Spartanburg Pediatric Dentistry

Welcome to Spartanburg Pediatric Dentistry!! We want to thank you for trusting us with your child's dental needs! The information you are providing is an important aid in making a thorough evaluation of your child's dental health. It also allows for us to plan and meet your child's emotional needs for all future visits. Therefore, this important document becomes an integral part of our continuing evaluation of your child's growth and development in these formative years. Thank you in advance for your cooperation.

Patient and Insurance Information

Patient's name:_____ Preferred name:_____

Date of Birth:_____ Age:____Male___Female___SS#_____-_____-_____

Address:_____City/State/Zipcode:_____

Home Phone:(____)____-_____ Cell Phone:(____)____-_____ Work Phone:(____)____-_____
Email:_____(only if you check email daily and wish to receive statements and appointment reminders)

Preferred method of contact: Home___ Cell___Work___Email____

Race/Ethnicity:Caucasian___ African American___Asian___Indian___Hispanic____Other:_____

Patient's primary physician:_____ Phone #:(___)_____-_____

Who is accompanying patient today?

Name:_____ DOB:_____
Relationship to patient:_____
Do you have legal custody of patient: Yes_____ No_____

If the legal guardian can't make it to a future visit, it is your responsibility to inform us and give verbal permission via phone. Please list the person(s) you give consent to treat below. This allows the person listed permission to make decisions regarding the treatment.
Name:_____ Relationship:_____
Name:_____ Relationship:_____
Name:_____ Relationship:_____

How did you hear about our office?

Referred by: Drive by___ SPD Website__
Family/Friend? Name:_____ Facebook__ Google__
General dentist? Name:_____
Pediatrician? Name:_____

Primary Dental Insurance

Subscriber's name:_____ Date of Birth:_____
Insurance company:_____ SS#_____-_____-_____
Employer:_____ Group#_____

Medicaid

Subscriber ID#:_____Medicaid Plan:_____

Dental and Health History

Dental History:

Is this your child's first visit to the dentist? Yes____ No____
If no, please list the date of last visit. _____
Were any x-rays taken at previous visit? Yes____ No____
Previous Office/Dentist's name: _____
Has your child had an exam, cleaning, and/or sealants done at school in the last 6 months? Yes__ No__

Does the patient have any of the following habits:

Lip sucking/biting? Yes_____ No_____ Nail biting? Yes_____ No_____
Nursing? Yes_____ No_____ Drinking from a bottle? Yes_____ No_____
Using a pacifier? Yes_____ No_____ Thumb/Finger sucking? Yes_____ No_____
Any habit that may be affecting the teeth that you feel we need to know?_____

Does the child drink or use water from the following:

Tap or City water? Yes_____ No_____ Well water? Yes____ No____ Bottled water? Yes____ No____

Is the patient currently taking a fluoride supplement? Yes ____ No____

Is the patient currently or previously experienced pain or tenderness in his/her jaw/joint? Yes____
No____

Does the patient grind his/her teeth? Yes____ No____

Does the patient brush and floss daily? Yes____ No____ Do you help with brushing/floss? Yes___ No___

Health History:

Does the patient have any of the following? Please check as it applies:

Allergies? Yes___ No___ Allergy to Latex? Yes___ No___
Drug Allergy? Yes___ No___ Abnormal bleeding? Yes___ No___
Blood disorder? Yes___ No___ Anemia? Yes___ No___
Hearing impairment? Yes___ No___ ADD/ADHD? Yes___ No___
Emotional disorder? Yes___ No___ Autism? Yes___ No___
Learning disability? Yes___ No___ Eating disorder? Yes___ No___
Asthma? Yes___ No___ Liver disorder? Yes____No___
Cancer? Yes___ No___ Convulsion/Epilepsy? Yes___ No___ Last seizure?_____
Heart disorder/murmur? Yes____ No___ (Does patient need to be Premedicated? Yes___ No___)

Has the patient ever had a serious/difficult problem associated with previous dental work? Yes___ No___

Please discuss any serious medical conditions/surgeries the patient has/had:

_____.

Please list any allergies that your child has:

_____.

Please list all current medications that the patient is taking:

_____.

I understand that the information I have given is correct to the best of knowledge, 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 the dental staff to perform the necessary dental services my child may need.

_____ _____
SIGNATURE OF PARENT/GUARDIAN **DATE**

SPARTANBURG PEDIATRIC DENTISTRY OFFICE POLICY

Missed appointments

We take our patient's dental needs very serious and set aside a specific time for you and your family that will insure that your dental needs are met. To insure our office runs efficiently, we require a 24 hour notice to any changes you may need. We allow **ONE** missed appointment without penalty. After the **SECOND** missed appointment, your scheduling privileges will be **revoked**! In order to regain these privileges you may pay $100 or you can transfer your records to another provider of your choice.

Sedation in Office

A facility fee of $100 is **required** to be placed on our schedule for a sedation appointment. Your appointment day and/or time for a sedation will be based on a "first come, first serve" basis. If you don't pay the fee, you do **not** have a sedation appointment. This fee is **non-refundable**. If a sedation appointment is missed or failed to comply with sedation instructions, you will be charged another facility fee $100 to get another sedation scheduled.

Hospital Sedation

No facility fee is required for scheduling a hospital sedation. **We reserve the right to dismiss you from Spartanburg Pediatric Dentistry if you do not show up or you do not give the office 48 hours notice.** It is your responsibility to inform us **AND** the hospital of any cancellations.

SPARTANBURG PEDIATRIC DENTISTRY FINANCIAL POLICY

Dental insurance

We are not an "In-network" provider for any insurance company. We do accept all insurances. Most plans only cover a portion of the dental fee. Some or all of the services provided may be a non-covered service not considered for payment based on your insurance plan. As a courtesy to our patients, we will file your insurance based on the information you provide. For more specific details concerning your insurance policy, please contact your insurance company as it is your responsibility. **Please note:** Any deductibles/copayments are strictly an "**ESTIMATE"** and there may be a balance remaining after your insurance pays. Payment of your "**ESTIMATED"** portion is **required at the time of service.**

Self pay - (No insurance coverage)

All fees must be paid at the time of service. To show appreciation for you choosing us as your provider, we offer a 10% discount if you pay by cash/check or a 5% discount if you pay by credit/debit card. _

Medicaid

We accept South Carolina Medicaid ONLY. It is your responsibility to provide us with the most current Medicaid card. If your child is ineligible at the time of service, you can reschedule until you get them eligible or you can pay at the time of service for the FULL amount charged. ***ALL services are not covered by Medicaid.***

*We are a **ZERO TOLERANCE** office. We have the right to dismiss you from the practice for being belligerent or cursing at the staff. *

By signing my name below, I certify that I have read the above information. I understand and agree with the above policies and any questions concerning these policies have been discussed.

Signature:_____ Date:_____

Acknowledgement of receipt of privacy practices notice

Spartanburg Pediatric Dentistry
1575 Skylyn Drive
Spartanburg, SC 29307

Section A: Patient Info

Name:_____ SS#:____-____-____

Address:_____ City/SC/Zip:_____

Telephone:(___)____-_____

Email: _____

Section B: Acknowledgement of Receipt of Privacy Practices Notice

I, _____, acknowledge that I have received a Notice of Privacy Practices from the above-named practice.

Signature:_____ Date:_____

*If a personal representative signs this authorization on behalf of the patient, complete the following:

Personal representative's name:_____ Date:_____
Relationship to patient:_____

Spartanburg Pediatric Dentistry Photo Release Authorization

Spartanburg Pediatric Dentistry requests the permission from a parent/legal guardian to display a photo of the following patient(s) for our company Facebook page and/or website. To decline, all you have to do is leave this section blank.*We are aware that foster children are not allowed to have photographs placed on social media.*
***If you do not give permission, a photograph will still be taken to be placed in the patient's chart and will be used for office purposes ONLY.**

Patient's name:_____

I, _____, am the parent/legal guardian of the individual named above, and have read this release and approve the patient's photo to be displayed on Facebook.

Signature: _____ Date: _____
Print name:_____

CONSENT FOR TREATMENT

I, _____, parent/guardian of _____, authorize Spartanburg Pediatric Dentistry to perform the following procedure(s) if needed. **This consent is for procedures needed day of service or for future appointments**. Anything more than a cleaning will always be discussed with you before performed.

Dental examination	___yes	___no
X-rays	___yes	___no
Fluoride treatment	___yes	___no
Prophylaxis(cleaning)	___yes	___no
Fillings	___yes	___no
Crowns	___yes	___no
Extractions	___yes	___no
Use of Nitrous Oxide	___yes	___no

(used to prevent gagging, anxiety, and pain)

I understand the risks inherent in the treatment(s). Spartanburg Pediatric Dentistry has addressed all questions and concerns I have presented. I understand the expected results of the procedure(s) or course(s) of treatment. I understand the procedures are done in the best interest of my child. I am aware of my right to waive treatment of any kind and I am aware of the possible consequences of non-treatment. _____

I have disclosed my child's current health and history information, including allergies, reactions to medicine, diseases, and past procedures. I understand that withholding this information may affect the outcome of the procedure(s) or course(s) of treatment, and Spartanburg Pediatric Dentistry and assistants can not be held liable. _____

I authorize Spartanburg Pediatric Dentistry and any other qualified assistants to perform the procedure(s) or treatment(s) listed above. I authorize any necessary life saving procedures to be performed in the event of an emergency during the procedure(s) of course(s) of treatment. _____

I am also aware I am financially responsible for any treatment rendered at the time of service. I understand that the treatment plan may change and may be more or less than the estimated responsibility. Insurance coverage is only an estimate and not a guarantee of payment. Guarantor is responsible for all treatment non covered by insurance. _____

X_____ **X**_____

Parent/Guardian /Date Office Personal /Date