to the mouth/teeth? ( ) Yes ( ) No

Please describe and specify at what age: _____

Does your child have any mouth habits? (Please check all that apply)

( ) Thumb/finger sucking ( ) Grinding during sleep ( ) Pacifier use

( ) Sleeping with bottle/sippy cup ( ) Mouth breathing ( ) Snoring

Is there anything else you would like to tell us regarding your child's dental health? _____

AUTHORIZATION TO BRING MINOR FOR DENTAL TREATMENT

List anyone who may accompany your child (please specify relationship) to an appointment and has permission to make decisions concerning his/her dental treatment:_____

_____

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 child's health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PARENT OR LEGAL GUARDIAN _____ DATE_____

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AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Date:_____

Patient Name:_____

Address:_____

_____

Home Phone: _____Cell Phone: _____

I authorize the professional office of my dentist named above to release health information identifying my child under the following terms and conditions:

1. Detailed description of the information to be released: Dental and/or Medical Concerns
   _____
2. To whom may the information be released [name(s) or class(es) of recipients]:
   _____
   _____
   _____
   _____
3. To whom specifically may the information NOT be released [name(s) of recipients]:
   _____
4. It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY CHILD'S HEALTH INFORMATION AS DESCRIBED IN THIS FORM. I understand that my healthcare provider will use judgement in determining the minimum amount of information that must be shared in order to care for my child.

Date:_____ Parent / Legal Guardian: _____

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OFFICE POLICIES

Patient Name: _____ **D.O.B.** _____

Please read over our office policies below and let us know if you have any questions or need anything explained in greater detail before signing.

FINANCIAL POLICY

Our policy requires payment in full at the time of service.

For those families utilizing insurance benefits, we are happy to file your insurance claim as a courtesy. However, **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. Reimbursement for covered services is subject to maximum allowable fees, deductibles, and copayments. All insurance information must be supplied before your child's visit in order to verify benefits. We cannot assume insurance is valid and cannot retroactively file insurance unless this is discussed ahead of time. Your estimated balance is due at the time of treatment. It is also your responsibility as a parent/guardian to pay any remaining balance on your account after any and all insurance benefits have been collected.

If your account is not paid within 60 days, you will be liable for all collection fees, legal fees, interest charges (1.5% per month), and any other expenses incurred while collecting your account.

I hereby authorize all insurance benefits, if any, to be assigned directly to Florence Pediatric Dentistry, otherwise payable to me for services rendered. I authorize the release of any information required to process insurance claims, including the use of my signature on all insurance submissions.

Initial:_____

MISSED APPOINTMENT POLICY

We are dedicated to provide the best dental care possible for your child. We want to give your child the time and individual attention he/she deserves. Your child's appointment will be specifically reserved for him/her. As a courtesy, we will try to contact you to confirm and remind you of your appointments, but it is your responsibility to make sure we have your most up to date contact information. In an effort to acknowledge the importance of each parent's time and to remain on schedule, we ask that parents arrive on time for their children's appointments. If a patient is more than 15 minutes late, we cannot guarantee that all treatment will be completed, or we may need to reschedule the appointment.

If an unforeseen circumstance arises, please give at least 24 hours notice if you must reschedule. Failure to comply with this policy may result in requiring a deposit to reschedule or the dismissal of your child from our practice. If this happens, you will be notified in writing and we will continue to provide emergency dental care for your child for up to 30 days following the dismissal, as required by law.

Initial:_____

CONSENT FOR TREATMENT

The information that I have given on the new patient forms is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform Florence Pediatric Dentistry's dental office of any changes in my child's medical status. I authorize Dr. Elvington and/or associates to perform the necessary dental procedures, including, but not limited to, the use of nitrous oxide (laughing gas), local anesthetic (like Lidocaine), and any necessary x-rays needed on my child.

All procedures will be discussed with you prior to any dental treatment.

Initial:_____

ACKNOWLEDGEMENT OF HIPAA, FINANCIAL & MISSED APPOINTMENT POLICIES, & CONSENT

I have read a copy of Dr. Kimberly C. Elvington's Notice of Privacy Policies and I am aware that I am entitled to a copy upon request.

I understand the financial and missed appointment policies.

I hereby consent for treatment to be completed on my child.

I authorize Florence Pediatric Dentistry to file my insurance and for payments to be made to the office.

Initial:_____

Parent/Guardian Signature:_____ Date: _____

Parent/Guardian Print Name:_____