WELCOME

1 About Your Child

Today's Date: ____ / ____ / ____ File #: ________

Child's Name: ______________________
LAST FIRST M.I.

Child's Nickname: ________________ ❑ Boy ❑ Girl

Child's Birthdate: ____ / ____ / ____ Age: ________

School: ______________________ Grade: ______

Child's Home Phone #: (______) ____________

Child's SS#: ______________________

Child's Address: ______________________
HOME ADDRESS

CITY STATE ZIP

Referred By: ______________________
(If doctor, please give address & phone number.)

2 Insurance Information

Primary Dental Insurance

Co. Name: ______________________

Address: ______________________

CITY STATE ZIP

Phone #: ______________________

Insured's ID#: ______________________

Group # (Plan, Local, or Policy #): ______________________

Insured's Name: ______________________

Relation: ____________ Date of Birth: ___ / ___ / ___

Insured's Employer: ______________________

Does either policy cover Orthodontics? ❑ Yes ❑ No

Secondary Dental Insurance

Co. Name: ______________________

Address: ______________________

CITY STATE ZIP

Phone #: ______________________

Insured's ID#: ______________________

Group # (Plan, Local, or Policy #): ______________________

Insured's Name: ______________________

Relation: ____________ Date of Birth: ___ / ___ / ___

Insured's Employer: ______________________

3 Child's Family Information

Who is accompanying this child today?

FULL NAME (IF OTHER THAN PARENT) RELATION TO CHILD

Do you have Legal Custody of this Child? ❑ Yes ❑ No

How many Brothers/Sisters? ______ Age(s): _____ _____ _____

MOTHER'S NAME ❑ STEP MOTHER ❑ GUARDIAN EMAIL ADDRESS

(❑ **CHECK IF SAME AS CHILD'S)** HOME ADDRESS CITY STATE ZIP

(______) ____________ (______) ____________ ______
HOME PHONE # WORK PHONE # EXT.

MOTHER'S SOCIAL SECURITY # ___ / ___ / ___ DATE OF BIRTH MOTHER'S DRIVERS LIC. #

Employer: ______________________ How Long? ______

EMPLOYER'S ADDRESS CITY STATE ZIP

FATHER'S NAME ❑ STEP FATHER ❑ GUARDIAN EMAIL ADDRESS

(❑ **CHECK IF SAME AS CHILD'S)** HOME ADDRESS CITY STATE ZIP

(______) ____________ (______) ____________ ______
HOME PHONE # WORK PHONE # EXT.

FATHER'S SOCIAL SECURITY # ___ / ___ / ___ DATE OF BIRTH FATHER'S DRIVERS LIC. #

Employer: ______________________ How Long? ______

EMPLOYER'S ADDRESS CITY STATE ZIP

4 Account Information

Person ultimately responsible for account

Name: ______________________ ______________
RELATION TO CHILD

Billing Address: ______________________

CITY STATE ZIP

SOCIAL SECURITY # ___ / ___ / ___ DATE OF BIRTH DRIVERS LIC. #

(______) ____________ ______ (______) ____________
WORK PHONE #: EXT. CELL PHONE #:

Payment method: ❑ Cash ❑ Check

______________________ ____ / ____

❑ Credit Card - Enter card # above (if accepted)

______ Initials I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

Please Continue On Back

5 Child's Dental Information

Reason for today's visit: ❑ Exam ❑ Emergency ❑ Consultation

Is Child in pain? ❑ No ❑ Yes How Long?____________

Please indicate ☑ any of the following problems:

❑ Discomfort, clicking or popping in jaw. ❑ Lost/Broken Filling(s) ❑ Stained teeth
❑ Red, swollen or bleeding gums. ❑ Teeth grinding ❑ Locking Jaw
❑ Sensitive tooth, teeth or gums. ❑ Ringing in Ears ❑ Bad breath
❑ Blisters/Sores in or around the mouth. ❑ Broken/Chipped tooth ❑ Loose tooth
❑ Other(s): ____________________

Does child require pre-medication? ❑ Yes ❑ No ❑ Don't know

Previous Dentist: ____________________ (_____) ______________

Last Dental exam: ____ /____ /____ Last Dental X-rays: ____ /____ /____

Times a day child brushes? _______ Times a week child flosses? ____________

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

How would you rate the child's smile? **Best** 1 2 3 4 5 6 7 8 9 10 **Worst**

6 Child's Medical History

Is Child taking any of the following medications? ❑ Pain killers (INCLUDING ASPIRIN) ❑ Ritalin ❑ Stimulants
❑ Blood Thinners ❑ Tranquilizers ❑ Insulin ❑ Muscle relaxers ❑ Others: ____________

Child's Physician: ______________________ (_____) ______________
DOCTOR'S NAME OR CLINIC NAME PHONE#

______________________________ Last Medical Exam: _____ /_____ /_____
ADDRESS CITY STATE ZIP

Does Child have or ever had any of the following diseases, medical conditions or procedures?

Y N Heart Murmur	**Y N** Tonsillitis	**Y N** High/Low Blood Pressure
Y N Rheumatic fever	**Y N** Respiratory Problems	**Y N** Hepatitis
Y N Artificial Heart Valves	**Y N** Asthma/Difficulty Breathing	**Y N** Artificial Bones/Joints/Implants
Y N Congenital Heart defect	**Y N** Blood Transfusion(s)	**Y N** Liver/Kidney/Organ Problems
Y N Scarlet Fever	**Y N** Leukemia/Anemia	**Y N** HIV+/AIDS/ARC
Y N Surgeries/Operations	**Y N** Diabetes/Hypoglycemia	**Y N** Tuberculosis TB
Y N Cancer/Tumors	**Y N** Hemophilia	**Y N** Psychiatric Problems
Y N Chemotherapy	**Y N** Abnormal Bleeding	**Y N** Hyper Active/ADD
Y N Jaw Problems TMJ/TMD	**Y N** Cleft Lip/Palate	**Y N** Fainting/Seizures/Epilepsy
Y N Hearing Problems	**Y N** Birth Defects	**Y N** Cerebral Palsy

Please list any other medical condition(s) child has or ever had: ____________________

____

Is Child allergic to: ❑ Latex ❑ Penicillin/Amoxicillin ❑ Tetracycline ❑ Dental Anesthetics (Novocaine)
❑ Aspirin ❑ Food allergies ❑ Other(s): ____________________

Please rate the child's general health from 1-10: _______ Does child wear contact lenses? ❑Yes ❑No

Has this child ever taken the drug Ritalin? ❑ No ❑ Yes/How long? ______ Child's Blood type: _____

Does this child do any of the following? ❑ Thumb/Finger Sucking ❑ Tongue Thrusting/Sucking
❑ Heavy Snoring ❑ Mouth Breathing ❑ Lip Sucking/Biting

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature ______________________________ Date _____ /_____ /_____
❑ Parent or Guardian ❑ Other:

UPDATE (OFFICE USE)

Initials ______ Date __/__/__
Comments

Initials ______ Date __/__/__
Comments

Initials ______ Date __/__/__
Comments

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Tender Care Pediatric Dentistry
6583 Rt. 819 South, Suite 1, Mt. Pleasant, PA 15666
724-542-4818

PARENT GUIDELINES

Dear Parent / Guardian:

You may choose whether or not you accompany your child in the clinical area. Although we sense that some children do better without parents present, we are open to having you with your child. If you choose to be present, we suggest the following guidelines to improve chances of a positive outcome:

1. Allow us to prepare your child.
2. Be supportive of the practice's terminology.
3. Please be a silent observer - support your child with touches:
   - A) This allows us to maintain communication with your child
   - B) Children will normally listen to their parents instead of us and may not hear our guidance.
   - C) You might give incorrect or misleading information.
4. If asked to leave, be ready to immediately walk away.
   This is intended for your child's safety.
   - A) Many children will try to control the situation.
   - B) "Acting out" is normal, but unacceptable during appointments.
   - C) This is intended to "short circuit" the control attempt.
   - D) We will continue to support your child at all times.

******After the initial visit, we only permit one parent to accompany your child into the clinical area for all other visits. Unfortunately there is not enough room in the operatories to allow all family members to be present.******

TCPD reserves time and staff for your child's appointment.
If you need to reschedule your appointment, we require that you call 24 hours prior to the appointment time.
Due to the high demand of appointments, we have found it necessary to dismiss patients after two broken appointments.

These are very important ways that you can actively help in the success of your child's visit. Please feel confident in knowing that our doctors and hygienists are experienced, compassionate professionals. With your assistance in following these guidelines, together we can create a positive experience for your child.

Signed: ____ Date: _________________

Tender Care Pediatric Dentistry
6583 Rt. 819 South, Suite 1, Mt. Pleasant, PA 15666
724-542-4818

AUTHORIZATION FOR TREATMENT OF A MINOR

Please include any/all children you are authorizing consent for:

I, ____, parent(s) / legal guardian(s) of;

____________________________________, a minor child born on _____ /_____ /_____.

Hereby authorize other than legal parent / guardian:

(Name)	(Relationship to child)	(Name)	(Relationship to child)
(Name)	(Relationship to child)	(Name)	(Relationship to child)

to give consent for the dental treatment of the above named child(ren) for any dental condition that he/she may encounter; or to bring the child(ren) to TCPD for routine checkups and associated procedures deemed necessary by TCPD. I also authorize the dentist, hygienists, and staff at TCPD to give information to the individual(s) named above regarding the diagnosis and plan of treatment, or any information necessary for the care of the above named child(ren).

• I hereby release TCPD of any liability regarding release of this information on the above named child(ren).

• **I understand that if someone other than the above listed on this form brings my child(ren) to the dental appointment, my appointment will be rescheduled for another time.**

• I understand that only the above listed have permission to make decisions regarding my child(ren)'s dental treatment, and it is my or other legal guardian's responsibility to notify TCPD of any desired changes.

• I understand changes can be made by a parent or legal guardian at anytime by filling out a new authorization for treatment of a minor, as these changes are not considered addendums to the existing form.

• I understand that even though I have authorized the above named to make treatment decisions regarding the above named child(ren), I will be financially responsible for this family account.

(Parent/Legal Guardian)	(Date)	(Parent/Legal Guardian)	(Date)

Please INITIAL if applicable:

________ I hereby authorize my child (ages 16 and above) to receive dental treatment (e.g. dental checkup, emergency visits, x-rays, cleaning, fluoride) without an authorized person accompanying him/her.

Tender Care Pediatric Dentistry, LLC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (04/14/2003), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revote it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $1.05 for each page, $18 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Office Manager
6583 Rt 819 South - Suite 1
Mt Pleasant, PA. 15666

Phone: 1(724) 542-4818
Fax: 1(724) 542-4828

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

you may refuse to sign this acknowledgement

I, ____ , have received a copy of this office's Notice of Privacy Practices.

____
Please Print Patient Name

____
Signature

____
Date

PLEASE SIGN & RETURN

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 acknowledgement
- ☐ Other (please specify)

____

____

____

____

TENDERCARE PEDIATRIC DENTISTRY LLC
6583 Rt 819 South - Suite 1
Mt Pleasant, PA. 15666
(724) 542-4818

PRACTICE TERMINOLOGY

Dear Parents:
In order to improve the chances of your child having a positive experience in our office, we are selective in our use of words. We try to avoid words that scare the child due to previous experiences. Please support us by NOT USING negative words that are often used for dental care. These include:

DON'T USE	OUR EQUIVALENT
Air/Water Syringe	Mr. Squirt
Needle or Shot	Sleepy Juice
Drill	Mr. Whistle
Drill on tooth	Clean tooth
Pull or yank tooth	Wiggle a tooth out
Decay, cavity	Cavity bug
Examination	Count teeth
Tooth Cleaning	Tickle teeth
Explorer	Toothpick
Rubber Dam	Raincoat
Gas	Magic air
Suction	Mr. Thirsty

This will also help you understand you child's description of the filling experience. Our intention is not to "fool" the child - it is to create an experience that is positive. We appreciate your cooperation in helping us build a good attitude for your child!