Eagle Crest
Pediatric Dentistry

484-454-3568
www.eagekcrestkids.com
31 S Eagle Road, Suite 100,
Havertown, PA. 19083

Thank you for choosing Eagle Crest Pediatric Dentistry for your child's dental care

PATIENT INFORMATION

Name _____ Nickname _____

DOB _____ Gender M F

Street Address _____ City _____ State _____ Zip _____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

PARENT INFORMATION

Name _____ SS# _____ DOB _____ Gender M F

Home # _____ Cell _____ Email address _____

☐ Check box if address is same as patient's

Street Address _____ City _____ State _____ Zip _____

Employer _____ Work # _____

DENTAL INSURANCE INFORMATION

PRIMARY COVERAGE

Name of Insured _____
Relationship to Patient _____
DOB _____ SS# _____
Cell _____ Home _____
Employer _____
Insurance Company _____
Street Address: _____
City _____ State _____ Zip _____
Phone _____
Group/Policy # _____
ID# _____

SECONDARY COVERAGE

Name of Insured _____
Relationship to Patient _____
DOB _____ SS# _____
Cell _____ Home _____
Employer _____
Insurance Company _____
Street Address _____
City _____ State _____ Zip _____
Phone: _____
Group/Policy # _____
ID# _____

The undersigned hereby authorizes the Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a diagnosis of the patient's dental needs. I authorize the Doctor to perform any and all forms of treatment, medication and therapy that maybe indicated. I also understand the use of anesthetic agents poses a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier. I give permission to Eagle Crest Pediatric Dentistry to release any information including diagnosis and treatment records or examination rendered to my dependents during the period of such dental care, to third party payers. I authorize and request my insurance company to pay directly to Eagle Crest Pediatric Dentistry dental insurance benefits otherwise payable to me.

PARENT / GUARDIAN SIGNATURE _____ Date: _____

MEDICAL AND DENTAL HISTORY

Patient's Name _____DOB _____Age _____

What is the primary reason for today's visit? _____

_____

Has your child ever been to the dentist? ☐ Yes ☐ No

Previous Dentist _____ Date of Last Exam _____

Date of last x-rays _____

Has the child had problems associated with dental treatment? ☐ Yes ☐ No

Is the child's water fluoridated? ☐ Yes ☐ No

Is the child taking fluoride supplements? ☐ Yes ☐ No

Has the child ever had pain in the jaw joint/TMJ? ☐ Yes ☐ No

Does the child brush / floss the teeth daily? ☐ Yes ☐ No

Habits (check all that apply)

☐ Thumb / Finger sucking ☐ Use Pacifier

☐ Tongue Thrust ☐ Mouth Breather

☐ Grind Teeth ☐ Other _____

Child's Physician _____

Phone: _____

Current Medications_____

_____

Has your child been diagnosed and/or treated for any of the following? (check all that apply)

☐ ADD/ADHD ☐ Developmental Delay

☐ Bleeding Disorder ☐ Hearing Impairment

☐ Heart Murmur ☐ Surgery / Hospitalization

☐ Hepatitis ☐ Autism Spectrum

☐ Asthma ☐ HIV / AIDS

☐ Cancer ☐ Kidney / Liver Problem

☐ Congenital Heart Disease ☐ Rheumatic Fever

☐ Convulsions / Epilepsy ☐ Sickle Cell Disease

☐ Diabetes ☐ Tuberculosis (TB)

☐ Other

If yes to any of the above, please explain

_____

_____

_____

Medications

_____

Allergies

_____

Acknowledgement of Patient Information

The information I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize Eagle Crest Pediatric Dentistry to perform the necessary dental services my child may need.

_____ _____

Signature of Parent / Guardian Date

_____ _____

Signature of Dentist Date

Delegation of Power by Parent or Guardian

I give my consent to allow person (s) named below other than me to accompany and oversee my child for appointments, to release healthcare information for the appointment or to secure payment for dental services and to provide consent for treatment or changes in treatment. I understand I can revoke this consent at any time by providing written notice.

1. _____ 3. _____

2. _____ 4. _____

_____ _____

Signature of Parent / Guardian Date

Practice Financial Policies & Procedures

We are committed to providing your child with the best possible care and are pleased to discuss our professional fees with you at any time. Your understanding of our financial policies is important to our professional relationship.

1. Verifying Insurance : As a courtesy to you, we will verify your insurance for eligibility benefits prior to your child's appointment as well as any time you notify us of a change in your coverage. The insurance companies do not guarantee payment based on the information that they provide us. You are ultimately responsible for knowing if there is a waiting period for work to be performed. Any treatment that is not covered by your insurance is your financial responsibility. Please keep your insurance information current by notifying us of any changes in employment, insurance coverage, etc.
2. Payment : Payment is due at the time of service. The adult accompanying a minor and/or the parent/guardian is responsible for payment at the time of the appointment. Additionally, if you have a balance following an insurance payment from a previous visit, you will be expected to pay that amount.
3. Balances : If your account balance exceeds 90 days, you will receive a notice informing you that your account is overdue. If you do not pay your balance or arrange a payment plan within 10 days, your account will be turned over to a collection agency. If this happens, a collection fee will be added to your balance. The collection agency will report any unpaid balance to the major credit bureaus.
4. Returned Checks : There will be a $30 fee for all returned checks. Once a check has been returned, the office will no longer accept personal checks for payment.
5. Cancellation/Failed Appointments : We request 24-hours notice if you are cancelling your appointment. In case of second cancellation without 24-hour's notice, you will have to call the day of the appointment to get an appointment. After a third cancellation, you will not be allowed to schedule any other appointment.

I certify that my child is covered by insurance and assign directly to Eagle Crest Pediatric Dentistry all insurance benefits, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not covered by dental insurance. I hereby authorize Eagle Crest Pediatric Dentistry to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions

_____ _____

Signature of Parent / Guardian Date

UPDATE OF MEDICAL HISTORY

Has there been any change in the child's health status since their last visit? ☐ Yes ☐ No

If so, please explain. Be sure to include new medication(s) or discontinued medication(s)

_____

_____

_____

_____ _____

Signature of Parent / Guardian Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT.

I, _____, have I been informed of and given the right to review and secure a copy of your Notice of Privacy Practices received a copy of this office's Notice of Privacy Practices.

Patient's Name: _____

_____ _____
Signature of Parent / Guardian Date

FOR OFFICE USE ONLY

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

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

Patient Name: _____ DOB: _____Age: _____

_____ / _____ _____
Signature / Name Date

My child's oral health needs has been explained to me. I am aware that my child has _____ cavities.

I understand that my child needs one or more the following procedures:

	Radiographs		Sealants		Fluoride ☐ Yes ☐ No ☐ 2x/yr ☐ 1x/yr		
	White Faced Crown		Resin		N2O ☐ Yes ☐ No		
	Stainless Steel Crown		Extractions		Pedi-Wrap ☐ Yes ☐ No		
	General Anesthesia		Space Maintainers		Nerve Therapy		

TREATMENT CONSENT

Pediatric dentistry includes but is not limited to sealant application, fillings, nerve treatment, crowns, extractions and space maintainers. It is your right, as a parent to understand the risks, benefits, and alternatives of your child's dental treatment before giving consent for specific dental treatment.

- Fluoride is a mineral that is effective in preventing and reversing the early signs of dental caries. Studies show that fluoride achieves its preventive effects by strengthening tooth structure so teeth are more resistant to acid attacks. Fluoride acts to repair or remineralize areas where acid attack has begun. The remineralization effect of fluoride is important as it creates a tooth surface that is more resistant to decay. Insurance companies typically cover fluoride treatment once or twice per year.
- Nitrous Oxide (laughing gas) reduces anxiety and relaxes children during dental treatment. Nitrous Oxide is given through a small breathing mask placed over the child's nose, allowing them to relax without putting them to sleep.
- Pedi Wrap is a safety equipment that prevents unpredictable movement. The device consists of a mesh wrap and velcro to secure the patient's limbs and abdomen during treatment. Benefits include protection from injury and safe delivery of dental treatment. The risks include but are not limited to temporary redness, bruises, and/or rash that may result on the part of the body that is secured.

I (parent / guardian) understand that my child's treatment may include the use of any of the above agreed treatment. These procedures have been explained to me and I understand their benefits and how they will be accomplished. My questions and concerns have been satisfactorily addressed. I give consent to these treatments and agree to hold harmless, release and indemnify the doctor and employees of the office of Eagle Crest Pediatric Dentistry from any and all causes of action, claims, demands, or liability that may arise out of such treatment. If any conditions are discovered in the course of treatment which require procedures in addition or different from those described, I also authorize the performance of these procedures.

_____ _____
Signature of Parent / Guardian Date

_____ _____
Signature of Dentist Date