



Dr. Jane Bennett, DDS • Pediatric Dentist

545 Fortune Drive • Suite 400 • Papillion, NE 68046

Phone: 402-502-1256 • Fax: 402-504-3322

email: drjane@janebennettdds.com

Patient Information, Office and Privacy Policies, Medical/Dental History Questionnaire, and Consent Forms

To provide the safest and most comprehensive dental care for your child, we ask for your cooperation in completing our detailed questionnaire.

Date: _____ Child's Name: _____

Nickname/Preferred Name : _____ Birth date: Mo: _____ Day: _____ Year: _____
Last First MI

Age: _____ SSN: _____ Gender (M/F): _____ Home Phone: _____

Address: _____ Apt No.: _____

City: _____ State: _____ Zip: _____ Primary Language Spoken: _____

Child Primarily Lives With: _____

Is your child presently under the care of a physician for any reason? Yes No

Explain: _____

Physician's Name: _____ Date of last exam: _____

Physician's Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____

Is your child taking any medications? Yes No

List: _____

Has your child ever been hospitalized, sedated, or had surgery? Yes No

Explain: _____

Does your child have any allergies to medicines, latex, foods, or metals? Yes No

List: _____

Are antibiotics necessary for dental work because of a heart murmur, defect, prosthesis, shunt, organ transplant or other medical reasons? Yes No

Explain: _____

Has any member of the family, including your child, had a problem with sedation or general anesthesia?

Yes No

Explain: _____

Are your child's immunizations up to date? Yes No

Medical History

If your child has or ever had any of the following conditions please check yes below.
Please explain any yes's to the Doctor.

- Yes No ADD/ADHD—Attention Deficit Disorder/
Attention Hyperactivity Disorder
- Yes No AIDS/HIV
- Yes No Asthma
- Yes No Autism
- Yes No Behavioral Problems
- Yes No Birth defects
- Yes No Bleeding gums
- Yes No Blood Transfusions
- Yes No Bone or Joint Problems
- Yes No Brain Injury
- Yes No Cerebral Palsy
- Yes No Cancer/Tumor
- Yes No Chemical Dependency
- Yes No Chemotherapy/Radiation
- Yes No Chicken Pox
- Yes No Child Abuse
- Yes No Cleft Palate/Lip
- Yes No Cold Sore/Canker Sores
- Yes No Developmentally Delayed Age level is ___
- Yes No Earaches/Ear Infections
- Yes No Epilepsy/Seizure Disorder
- Yes No Eye Conditions
- Yes No Females: Are you Pregnant?
- Yes No Females: Are you taking Birth Control medica-
tion?

- Yes No Hearing Impairment
- Yes No Heart Disease
- Yes No Heart Murmur
- Yes No Hemophilia
- Yes No Hepatitis/Liver Disease
- Yes No High Blood Pressure
- Yes No Injury to Front Teeth
- Yes No Kidney Disease
- Yes No Mentally Handicapped
- Yes No Metallic Implant, Shunts, Pins/Rods
- Yes No Premature Birth
- Yes No Prolonged bleeding When Cut
- Yes No Psychiatric Care
- Yes No Rheumatic Fever
- Yes No Sickle Cell Disease
- Yes No Sore Throats
- Yes No Speech Impairment
- Yes No Thyroid Disease
- Yes No Tonsillitis
- Yes No Transplants, Organ Specify

- Yes No Tuberculosis
- Yes No Other Please Specify

Is there any other health information that should be known? Yes No

Explain: _____

Staff Medical History Review (for internal use only)

Signed: _____	Date: _____	Signed: _____	Date: _____
Signed: _____	Date: _____	Signed: _____	Date: _____
Signed: _____	Date: _____	Signed: _____	Date: _____
Signed: _____	Date: _____	Signed: _____	Date: _____
Signed: _____	Date: _____	Signed: _____	Date: _____

Dental History

Is this your child's first dental visit? Yes No

Previous Dentist: _____ Date of Last Visit: _____

Date of Last X-rays: _____

Has your child experienced any unfavorable reaction from previous dental or medical care? Yes No

Explain: _____

How often does your child brush? _____

Is tooth brushing supervised? Yes No

Is dental floss used? Yes No

Does your child receive (check all that apply):

Fluoride in vitamins Bottled water Fluoridated water Fluoride tablets/drops Well water

Has there been any injuries to your child's teeth or jaws? Yes No

Explain : _____

History of (check all that apply):

Breast feeding Thumb sucking Bottle habits Pacifier Sippy cup Teeth grinding/clinching

How do you think your child will act toward the dentist?

Explain: _____

Has your child had recent dental pain? Yes No

Explain: _____

Does your child have a specific dental problem that needs attention? Yes No

Explain: _____

How Did You Hear About Us?

Family Friend Doctor Other: _____

Referrer's Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Primary Responsible Party Information

Resident Parent's Name: _____
Last First MI Gender (M/F): _____

Marital Status: _____ SS#: _____ Birth Date: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Email: _____ Cell Phone: _____

Home Phone: _____ Work Phone: _____ Ext: _____

Secondary Responsible Party Information

Secondary Name: _____
Last First MI Gender (M/F): _____

Marital Status: _____ SS#: _____ Birth Date: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Email: _____ Cell Phone: _____

Home Phone: _____ Work Phone: _____ Ext: _____

Primary Dental Insurance

Insured's Name: _____
Last First MI

Insurance Company Group Plan: _____

Employer: _____

Insurance Company Address: _____

City: _____ State: _____ Zip: Code: _____

Insurance Company's Phone #: _____

Group #: _____ Local Group #: _____

Secondary Dental Insurance

Insured's Name: _____
Last First MI

Insurance Company Group Plan: _____

Employer: _____

Insurance Company Address: _____

City: _____ State: _____ Zip: Code: _____

Insurance Company's Phone #: _____

Group #: _____ Local Group #: _____

Emergency Contact Information

Name: _____

Relationship to child: _____

Address: _____

City: _____ State: _____ Zip: Code: _____

Phone: _____ Cell Phone: _____ Work Phone: _____

Treatment Consent

The permission of a parent or legal guardian is necessary for dental treatment of a minor. As a minor child, it is necessary that signed permission be obtained from a parent or legal guardian before any dental care can begin. As a parent or legal guardian of the above patient, I acknowledge that the above information is correct and grant Papillion Pediatric Dentistry permission to provide my child's dental and related medical/surgical treatment as deemed necessary, including digital radiographs (x-rays), diagnostic, restorative, oral surgery, and patient management techniques that are reasonable, necessary and advisable. Protective restraints are used when a child might harm themselves or when certain procedures may jeopardize their health and welfare without such restraints. I also authorize the administration of anesthetics or analgesics that are advisable by Dr. Bennett, such as nitrous oxide (laughing gas).

Potential Postoperative soft tissue injury. Self-induced soft tissue injury caused by lip- and cheek-biting is an unfortunate complication of local anesthetic used in the mouth and is usually self-limiting and heals without complications, although bleeding may result. The frequency of self-induced soft tissue injury is higher when only 1 side is anesthetized. To help avoid the possibility of soft tissue injury, patients and their parents or caregivers need to be especially watchful and not allow the patient to bite, suck, or scratch on their lip, cheek, or tongue, and do not allow them to eat food while the anesthesia persists (still numb). If an injury does occur, it is best to cleanse the mouth with either OTC (over the counter) peroxyol rinse, or warm salt water. If not allergic, Tylenol or Motrin, in age appropriate doses, can be used to alleviate pain while the area is healing.

I have given an accurate report of this patient's physical and mental health history. I have also reported any prior allergic or unusual reactions to medications, latex, foods, or metals, and any other disease or condition, including pregnancy.

I agree to inform Dr. Bennett and the staff of Papillion Pediatric Dentistry of any changes in the medical history. This authorization is valid until revoked by me in writing.

Signature

Relationship to Child

Date

Financial Consent

The Financial responsibility of a parent or legal guardian is necessary for dental treatment of a minor.

I accept financial responsibility for this child.

I authorize the release of any dental information necessary to process this claim and all future claims.

I authorize insurance payments directly to Dr. Jane Bennett/Papillion Pediatric Dentistry.

I will be responsible for reporting any changes in my child's dental insurance coverage,

I will be responsible for any late fees due on my account.

I agree to inform Dr. Bennett and the staff of Papillion Pediatric Dentistry of any changes in the Financial arrangements prior to treatment. This authorization is valid until revoked by me in writing.

Signature

Relationship to Child

Date

Office Policies

No-show Policy

Missed appointments without 24 hour prior notification are considered 'NO SHOW' appointments and will result in a \$55.00 fee. This fee must be paid before being scheduled again.

Missed Appointments

After **THREE** 'No Show' appointments (missed appointments without 24 hour prior notification) you will be dismissed from our practice.

Late Arrivals

Late arrival for a scheduled appointment leads to inadequate time to accommodate the remaining patients on the schedule. As such, late arrivals of greater than 10 minutes may not be seen depending on the time available. In addition, those patients who are on the schedule and here at the assigned time will be seen first. We will try to accommodate late appointments if time permits.

Payment Policies

For patients without insurance, payment in full is expected for services rendered on that day of service. Major credit cards , checks, and cash are accepted.

For those patients with dental insurance, the office will send claims to the insurance carrier, provided that the insurance card is presented to the office at the time of the visit. Dental insurance may not cover all of the costs of your child's dental care. **Most plans include coinsurance provisions, a deductible, and certain other expenses which must be paid by the responsible party at the time of services.**

Any portion of services not covered by dental insurance along with your deductible is due on the day services are rendered. Based on the information from your insurance, we give you an **estimate of** the total cost to you, however if there is a balance due after insurance pays, it will become your responsibility, and is due within 30 days.

Payment plans are available through the Citi Health card program. Please ask for details.

By my signature, I acknowledge and understand the office policies at Papillion Pediatric Dentistry.

Signature

Relationship to child

Date