Advantage Dental+

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.

If you require a language interpreter specify language: Did an interpreter help you with these forms? ☐ YES ☐ NO

Last Name | First Name | MI | Suffix (check one) ☐ Sr ☐ Jr ☐ I ☐ II ☐ III | Preferred Name

Gender (choose one) ☐ M ☐ F ☐ Other ☐ Choose Not to Disclose

Race/Ethnicity: ☐ Caucasian ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐ Other: ☐ Choose not to disclose

Date of Birth (mm/dd/yyyy) | SSN | School

PLEASE FILL OUT INFORMATION FOR ADDITIONAL PATIENTS ON BACK

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+ 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 ☐ Other

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

Is this visit a result of a motor vehicle accident? ☐ Yes ☐ No Is this visit a result of a work accident? ☐ Yes ☐ No

Communication Agreement

Advantage Dental+ 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.

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

Print Name ______ **Date** ______

PLEASE FILL OUT INFORMATION FOR ADDITIONAL PATIENTS ON BACK - OVER →

Staff Initials ______

ADDITONAL PATIENT INFORMATION

Last Name	First Name	MI	Suffix (check 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
Date of Birth (mm/dd/yyyy)	SSN		School	

Last Name	First Name	MI	Suffix (check 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
Date of Birth (mm/dd/yyyy)	SSN		School	

Last Name	First Name	MI	Suffix (check 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
Date of Birth (mm/dd/yyyy)	SSN		School	

Last Name	First Name	MI	Suffix (check 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
Date of Birth (mm/dd/yyyy)	SSN		School	

Last Name	First Name	MI	Suffix (check 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
Date of Birth (mm/dd/yyyy)	SSN		School	

Do any of the children listed above have insurance other than what's provided on the front of the form? ☐YES ☐NO

If yes please provide copies of insurance card to front office staff.

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

Staff Initials ________

PEDIATRIC DENTAL AND HEALTH HISTORY
(patients under 14 years old)

Advantage Dental+

Patient Name: ______ Patient Date of Birth: ______

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

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

______

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

Check the box next to any question with a yes answer:

Is the child currently experiencing dental pain or discomfort? ☐	Does the child clench, brux, or grind their teeth? ☐
Does the child have problems with eating (trouble chewing, vomiting, etc.)? ☐	Does the child have any pacifier/thumb sucking habits? ☐
Does the child have a history of jaw joint problems (popping, etc.)? ☐	Has the child ever had orthodontics (braces) treatment? ☐

Check the box next to any of the below that apply:

- AIDS/HIV Positive ☐
- Anaphylaxis/Allergic Reaction ☐
- Asthma/Lung/Breathing problems ☐
- Behavior or emotional problems ☐
- Blood problems, anemia, sickle cell disease ☐
- Brain or nervous system problems ☐
- Cancer/cancer treatment ☐
- Diabetes ☐
- Eating Disorder ☐
- Epilepsy or Seizures ☐
- Excessive Bleeding, Bruise Easily ☐
- Fainting spells/Dizziness ☐
- Developmental Disorder ☐
- Heart Problems/Blood Pressure Problems ☐
- Kidney Problems ☐
- Learning problems/delays, intellectual disability ☐
- Liver Disease/ Hepatitis ☐
- Rheumatic Fever ☐
- Stomach/Intestinal Disease/Acid Reflux ☐
- Thyroid Disease ☐

Provide details to all boxes checked answers here AND provide details about any other medical condition not covered above :

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, fluoride or fluoride supplements, 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**

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 ☐ Other: ______

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

PATIENT FINANCIAL POLICY

Advantage Dental+

You are fully responsible for all fees charged by this office regardless of your insurance coverage.

If you have dental insurance, your portion of the fee is due at the time of service. As a courtesy, this office may file your insurance claim, but we do not guarantee any benefit. 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. You authorize and direct payment to Advantage Dental+ of the dental benefits otherwise payable to you under any applicable dental insurance plan.
2. 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.
3. 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 third-party financing options (for those who qualify).
4. 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.
5. 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.
6. 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.
7. 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.
8. 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+ and agree to all the terms described in it.

Signature of Patient (or Person Authorized to Sign for Patient)	Patient Name
Relationship to Patient	Date

CONSENT FOR DENTAL PROCEDURE

Advantage Dental+

Patient(s): ______________________________ 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+This consent includes my consent for all treatment performed by a Advantage Dental+ 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+ 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+ 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

Advantage Dental+

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES AND NON-DISCRIMINATION NOTICE

Patient Name: ______________________________

Additional Patients in same Family: ______________________________

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* 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)

AUTHORIZATION TO ACCOMPANY A MINOR

Advantage Dental+

To be completed by the patients authorized representative

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 individual(s) named below to escort my child(ren) for dental treatments. The individual(s) are at least 19 years old and shall remain on the premises at all times during treatment.:

Name	Relationship
Name	Relationship
Name	Relationship

For a child/children over 13 please check one:

☐ Since my child/children is/are over the age of 13, I also give permission for him/her/them to present for treatment unaccompanied by an adult.

☐ Although my child is/are over 13, 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)