Date: _____

Your Child

Patient Name_____ **Nickname**_____ **Sex** _____

Birth Date _____ **Age** _____ **Email:** _____

Address _____

Street **City** **Zip**

Home (_____**)**_____ **Cell (** _____**)**_____ **Work(** _____**)**_____

School _____ **Grade** _____ **May we send you text/email reminders** **Yes** **No**

Responsible Party Information

Name _____ **Relationship** _____ **Birth Date** _____

(IF DIFFERENT FROM ABOVE PLEASE FILL THE INFORMATION BELOW)

Address _____

Street **City** **Zip**

Home (_____**)**_____ **Cell (** _____**)**_____ **Work(** _____**)**_____

Primary Dental Insurance

Subscribers Name _____ **Relationship** _____ **Birth Date** _____

Insurance Company _____ **Ins. Phone #** _____

ID# or SS# _____**Employer/Company** _____**Grp#**_____

Referral Information

Whom may we thank for referring you to our office? _____

Do you have any other family members that come to our practice? _____

About my Child

Favorite Pet (if any) _____ Siblings _____

☺Tell me your favorite: ☺

Game or Hobby _____ School Subject _____

Sports _____ T.V Show _____ Song _____

Dental History

Is this the child's first visit to a dentist? ☐ YES ☐ NO Last Dental Visit: _____

Name of Previous Dentist: _____ Telephone # _____

Explain any unpleasant dental experiences your child had: _____

Explain any tooth/mouth injuries your child had/has: _____

Circle any of the following habits your child HAD:

t*humb sucking* **finger sucking** ***pacifier*** **grinding** ***tongue-thrusting***

Circle any of the following habits your child HAS:

t*humb sucking* **finger sucking** ***pacifier*** **grinding** ***tongue-thrusting***

Does your child have speech issues? ☐ YES ☐ NO Explain: _____

What is your child's attitude towards dentistry? _____

Oral Hygiene

How often does your child brush? _____ How often does your child floss?_____

Does anyone in the family ever help your child with brushing and flossing? ☐ YES ☐ NO

Circle the type of water provided in your community: Fluoridated Well

What type of water does your child drink (please circle): BOTTLE TAP FILTERED

Does your child have any abnormal dietary habits? YES NO if so please explain: _____

_____

Health History

Child's Physician _____ Phone# _____

Date of last Examination _____ Results _____

☐ YES ☐ NO Child under care of physician now? Why? _____

☐ YES ☐ NO Child receiving any medication now? What? _____

☐ YES ☐ NO Child ever been hospitalized? Why? _____

☐ YES ☐ NO Child bleeds excessively when cut? Describe: _____

☐ YES ☐ NO Child has emotional or nervous problems? Explain _____

**Does your child have any allergies to the following? (CIRCLE)

Penicillin; Other Antibiotic; Novocain's (local anesthetics); Aspirin; Latex; Any Foods; Other

IF SO (explain) _____

Does your child have or ever had any of the following? (Please mark the ones that apply with an "X")

___ Anemia
___ Asthma
___Autistic Spectrum
___ Bladder Problems
___ Cerebral Palsy
___ Chronic Sinus
___ Cleft Lip
___ Cleft Palate
___ Convulsion
___ Diabetes
___ Epilepsy
___ Fainting
___ Hearing Problems
___ Jaundice
___ Kidney problems
___ Mentally Challenged
___ Heart Murmurs
___ Liver Problems
___ Rheumatic Fever
___ Sight Problems
___ Thyroid Problems
___ Tuberculosis
___ Cancer
___ HIV/AIDS
___ Hemophilia
___ Acid Reflux
___ Chronic Cough
___ Other

Would you like to talk with the doctor privately about certain personal issues? ☐ YES ☐ NO

Authorization & Release

If this patient is a minor, it becomes necessary that signed permission be obtained from the parent or guardian. Authorization is herby granted. I understand that providing incorrect information can be dangerous and it in my responsibility to inform the office of any changes in my child's health. I also authorize the staff to perform the necessary services that my child needs only after a consultation and/or explanation. Furthermore, I will be responsible for any bill incurred on this patient for dental treatment or, if I indicated someone else is responsible, permission is granted for verification.

Signature: _____ Relationship _____ Date _____

_____ _____ _____

SAMIRA ALEMPOUR, D.M.D. MARCELA SOLARTE, D.M.D SABRINA ROBERTI, D.M.D

If You Have Dental Insurance

Due to the constant changes in insurance coverage, we must have you read and sign the following in order for us to accept your insurance plan:

It is our pleasure to accept your dental insurance. This office will also be more than happy, to file the insurance forms for you at no charge.

We treat every patient with equal care, with or without insurance. Unfortunately, some insurance companies do not always cover certain established, routine and acceptable procedures. Your child deserves proper treatment that should not be influenced by your insurance company's limitations. This office files forms for more than 1000 different insurance plans. Since we do not have access to each plans contract, it is therefore difficult and nearly impossible, for us to know every limitation, deductible or allowable procedure for every single policy. Therefore it is imperative for you to know your policy's limitations. If you have any questions about your policy, we would be happy to help you review the terms.

As a disclaimer: The insurance company DOES NOT guarantee any benefits, the guarantor is ultimately 100% responsible for the fee charged; should the insurance not pay. A pre-determination can always be filed on your behalf. The insurance does have the right to downgrade any procedure. In the case that occur the patient is responsible for any balance or difference owed.

We will give you the most accurate **ESTIMATED** treatment plan possible, but treatment may change during the course of your visit as Dr. Alempour sees fit. Coverage by yours insurance companies is also subject to change based on your policy and on the information obtained from the insurance representative. Your insurance company will pay up to the limits it has previously contracted with your employer. The balance, which reflects your insurance policy's limitations or deductibles is payable by you. It is appropriate to pay your estimated portion of the fee when the services are rendered.

If at any time you have any questions about your insurance policy or plan, feel free to speak with our staff. We will try to clear up any confusion that may exist.

Thank you very much for allowing Pediatric Dentistry of Weston to serve your family.

I have read and understand the office policy on insurance. I am aware that any balance or difference owed after the insurance has issued a payment is my responsibility and will have to be paid to the provider.

Parent/Guardian **Signature**:_____ Date: _____

Patient Name: _____

Informed Consent

I hereby give Samira Alempour and staff at The Pediatric Dentistry of Weston and Associates, my informed consent to provide dental treatment to my child (or myself).

This includes consent to undergo a comprehensive examination, including x-rays (if permitted) and a periodontal charting (if necessary), from which a treatment plan will be formulated. From this treatment plan, this office can provide me with an estimate of the cost of the treatment.

I also understand that during the course of the procedure(s), unforeseen conditions may be reveled that necessitate a change in the original procedure(s). I therefore authorize and request that the doctors and staff of this practice to complete such procedures as are necessary and desirable in the exercise of professional judgment. If necessary, additional explanation of the new procedures will be made by the doctors or staff.

Furthermore, I understand that no dental treatment is completely risk free, and that my dentist will take reasonable steps to limit any complications. Possible complications in pediatric dentistry include, but are not limited to:

- Post operative discomfort and swelling. (This included the discomfort and swelling due to the patient's rubbing and biting of the cheek, tongue and lips as a result of the "numb" feeling).
- Injury to adjacent teeth, fillings and gum.
- Post-operative infection requiring additional treatment.
- Stretching of the corners of the mouth with resultant cracking and bruising.
- Restricted mouth opening for several days
- Decision to leave all small root fragments in the jaw after extractions
- Injury to the nerve underlying the teeth during anesthesia (shots) or extractions resulting in numbness or tingling of the chin, lip, cheek, gum, and/or tongue; which may persist for several weeks or, in rare cases, permanently. NOTE: This is different from the 1-3 hours of numbness from routine injections.
- Discoloration or bruising of the cheek close to the injection site
- Exposure of the nerve (not from tooth decay) while preparing a tooth for a crown or filling
- The need for root canal therapy after restorative work, resulting from damage caused by the drill or deep restorations.

It is important for me to understand the treatment being rendered, pros and cons of that treatment, and any possible alternative treatment. I understand that if the planned treatment is not clear to me, it is better to ask any questions I wish before treatment is started.

_____ _____ _____

Parent/Guardian's signature Child's Name Date

SAMIRA ALEMPOUR, D.M.D., AND ASSOCIATES

ACKNOWLEDGE OF RECEIPT OF "NOTICE OF PRIVACY PRACTICES" AND CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

You may refuse to sign this authorization

The undersigned acknowledge receipt of a copy of the currently effective "Notice of Privacy Practices" for the office of Samira Alempour, D.M.D., and Associates and hereby authorizes this dental office to use and disclosure in any form or format the Protected Health Information of this patient but only as follows:

1. To carry our treatment (normal treatment of your child's dental care)
2. Payment activities (billing and submission of insurance forms)
3. Healthcare operations (quality assessment, internal grievance, customer service, etc.)

The practices will not disclosure the following information unless you additionally initial:

_____HIV records

_____Alcohol and substance abuse diagnosis

_____Psychotherapy records

You have the right to read our "Notice of Privacy Practices" which accompanies this form 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 heath information, and of other important matters about your protected health information.

You have the right to evoke this Consent at any time by giving us written notice of your revocation submitted to our Privacy Officers. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or your child or to continue treating you or your child if you revoke this Consent

Parent/Guardian Signature:_____ Relation to patient:_____ Date:_____

Print Patient Name:_____ Date of Birth: _____

A copy of this signed and dated Acknowledge/Consent shall be as effective as the original. You may request a copy of the notice of privacy.

Thank you and if you have any questions about this form or the attached notice, please contact our privacy officer.

NO SHOW/CANCELLATION POLICY

We understand that there are legitimate reasons for having to cancel an appointment. We ask you to show consideration by calling well in advance if you are unable to keep an appointment. We would like to have the option to offer that appointment to another patient who needs to see the doctor as soon as possible. Please let this notice serve to notify you that if you fail to give us a 24-48 hour notice of cancellation, there will be a $50.00 cancellation fee applied to your account.

_____ _____ _____

Signature of Parent /Legal Guardian **Relationship to Patient** **Date**

_____

Patient Name

FLUORIDE TREATMENT CONSENT FORM

In an effort to provide the best preventative dental care available, we have included fluoride treatment to our cleaning protocol. The Academy of Pediatric Dentistry (AAPD) has continued to endorse the importance of fluoride during each dental cleaning. The efficacy of fluoride has been proven to combat the formation of tooth decay. In some cases your insurance will cover the fluoride, if not there will be a co- payment of $35.00. Here is some important information about the benefits of FLUORIDE:

1. FLUORIDE PROMOTES THE REMINERALIZATION OF A TOOTH

Fluoride has been found to enhance the tooth remineralization process on demineralized enamel. Fluoride found in saliva will absorb onto the surface of a tooth where demineralization has occurred. The presence of this fluoride in turn attracts other minerals (such as calcium), thus resulting in the formation of new tooth minerals.

2. FLUORIDE CAN MAKE A TOOTH MORE RESISTANT TO THE FORMATION OF TOOTH DECAY

Fluoride inhibits the dental caries by affecting the metabolic activity of cariogenic bacteria. The fluoride is released when the pH drops in response to acid production and becomes available to re-mineralize enamel. It has been proven that fluoride use for the prevention and control of caries is both safe and highly effective in reducing dental caries prevalence.

I understand and have been educated on the importance of the fluoride treatment every time my children have a dental cleaning. I consent to the fluoride treatment in every cleaning visit even though my insurance might not cover it more than once per year.

_____

Patient Name

_____ _____ _____

Parent/Guardian Printed Name Parent/Guardian **Signature** Date