MEDICAL INFORMATION
Upper Valley Pediatric Dentistry

Child's Name:____

Parent/Legal Guardian Name: __________________________________

Mailing Address:____

Parent's Phone:(H)________________(C)________________ Email: ________________

Child's Pediatrician:________________________ Date of Last Physical:____________

Is your child in good health? □ Yes □ No

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

Has your child ever been hospitalized? □ Yes □ No

If yes, please explain:____________________________________

Has your child ever had surgery? □ Yes □ No

If yes, please explain:____________________________________

Prior to receiving dental treatment, does your child require antibiotic pre-medication? □ Yes □ No

Is your child being treated for any condition presently? □ Yes □ No

If yes, please explain:____________________________________

Is your child taking any over the counter or prescription medications? □ Yes □ No

If yes, please list: ____________________________________

____

Does your child have any allergies or had any reaction to any medications? □ Yes □ No

If yes, please explain:____________________________________

Does your child have allergies to pollen, nuts, food dyes, dust, gluten, metal, or other? □ Yes □ No

If yes, please specify allergy and explain reaction:________________________

____

Has your child ever been diagnosed as having any of the following conditions? Please check yes or no:

Yes	No		Yes	No		Yes	No	
□	□	ADD/ADHD	□	□	Congenital Heart Disease	□	□	Mental Disability
□	□	AIDS or HIV	□	□	Convulsions/seizures	□	□	Nutritional Deficiency
□	□	Anemia	□	□	Diabetes	□	□	Oral Ulcers
□	□	Asthma	□	□	Drug/alcohol abuse	□	□	Orthopedic problems
□	□	Autism	□	□	Emotional disturbance	□	□	PDD
□	□	Bladder conditions	□	□	Epilepsy	□	□	Premature birth
□	□	Bleeding problems/transfusions	□	□	Excessive gagging	□	□	Psychiatric disorder
□	□	Birth defects	□	□	Fainting/dizziness	□	□	Rheumatic fever
□	□	Bone or joint problems	□	□	Gastrointestinal problems	□	□	Sensory Issues
□	□	Brain/spinal injury	□	□	Growth + development problems	□	□	Sickle cell anemia
□	□	Bruising problems	□	□	Hearing loss/deaf	□	□	Speech disorder
□	□	Cancer or malignancies	□	□	Heart murmur	□	□	Steroid therapy
□	□	Cerebral palsy	□	□	Hepatitis	□	□	Thyroid problems
□	□	Child abuse	□	□	Kidney disease	□	□	Tuberculosis
□	□	Chronic tonsil/adenoid infection	□	□	Learning disabilities	□	□	Vision problems
□	□	Chronic ear infections	□	□	Leukemia	□	□	Other:________
□	□	Cleft lip/palate	□	□	Liver disease			

Please describe any current medical treatment including drugs, pending surgery, recent injuries or other information we should be aware of that has not been covered:________________________

____

DENTAL INFORMATION

Is/was your child bottle fed? □ Yes □ No
Is/was your child breast fed? □ Yes □ No

Does your child brush daily? □ Yes □ No Does an adult assist with brushing? □ Yes □ No
What kind of toothpaste do you use for your child? ______________________

Does your child floss daily? □ Yes □ No Does an adult assist with flossing? □ Yes □ No

Does your child have any of the following habits?
□ finger sucking □ thumb sucking
□ tongue thrusting □ nail biting □ pacifier □ teeth grinding □ mouth breathing
□ lip licking □ sippy cup

Does your child receive any fluoride supplements? □ Yes □ No
If yes, in what form? □ drops □ vitamins/tablets

Has your child ever had any injuries to the teeth, mouth, head or jaws? □ Yes □ No
If yes, please explain: ______________________

Has your child ever had a negative dental experience? □ Yes □ No
If yes, please explain: ______________________

If there is anything additional that you would like us to know about your child (favorite shows, favorite colors, anything that hasn't been mentioned that you feel is important), please list below: ______________________

How did you hear about us?

____

AUTHORIZATION

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform Upper Valley Pediatric Dentistry of any changes in my child's medical status.

Signature of Parent or Guardian: ______________________ Date: ______________

Appointment Policy

Upper Valley Pediatric Dentistry is dedicated to your child's quality care and is pleased to offer appointment time dedicated to them. We also do our best to schedule appointments that are most convenient for your family. Because we reserve time exclusively for each child, we ask that you make every effort to not change your child's dental appointment. If you find that you cannot keep the scheduled appointment, we require a **minimum notice of 48 BUSINESS HOURS**. This allows us to offer the time to other patients in need of treatment. To notify us of any change, please contact our office during business hours. We understand that there are unforeseen circumstances that can cause reserved appointments to be missed without proper notice. In these instances, we ask that you contact us as soon as possible.

In order to maintain the most efficient schedule, our Appointment Policy is as follows:

• As a courtesy, our office tries to confirm appointments one week before the scheduled date and time by phone call, text, and email. If we do not hear from you, we will contact you again, **48 BUSINESS HOURS** before the reserved time. If you do not confirm by **5:00pm that day**, your child's appointment will be cancelled and given to the next patient in need of treatment. It is your responsibility to notify us of any changes to your family's contact information.

• Late arrivals cause schedule delays for those patients who arrive promptly for their appointment time. Late arrivals will be worked into the schedule if time allows or re-appointed to another day.

• Patients who do not show up for their appointment or reschedule without the required 48 hours' notice, will be charged a **$50 fee per missed/rescheduled appointment or may face possible dismissal from the practice.**

Thank you for understanding and respecting our policy.

Signature: ______________________________ Date: ________________

Upper Valley Pediatric Dentistry
30 Airport Rd, Suite 7
West Lebanon, NH 03784
Phone: (603) 790-8130
Fax: (603) 790-8416

Financial Policy

Thank you for choosing Upper Valley Pediatric Dentistry to care for your child's dental needs. Please read the financial policy below and sign before treatment is rendered.

Patients under the age of 18 years old must be accompanied by a parent or legal guardian for their first visit and any additional visits requiring treatment consent and to sign the child's medical history. The person who accompanies the child to the office, whether is it the parent, legal guardian, or person that has been given permission on the consent form to bring the child, is responsible for payment of the fee due at appointment.

Full payment is due at the time of service. We accept cash, credit cards, and checks. We also work with Care Credit, a patient financial plan, and would be happy to discuss this with you.

We are Northeast Delta Dental, New Hampshire Medicaid, and Vermont Medicaid providers. As a courtesy, we do submit to other insurance plans for you, but we cannot guarantee their fees or estimate what they will reimburse to you. If you carry any other insurance than the ones listed above, you will be required to pay the full amount of the visit at the time of service and your insurance company will directly reimburse you based on your agreement with them. Regardless of your coverage, you are responsible to pay any amount that is unpaid by your insurance.

An interest rate of 1.5% per month will be charged on balances unpaid after 30 days.

Our office **requires 48 hours business days notice** for cancellation or change of any appointments. Any cancelled or missed appointment without appropriate notice will incur a $50 fee, which must be paid at the next scheduled appointment.

Please let us know if you have any questions regarding the policy above.

I have read the Financial Policy above for Upper Valley Pediatric Dentistry. I understand and agree to this policy.

_________________________________ Signature

_____________________ Date

Upper Valley Pediatric Dentistry, PC
PATIENT CONSENT (MINOR)

1. As the parent /legal guardian of __________________ ("Patient"), I authorize Upper Valley Pediatric Dentistry, PC to perform all recommended treatment on the Patient.

2. I authorize the Practice to take radiographs, study models, photos, and other diagnostic aids or materials (collectively, "Diagnostic Material") as needed to make a thorough diagnosis. I authorize that such Diagnostic Material may be released to third-party payers and/or other health professionals.

3. I authorize the use of anesthetics, sedatives, and other medication, as needed, and am fully aware that using anesthetic agents involves certain risks, including but not limited to redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest, drowsiness and/or lack of coordination.

4. I authorize the Practice to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, any and all information, records, and radiographs about the Patient's medical history, services rendered, or recommended treatment.

5. I authorize the Practice to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company, on my behalf or on the Patient's behalf and in my name listed as "signature on file" and assign to the Practice the insurance benefits providing assignment is accepted. I am responsible for payment regardless of the coverage provided.

6. If your child is under 18 years old, he/she must be accompanied by a parent or legal guardian to his/her first dental visit and any visits requiring treatment consent or a medical history update. If you are unable to bring your child to his/her other scheduled dental visits that do not require your presence, you can give permission to other people to bring your child below with the understanding that that person will also be responsible to bring any payments that are due on the day of the visit.

7. Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians and people that may bring your child for treatment visits:

1. ____ Date Added:_________

2. ____ Date Added:_________

3. ____ Date Added:_________

4. ____ Date Added:_________

I have read this Patient Consent and agree to the terms and conditions herein.

Patient's Name: ______________________________ DOB: ______________

Signature of Patient/Guardian: ____________________ Date:______________

Relationship to Patient: ______________ Address:________________________

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

Upper Valley Pediatric Dentistry

Acknowledgement

I, ___________________________ , hereby acknowledge that I have received and reviewed a copy of Upper Valley Pediatric Dentistry's ("Dental Practice") *HIPAA Notice of Privacy Practices*.

I understand that Upper Valley Pediatric Dentistry's *HIPAA Notice of Privacy Practices* may change periodically and that I am entitled to receive a copy of Upper Valley Pediatric Dentistry's revised *HIPAA Notice of Privacy Practices* upon request.

I understand that, if I have questions about Upper Valley Pediatric Dentistry's *HIPAA Notice of Privacy Practices*, I may contact Eileen Saunders, DMD. I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that Upper Valley Pediatric Dentistry's will not refuse treatment to me if I refuse to sign this Acknowledgement.

I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding Upper Valley Pediatric Dentistry's privacy policies and procedures. For information on how to contact the U.S. Department of Health and Human Services, please ask Eileen Saunders, DMD noted above, for assistance.

____ ____

Patient Representative Signature / Date

____ ____

FOR OFFICE USE ONLY

Upper Valley Pediatric Dentistry's made a good-faith effort to obtain Acknowledgement, from the patient noted above, of receipt of its *HIPAA Notice of Privacy Practices*. In spite of these efforts, Upper Valley Pediatric Dentistry was unable to obtain a signed Acknowledgement for the following reason(s):

- ☐ Refusal to sign Acknowledgement on ______________________________, 20______.
- ☐ Communications barriers prohibited us from obtaining a signed Acknowledgement.
- ☐ An emergency situation prohibited us from obtaining a signed Acknowledgement.
- ☐ Other (Describe):____

Date Received	By	Patient ID

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

UPPER VALLEY PEDIATRIC DENTISTRY
30 AIRPORT ROAD SUITE 7
[WEST LEBANON, NH 03784]

Patient Authorization

I, ____________________, hereby authorize UPPER VALLEY PEDIATRIC DENTISTRY to release, use and/or disclose my protected health information as directed below.

Health Information

This Authorization pertains to the following types of protected health information about me:

- ☐ All dental records received or created by UPPER VALLEY PEDIATRIC DENTISTRY
- ☐ Dental report(s) ____________________
- ☐ Dental image(s) ____________________
- ☐ All dental records relating to (any injury or condition) ____________________
- ☐ Other (please describe) ____________________

Authorization Expiration

This Authorization will not expire, unless I indicate in writing otherwise.

Know Your Rights

Your decision to sign this Authorization is voluntary. UPPER VALLEY PEDIATRIC DENTISTRY will not refuse treatment to you if you refuse to sign this Authorization.

When your protected health information is released as provided by this Authorization, please be aware that the named recipient (above) may not be legally obligated (under HIPAA) to obtain an authorization for subsequent re-disclosure of your protected health information.

Representative Signature

I affirm that I am the personal representative of the patient noted above and that I have the authority to authorize the release, use or disclosure of the patient's protected health information on his/her behalf. I have read the contents of this Authorization, and I confirm that the contents are consistent with my directions. I understand that by signing this form, I am authorizing, on behalf of the patient, the release, use or disclosure the patient's protected health information.

FLIP OVER ☺

Signature	Date
Print Name	Relationship to Patient

☐ Parent ☐ Guardian ☐ Power of Attorney

Sleep, Breathing & Habit Questionnaire

Children & Adolescents

Full Name:	Age:	Date:

Please indicate if your child experiences or has experienced any of these symptoms below by using this scale to measure the severity of these symptoms.

0 - No Occurrence **1 - Occurs Rarely** **2 - Occurs 2 to 4 times per week** **3 - Occurs 5 to 7 times per week**

1. ________ Snoring
2. ________ Interrupted snoring where breathing stops
3. ________ Labored, difficult or loud breathing at night
4. ________ Gasping for air while sleeping
5. ________ Mouth breathes while sleeping
6. ________ Mouth breathes during day
7. ________ Restless sleep
8. ________ Grinds teeth while sleeping
9. ________ Talks in sleep
10. ________ Excessive sweating while sleeping
11. ________ Wakes up at night
12. ________ Wets the bed (currently)
13. ________ History of bed wetting
14. ________ Feels sleepy and/or irritable during the day
15. ________ Headaches
16. ________ Frequent throat infections
17. ________ Seasonal allergies
18. ________ Ear infections of history of ear infections
19. ________ Short attention span
20. ________ Trouble focusing
21. ________ Difficulty listening/ often interrupts
22. ________ Hyperactive
23. ________ ADD/ADHD
24. ________ Sensory Issues
25. ________ Struggles in math at school
26. ________ Struggles in reading at school
27. ________ Speech issues*
28. ________ Avoidance behavior towards food or certain types of food

***Speech Questionnaire -** to be filled out only if #27 was indicated above

Please check all that apply

________ Is it difficult to understand your child's speech?

________ Difficult to understand over the phone?

________ Nasal speech?

________ Hoarseness?

________ Other have difficulty understanding speech?

________ Gets frustrated when people can't understand speech?

________ Speech sounds abnormal?

________ Sometimes omits consonants?

________ Uses M, N, NG instead of P, V, S, Z sounds?

________ Liquids and/or solids get into nasal area when eating or drinking?