Anantuni
FAMILY DENTAL

Welcome to Anantuni Family Pediatric Dentistry. Our staff would like to welcome you and your child to our dental office. We strive to provide a fun and educational experience for your child while also maintaining the highest level of excellence in your child's care and treatment. Our ultimate goal is teaching good oral hygiene that will enable our patients to maintain beautiful smiles for a lifetime!

Please complete the detailed medical form. This information will allow us to provide your child with the safest comprehensive dental care possible. Please feel free to ask questions about an item that is not familiar.

Pediatric Patient Information

Patient's name: _____ Nickname: _____

Home address: _____ Home phone: _____

City: _____ ____ State: _____ Zip Code: _____

Date of Birth: _____Age: _____ Social Security #: _____ □Male □Female

How did you hear about us? _____

Legal Guardian Information

Mother's Information: □Mother □Step Mother □Legal Guardian □Grandmother

Name: _____ Date of Birth: _____ Social Security #: _____

Address: _____ City, State & Zip: _____

Email: _____ Cell: _____ Work: _____ Prefer: _____

Occupation: _____ Employer: _____

Father's Information: □Father □Step Father □Legal Guardian □Grandfather

Name: _____ Date of Birth: _____ Social Security #: _____

Address: _____ City, State & Zip: _____

Home Phone: _____ Cell: _____ Work: _____ Prefer: _____

Occupation: _____ Employer: _____

Emergency Contact Information

In case of an emergency where either the parent or legal guardian cannot be reached, please identify the following information for the next closest relative not living with the patient.

Name: _____ Relationship to patient: _____

Address: _____ Phone: _____

Medical History

Please list the name and phone number of any physicians that are currently treating your child. When was your child's last medical check-up with his/her primary care physician?

_____

Please list **all medications** patient is currently taking? _____

Please list **all allergies (food/medications)**? _____

Has your child ever had any of the following conditions?

Yes	No		Yes	No	
□	□	Sickle Cell Anemia or Trait	□	□	Measles, Mumps or Chicken Pox When? _____
□	□	Bleeding Disorders/ Hemophilia	□	□	Skin Disorder or Eczema
□	□	Blood Transfusion Date(s): _____	□	□	Tonsillectomy and/or Adenoidectomy When? _____
□	□	Hypertension	□	□	Chronic Ear Infections / Otitis Media
□	□	Anemia	□	□	Tuberculosis or Positive Test Result When? _____
□	□	Heart Murmur (innocent or Pathologic)	□	□	Heart Condition _____
□	□	Immunologic Disorder, HIV, AIDS, ARC	□	□	Hepatitis Type: _____ When? _____
□	□	Hearing Impairment (right, left or both)	□	□	Eye Problems (right, left or both)
□	□	Rheumatic Fever	□	□	Thyroid Disorder
□	□	Bruises or Bleed Easily	□	□	Stomach or GI Disorder
□	□	Cystic Fibrosis	□	□	Implanted Shunt
□	□	Asthma or Lung Problems (Inhaler, Nebulizer)	□	□	Pneumonia When? _____
□	□	Seasonal Allergies, Hay Fever, etc.	□	□	Diabetes Mellitus (NIDDM or IDDM _____x day)
□	□	Cancer, Malignancy, Leukemia, or Lymphoma	□	□	Appendectomy When? _____
□	□	Kidney Disease of Transplantation	□	□	Liver Disease or Transplantation
□	□	Urinary Tract Disorder	□	□	Chronic Constipation
□	□	Febrile Seizure, Fainting Spells	□	□	Seizure Disorder, Epilepsy Last episode? _____
□	□	Congenital Birth Defects/Syndromes	□	□	Cleft Lip/Palate (bilateral/unilateral)
□	□	ADD, ADHD or Hyperactivity	□	□	Emotional or Behavioral Problems
□	□	Learning Disability	□	□	Psychiatric Problems
□	□	Autism	□	□	Physical or Emotional Abuse
□	□	Neurological Disorder (Hydrocephaly, Microcephaly)	□	□	Delayed Development, MR approx. age child functions?

Dental History

□ Yes □ No Has your child ever been treated by a dentist? _____ Date of last dental visit? _____

□ Yes □ No A Pediatric Dentist? If yes, whom? _____

□ Yes □ No Has your child ever had dental x-rays? Date? _____

□ Yes □ No Does your child suck his/her thumb, finger, pacifier or blanket? _____

□ Yes □ No Does your child brush his/her teeth? Do you assist? _____ How often? _____

□ Yes □ No Does your child floss his/her teeth? Do you assist? _____ How often? _____

□ Yes □ No Does your child snack between meals? _____

□ Yes □ No Has your child been prescribed fluoride supplements? _____

How would you predict your child's behavior to be today? □ Cooperative □ Nervous □ Defiant □ Don't Know

What are your primary concerns regarding your child's oral health and/or reason for today's visit?

Has your child ever suffered from or been treated for any of the following dental related problems?

Yes	No		Yes	No	
□	□	Bad breath/Halitosis	□	□	Popping or soreness of the jaws (right, left or both)
□	□	Bleeding Gums	□	□	Dental infection or abscess
□	□	Stained or Discolored teeth	□	□	Missing or extra teeth
□	□	Pain from teeth	□	□	Cold sores or fever blisters
□	□	Dry mouth	□	□	Previous injury or trauma to teeth, mouth or face
□	□	Orthodontics	□	□	Cavities If so please explain: _____

NOTE: Both doctor and patients are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Patients Name Print | Print Parent/Legal Guardian Name | Signature Parent/Legal Guardian | Date

Print Name of Treating Dentist | Signature of Treating Dentist | Date

Informed Consent for Initial Pediatric Dental Visit

It is our intent that our dental care delivery be the best quality available. We are highly experienced in helping children overcome anxiety and we ask that you allow your child to accompany us through the dental experience. Dental anxiety is not uncommon in children so please try to not be concerned if your child exhibits some negative behavior; this is normal and will soon lessen with time. Studies and experience have shown that most children react more positively when permitted to experience the dental visit in an environment designed for children. Our goal is to prevent decay and have our entire patient's be **"CAVITY FREE"!**

Please read this carefully. If you do not understand something to your satisfaction, please ask questions. We will be please to explain.

1. I request and authorize the taking of oral dental x-rays, a full comprehensive exam and a prophylaxis (cleaning) with the use of fluoride to evaluate and diagnosis my child's oral health.

2. I understand that during the course of the patient's dental treatment, something unexpected may arise that may necessitate procedures in addition to or different from those listed on the patient's Treatment Plan and that I will be consulted prior to the initiation of the treatment procedures not listed. I am aware that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the dental treatment that the patient receives in our office.

3. I understand that treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Behavior will be guided using praise, explanation and demonstration of procedures and instruments, using variable voice tone and loudness.

4. I understand that should the patient become uncooperative during dental procedures with movement of the head, arms and/or legs, dental treatment cannot be safely provided. During such disruptive behavior, it may be necessary for the assistant(s) to hold the patients hands, stabilize the head and/or control leg movements.

5. I further understand that should the patient become uncooperative during dental treatment with excessive body movements the patient may need to be wrapped in a "hug blanket" or "papoose board" to prevent injury and enable the dentist to safely provide the necessary treatment. This will not be used without your prior knowledge and additional written consent.

6. I understand that I may revoke this consent to treatment at any time and that no further action based on this consent will be initiated except to the extent that treatment and procedures have already been performed or initiated.

7. I confirm that I have read and understand this form or it was read to me and all of my questions have been answered to my satisfaction.

Patient's Name Print	Print Parent/Legal Guardian Name	Signature Parent/Legal Guardian	Date

Treating Dentist Name	Signature of Treating Dentist	Date

Office Policies

Notice of Privacy Practices & HIPAA

A laminated copy of our office Notice of Privacy Practices and HIPAA is available in our office. You have the right to read our Notice before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this consent. Upon your request we will be happy to provide you with your own personal copy of our Privacy Practices.

HIPAA regulations authorize the release of PHI for the purpose of treatment, obtaining payment from Third party payers, and the standard healthcare operations. Other than those releases authorized by HIPAA, PHI will only be released to persons listed on this authorization. If you choose not to authorize any family members or friends, we will not be able to release any information to anyone other than the patient.

I hereby authorize Anantuni Family Dental, PC to release my patient health information as described below:

Authorized Individual Name	Relationship
Type of Information allowed to Disclose:	**Type of Disclosure**:
□ Dental Records □ Financial	□ Phone □ Person □ Email

I understand that I am not required to sign this authorization. I acknowledge that I have read or received a copy of this office's Notice of Privacy Practices and that Anantuni Family Dental abides by the HIPAA Law and will protect the privacy of my personal information.

Patient Name (Print) Signature or Patient or Guardian Date

Authorization for Signature on File

I (name of patient), _____ and/or (name of insured) _____, hereby authorize Anantuni Family Dental to affix my name to any and all claims or documents as related to any and all health benefits due me and my dependents through my insurer. I hereby authorize payment of dental benefits otherwise payable to me directly to the office above. I agree to be responsible for all charges for dental services whether or not paid by my insurance. I authorize the release of any information relating to this claim to obtain payment. I authorize the use of this signature on all insurance submissions.

Signature of Patient Date

This authorization will be valid from this date and shall expire in one year.

Financial Policy

Thank you for choosing Anantuni Family Dental to serve your dental care needs. We provide high-quality dental care to our patients and are committed to your treatment being successful. Please understand that your financial obligation is considered a part of your treatment. In the interest of good dental care practice, it is desirable to establish a credit policy to avoid misunderstandings. To assist our patients, we offer the following methods for taking care of their account in our office.

- On your first visit we expect you to supply our office with your insurance information and a photo ID. If any changes should occur during the time you are a patient, it is your responsibility to inform our office with any changes. Our office will not be responsible for claims submitted to insurance companies by which you are no longer covered.

- As a **courtesy**, we will gladly bill your insurance. While we accept most insurance plans, and are happy to aid in submission of your claims, it is your responsibility to read your policy and understand that this is a contract between your employer, your insurance company and yourself. Please be aware of some and perhaps all of the services rendered may be not covered by your individual plan and you are ultimately responsible for the payment on the account.

- We cannot accept responsibility for collecting an insurance claim after 60 days or for negotiating a disputed claim. If no payment is received on an account after two monthly statements our office will make every effort to contact the responsible party. If the party responsible cannot be reached, a third bill will be sent indicating that **"This will be the final notice for payment"**. If the party fails to contact our office after receiving such notice, the account will be sent to a collection agency.

- We ask that you either pay your estimated patient portion of the bill at the time of service, or that a suitable written financial arrangement be reached at the time of service. We accept cash, all major credit cards, personal checks, and financing from Care Credit. For all checks returned due to **non-sufficient funds**, there will be a $35 fee added to your account.

- If an insurance company pays more than anticipated creating a credit for the patient, we are happy to either refund the patient or leave the credit on the account to be applied toward future treatment.

- The original dental record, including but not limited to treatment notes, x-rays, study models are the property of Anantuni Family Dental. These originals will not be released to patients or other healthcare providers, without written request. I understand that a $25 fee may be applied to my account for duplication of my dental records and x-rays.

Delinquent Accounts

On occasion, after repeated attempts to collect a balance due, we may need to turn an account over to a collections agency. Should this occur, it is agreed that the financially responsible party listed below shall pay all finance charges, collection cost, attorney fees and any other costs that may be incurred to enforce collection of any amount outstanding. In addition, a 35% collection fee based on the balance of the account will be added.

Failed or Cancelled Appointments

If an appointment has been reserved for you, we kindly ask that patients give us 48 hour notice for cancellations; otherwise, we reserve the right to charge a minimum of **$50 per hour** of scheduled appointment. If the appointment is with a specialist, the minimum fee is **$75 an hour**. We will only offer appointments **SAME DAY** to patients who fail multiple appointments without having given us proper notice.

I confirm that I have read and understand this form or it was read to me and all of my questions have been answered to my satisfaction.

Patient Name | Signature of Patient or Guardian | Date