



Welcome to our practice!

Our goal is to make each of your child's visits pleasant and comfortable.
Our mission is to teach your child good oral habits which will help your child
keep their teeth healthy and smiles beautiful!

Your Child

First M.I. Last Birthdate Age Sex
Address _____ City/State _____ Zip _____
Home Phone _____ Siblings _____
Nickname _____ Pets/Hobbies _____

Father Responsible Billing Party

First Name MI Last
Address _____ City/State _____ Zip _____
 Same as Above
Home Phone _____ Cell _____
Work Phone _____
Soc. Sec. No. _____ / Birthdate _____
Email _____
Employer _____
Occupation _____

Mother Responsible Billing Party

First Name MI Last
Address _____ City/State _____ Zip _____
 Same as Above
Home Phone _____ Cell _____
Work Phone _____
Soc. Sec. No. _____ / Birthdate _____
Email _____
Employer _____
Occupation _____

Parent's Marital Status:

- Single Married Divorced
 Widowed Separated

Who is responsible for making appointments?

Name _____
Home Phone _____ Work Phone _____
Best time to call _____ Days _____
Email _____

Referred by _____

Phone Number _____

Primary Dental Insurance

Insured's Name _____
Relationship _____
Birthdate _____ Soc. Sec. No. _____
Employer _____
Insurance Co. _____
Group/Policy # _____ ID # _____
Insurance Co. address _____
Insurance Co. phone _____

Additional Insurance

Insured's Name _____
Relationship _____
Birthdate _____ Soc. Sec. No. _____
Employer _____
Insurance Co. _____
Group/Policy # _____ ID # _____
Insurance Co. address _____
Insurance Co. phone _____

Today's Date _____

New Patient Dental History

Child's Name _____ Birthdate _____

Is this your child's first visit to a dentist? **Yes** **No**

If no, who was your child's previous dentist? _____

Office phone number _____

Date of last exam _____ Date of last x-rays? _____

At what age did your child's first baby tooth come in? _____

Was your child breastfed? If yes, for how long? _____

Was your child bottle fed? If yes, for how long? _____

Does your child use a sippy cup? **Yes** **No**

Throughout the day or just with meals? _____

Does your child snack throughout the day? **Yes** **No**

If yes, what and how much? _____

Does your child drink juice or pop on a daily basis? **Yes** **No** if yes, how much? _____

Does (or did) your child have habits which might affect oral health?

- Finger or thumb habits **Yes** **No**
- Pacifier user **Yes** **No**
- Clenching or grinding teeth **Yes** **No**
- Mouth breathing **Yes** **No**

Has your child had any injury to any teeth?

If yes, when and what kind of injury? _____

How often are the child's teeth brushed/flossed? _____

Who brushes the child's teeth? _____

Is your tap water fluoridated? **Yes** **No** Does your child take fluoride supplement? **Yes** **No**

Has your child ever had a negative dental experience? If yes, please explain _____

Signature

Print name please

Relationship to child

Child Medical History - Recall Consent

Patient Name:

Birth Date:

Date Created:

Health issues and medications have a critical interaction(s) with dental treatment. Please answer the following questions about your child.

Recall Consent

I consent to digital X-Rays(taken every 12+ months) Yes No

I consent to fluoride treatment every 6 months Yes No

I prefer for my child to have fluoride once every 12 months Yes No

***Please note, we recommend fluoride for your child every six months. Dependent on your dental insurance provider, this may or may not be a covered procedure due to benefit limitations. If you have any questions, please speak to the front desk.

Health History

Does your child have, or has your child had, any of the following?

Table with 3 columns of health conditions and Yes/No radio button options. Conditions include Diabetes, Jaundice, Hepatitis A,B or C, Asthma or hay fever, Autism spectrum, etc.

**If your child has been diagnosed with a heart murmur, we require written documentation from the child's physician stating if a premedication is required or not required.

Please explain "yes" answers [checkbox] If yes [text box]

Has your child ever had any serious illness not listed above? Yes No If yes [text box]

Is your child allergic to any of the following?

Table with 3 columns of allergens and Yes/No radio button options. Allergens include Penicillin, Latex, Amoxicillin, Metals, Codeine, Local Anesthetics.

Any other allergies not listed? Yes No If yes [text box]

Does your child have a pediatrician or family physician? If yes, the doctor's name/phone number Yes No If yes [text box]

Is your child seeing a specialist(ex: cardiologist) if yes, doctor's name/phone number Yes No If yes [text box]

Did your child have health problems at birth or during infancy? Yes No If yes [text box]

Is your child currently taking any type of medications or drugs? Yes No If yes [text box]

Has your child ever had any unfavorable reactions to food, drugs, medicines or anesthesia? Yes No If yes [text box]

Is your child on a special diet?(ex: gluten free) Yes No If yes [text box]

Has your child ever been hospitalized/surgery? Yes No If yes [text box]

Do you think your child will be a cooperative patient? Yes No

If no, why?

Large empty text box for providing reasons if the answer is 'no'.

Is there any additional information you would like us to know about the patient?

Large empty text box for providing additional information.

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

Signature of Patient, Parent or Guardian:

X

Date: _____

Consent for Use and Disclosure of Health Information

(For updated guidelines effective September 2013)

Patient Name _____ Date of Birth _____

TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed on our Notice of Privacy Practice. Please understand that revocation of the Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this Consent.

I also do hereby grant permission to Baylon & Baylon PLLC, to disclose (the patient named on this Consent) personal health information to the following personal representative(s): (spouse, sibling, parent, friend, etc.)

Information to be disclosed (please check):

- Appointment dates and times
- Treatment plans and referrals
- Financial and billing information related to treatment at this office.
- None of the above

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Policy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature : _____ Date: _____

If the Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name (print) _____

Relationship to Patient: _____

Baylon Family Dentistry – Baylon Pediatric Dentistry

New Financial Policy effective 1/1/2018

Our doctors are dedicated to providing you with high quality dental care. In order to maintain that commitment we realize the need to collect billing in a timely manner. This credit policy is designed for that purpose.

1. New patients are required to pay for services in full at the time of their visit unless dental insurance is provided and verified. Dental claims for service provided will be filed by our office to insurance.
2. We do participate with many insurance companies but we do recommend that you verify with your insurance company in advance your eligibility and benefits with our clinic. Please understand that the amount of benefits to be derived under your policy is a predetermined arrangement between your employer and the insurance company; we are unable to increase benefits beyond that which your insurance agreement allows.
3. For your convenience, we are able to do a predetermination of benefits with your insurance company for diagnosed treatment. This is just an estimate as treatment sometimes changes.
4. Patients will be required to pay their portion of crowns, bridges, dentures and partials at the time they are seated or inserted.
5. We offer a 5% discount for patients without insurance who pay with cash or check at the time of service.
6. We offer a 10% discount for patients over 55 without insurance who pay with cash or check at the time of service.
7. We accept most major credit cards and offer Care Credit.
8. An interest rate of 1.5%/month or 18% annually will be charged on all unpaid accounts after 60 days. Please call our office if you have a balance over 60 days to make payment arrangements to avoid the automatic interest charges.

Office Policy

1. The office will attempt to schedule appointments at your convenience and when time is available. Children under 5 should be seen in the morning as they tend to be more cooperative at that time.
2. Please notify our office 24 hours in advance of your scheduled appointment if you are unable to keep the appointment. Not showing for 2 appointments may result in the family being dismissed from the practice.
3. Please plan to arrive 5 minutes before your scheduled appointment. This will allow for any additional paperwork if it's needed. A parent or legal guardian must be present in the office during the initial examination and/or any restoration appointments.

I hereby authorize the administration of such diagnostic and therapeutic procedures as may be necessary for the proper dental care of myself or family members. I authorize the dentist to release any information including the diagnosis and the records of treatment rendered to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist benefits otherwise payable to me. I understand that my dental carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services on behalf of myself and any dependants.

I have received and understand the above information.

Date _____

Signature (Parent or Legal Guardian)

Baylon Family Dentistry – Baylon Pediatric Dentistry

Informed Consent

I hereby authorize my treating dentist, and whomever he/she may designate as his/her assistants and/or hygienists, to perform upon me those dental procedures which we have discussed, and I have accepted in the treatment plan.

I am informed and fully understand that there are certain risks in any dental treatment. These risks include but are not limited to: post-treatment pressure and temperature sensitivity, pain or throbbing, pulpal inflammation, fracturing of new restorations due to early biting pressures, tenderness of abutment teeth, tenderness of tissues under removable dentures, post-operative pain and throbbing, swelling and infection, fracturing of files or the crown portion of the tooth during and following root canal therapy, sensitivity of the teeth and gums during and following dental cleanings.

I further consent to the administration of any drugs that may be deemed necessary in my case, including, but not limited to: local anesthetics, antibiotics, and analgesics. I understand that there is a slight risk inherent in the administration of any drug or anesthesia. This risk includes, but is not limited to, the following complications: adverse drug response (e.g. allergic reactions), cardiac arrest, thrombophlebitis (e.g. irritation and swelling of a vein), aspiration, pain, discoloration, and injury to blood vessels and nerves which may be caused by injections of any medications or drugs.

I am aware that, in spite of the possible complications and risks, my treatment is necessary and desired by me. I realize that the practice of dentistry is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the procedures.

Print name

Signature (Parent or Guardian)

Date _____