Peter LF Cao, DMD, FRCDC, Oak Harbor Pediatric Dentistry

Child's Name_____ Preferred Name_____ DOB_____M/F___

email_____

Father's Name_____ Social Security No._____

Mother's Name_____ Social Security No._____

Home Address _____

Home Phone_____Cell Phone_____ School_____ Grade_____

Emergency Contact

Name_____ Relationship_____Phone_____

Name and Ages of other children in the family

Name_____ DOB_____ Seen at this office? _____

Name_____DOB_____Seen at this office? _____

Name _____ DOB_____ Seen at this office? _____

Father's Occupation_____ Work Phone_____ Military? _____Rank_____

Name of Employer_____ City_____

Mother's Occupation_____Work Phone_____Militayr? ____ Rank_____

Name of Employer_____ City_____

Person Responsible for this account: Name_____

Address (Street/city/state/zip)_____

Does child live with person responsible for account ☐ Yes ☐ No Is child a foster child/ adopted ☐ Yes ☐ No

Primary Dental Insurance Carrier

Insurance Company_____ Addresss_____

Employee covered under this plan_____Social Security/ID #_____

Birthdate_____Group No._____ Union or Local No._____

Relationship to child_____Effective date_____

Secondary Dental Insurance Carrier

Insurance Company_____Address_____

Employee covered under this plan_____Social Security/ID #_____

Birthdate_____Group No._____Union or Local #_____

Relationship to child_____ Effective date_____

Who may we thank for referring to our office?

Oak Harbor Pediatric Dentistry may contact me via phone, text and /or email as needed to ensure accurate patient scheduling a nd information as available for their dental appointments and/ or dental health needs.

I authorize routine dental diagnostic procedures for my child. If I accept the proposed treatment plan for additional treatment , I also agree to the use of anesthetics and pre medications considered necessary or advisable by the dentist for the comfort and wellbeing of the child.

I understand that it is my responsibility to inform the office of any changes to my insurance. I also understand that I am in contract with the insurance and it is my responsibility to verify eligibility with this office before the a ppointments. Finally, I accept full financial responsibility for my child's account regardless of my ability to be reimbursed by insurance, ex-spouse or any other third party.

Parent or Legal Guardian_____ Date_____

Peter LF Cao, DMD, FRCDC, Oak Harbor Pediatric Dentistry

DENTAL HISTORY

Child's Name_____ Date of last Dental visit_____

previous office name/ address _____

Reason for visit_____

Has child complained of tooth pain? ☐ Yes ☐ No

Any unhappy dental experiences? ☐ Yes ☐ No

Please explain_____

Any injuries to mouth/teeth/head? ☐ Yes ☐ NO

Please explain_____

Any mouth habits? (thumbsucking, nailbiting, bottlehabits, etc) ☐ Yes ☐ NO

Orthodontic appliance? _____

Do you assist your child with brushing? _____

Child's attitude toward dentistry_____

Any unusual speech habits? ☐ Yes ☐ No

Please explain _____

HEALTH HISTORY

Childs Physician _____Phone_____

Address_____Date of last physician exam_____

May we contact your physician? _____

Has the child had any history of, or conditions related to, any of the following:

- ❑ Anemia
- ❑ Arthritis
- ❑ Asthma
- ❑ Autism
- ❑ ADHD
- ❑ Bleeding disorders
- ❑ Tobacco/Drug Use
- ❑ Complications from Immunizations
- ❑ Taking oral contraceptives
- ❑ Cancer
- ❑ Cerebral Palsy
- ❑ Chicken Pox
- ❑ Chronic Sinusitis
- ❑ Bladder Control
- ❑ Diabetes
- ❑ Ear Aches
- ❑ Epilepsy
- ❑ Fainting
- ❑ Growth Problems
- ❑ Rheumatic fever
- ❑ Tuberculosis
- ❑ Chronic cough
- ❑ Stomach Ulcer or intestinal problems
- ❑ Impaired hearing/vision
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ HIV +/AIDS
- ❑ Mononucleosis
- ❑ Seizures
- ❑ Kidney Failure
- ❑ Jaundice
- ❑ Latex allergy
- ❑ Liver Disease
- ❑ Measles
- ❑ Sickle cell
- ❑ Thyroid
- ❑ Rash/ Hives
- ❑ Pregnancy (teens)
- ❑ Venereal Disease (STD)

* Please list any additional medical concerns and/or allergies and **any medications your child is taking now:**

_____

_____

_____

_____

_____

I certify that all information I have provided is current and up to date to the best of my knowledge.

Parent or Legal Guardian_____ Date_____

Peter LF Cao, DMD, FRCDC, Oak Harbor Pediatric Dentistry

Financial Agreement

Our goal at Oak Harbor Pediatric Dentistry is to help your make the best decisions concerning your child's dental health and to provide quality dental care. At your child's visit we will discuss proposed treatment, cost involved and any alternative treatments. Estimates given at the appointment are valid for 90 days and are only ESTIMATES of what your insurance coverage will be. Treatment may change during the appointment to provide the best possible care for your child, at which time you will be notified of your change in financial liability.

We CANNOT guarantee the amount the insurance company will pay. We do our best to provide you with the most accurate information but it is your responsibility to notify us of any changes that have occurred. If there is a dispute with your insurance company, we will assist you in resolving the problems, but the responsibility for resolving the problem remains with you, the subscriber. During this time we do expect payment of your account.

Payment for the estimated amount not covered by the insurance is due on the day of treatment. We accept cash, check, Visa, Master card, or Discover Card. Please advise us of your payment concerns prior to your child's appointment. Once the insurance company has processed your claims, we will advise you of any differences and will refund any over payment or send you a statement for any remaining balance due. Please be aware any balance that is unpaid is subject to interest charge and if payment is not received within 90 days, the account will be subject to collections. There is also a $40 charge for any checks returned for insufficient funds.

MISSED APPOINTMENTS

It is important for you to keep your scheduled appointments for the health of your child. We do understand that situations occur that prevent you from coming in, however we ask that you give us a 24 hour notice of changing appointment. **If there is repeated missed or late cancelled appointments the patient will be subject to dismissal from the practice.**. If notice is not given 24 hours before, accounts with private insurance will be subject to a:

- **$25 fee for a missed/ late cancelled hygiene appointment**
- **$50 fee for a missed/ late cancelled restorative appointment(including sealants)**
- **$125 fee for a missed anesthesiologist appointment**

*charges are per family member
* Illness and emergencies do not incur a fee

Parent or Legal guardian_____ Date_____

Peter LF Cao, DMD, FRCDC, Oak Harbor Pediatric Dentistry

Silent Observer Agreement

Here at Oak Harbor Pediatric Dentistry we happily welcome **one** parent/guardian to accompany their child in the clinic during treatment. In order for us to continue offering this as an option we require all parents read and sign this agreement stating that the below guidelines will be followed at every visit.

Due to limited seating, please decide prior to appointment(s) which **one** parent/guardian will be present in the clinic during treatment. Too many people in the clinic can be overwhelming for some patients, staff and doctors.

Due to HIPPA guidelines, we ask that no pictures or video recordings are taken during treatment. Additionally, we require all children who aren't being seen for an appointment today have *constant supervision* in the reception area. No children under the age of 13 are to be left unattended. Please note: children 13 and under may not be responsible for younger children in the reception area; we require that a parent be present to care for younger children at all times.

If you choose to accompany your child you will not be permitted to walk freely around the clinic and office. We ask that you remain seated throughout the duration of the appointment. We also ask that for the safety of your child, you do not stand over the doctor or assistants during treatment.

Our staff devotes treatment time to your child. We understand that parents can offer emotional support during procedures but we ask that you be a silent observer. This ensures that we can focus on your child and offer quality care without distractions. We ask that you respect other patient privacy and anything overheard or observed in this office remain private. Some of the material or conversations may be sensitive to other individuals so we ask that you do not share private personal information. **Thank you for trusting us with your child's dental care needs. We look forward to a great visit!**

I undertand that by signing this document I have read the above guidelines, asked any questions for clarification if needed and hereby sign below and consent to be a "silent observer" in this office.

Dependent name(s):_____

Parent/Guardian Signature:_____ Date:_____