WONDERLAND
PEDIATRIC DENTISTRY

Thank you for selecting Wonderland Pediatric Dentistry! We strive to make each of your child's visits pleasant and comfortable. Please fill out this form completely in ink.

***Please share with us how you were referred: _____**

Your Child		
Child's Name:		
Nickname:	Sex:	
Birthdate:	Age:	
SS#/SIN:		
School:		
Child's Home Address:		
City:	St:	Zip:
Responsible Party		
Name:		
Relationship:		
Address:		
City:	St:	Zip:
Email:		
Phone: (Home)	(Other)	
SS#:	DOB#:	

Primary Insurance			**Secondary Insurance**		
Insured's Name:			Insured's Name:		
Relationship:			Relationship:		
Birthdate:	SSN/SIN#:		Birthdate:	SSN/SIN#:	
Employer:	DOH:		Employer:	DOH:	
Occupation:			Occupation:		
Insurance Company:			Insurance Company:		
Group #:	Subscriber ID #:		Group # :	Subscriber ID #:	
Ins Co Address:			Ins Co Address:		
City:	St:	Zip:	City:	St:	Zip:

Please Turn Over

Photo Release

I grant to Wonderland Pediatric Dentistry, its representatives and employees the right to take photographs of my child and his/her mouth. I agree that Wonderland Pediatric Dentistry may use such photographs of my child without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, Web content, and training.

( ) Yes ( ) No

_____

Patient/Parent/Agent/Guardian Signature

NAME: **AGE:**

DENTAL HISTORY (CONFIDENTIAL)

Medications and your child's overall health have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely.

Previous Dentist:		Phone:
Address:		
City:	State/Prov:	Zip/PC:
Date of last dental visit:		
Were x-rays taken?	☐ Yes Type:	☐ No
Has your child had difficulty with previous dental visits?	☐ Yes Please Explain:	No
Are you aware of any problems with your child's mouth or teeth?	☐ Yes Please Explain:	☐ No
Has your child ever pre-medicated for dental treatment?	☐ Yes Please Explain:	☐ No
Has your child injured head, mouth, or teeth?	☐ Yes Please Explain:	☐ No
Is your child's water fluoridated?	☐ Yes	☐ No
Does your child take fluoride supplements?	☐ Yes	☐ No
Does your child have a history of, or is your child currently doing any of the following?		
Pacifier	☐ Yes	☐ No
Suck Thumb/Finger	☐ Yes	☐ No
Suck/Bite Lip	☐ Yes	☐ No
Bite/Chew Nails	☐ Yes	☐ No
Chew Hard Objects (pencils, etc.)	☐ Yes	☐ No
Grind Teeth	☐ Yes	☐ No
Was your child	☐ Yes	☐ No
Bottle Fed	☐ Yes When weaned:	☐ No
Breast Fed	☐ Yes When weaned:	☐ No

MEDICAL HISTORY (CONFIDENTIAL)

Physician's Name:	Phone #:
Date of Last Visit:	
Previous Hospitalizations/ Surgeries/ Serious Illnesses:	When?

Had a Blood Transfusion	☐ Yes When:	☐ No
Are immunizations up to date	☐ Yes	☐ No
Is your child taking any Medications:	☐ Yes Which Ones:	☐ No
Is your child Allergic to any medications?	☐ Yes Which Ones:	☐No
Has your child ever developed any condition including bleeding, drug or anesthesia reaction or rash requiring special treatment after your last dental visit?	☐ Yes Please Explain:	☐No

HEALTH HISTORY (CONFIDENTIAL)

Does your child have a Blood Disorder?	☐ Yes	☐ No	If you chose yes, please check the box that applies.			
Anemia	☐ Yes		Von Willebrand	☐ Yes		
Hemophilia	☐ Yes		Sickle Cell	☐ Yes		
Excessive Bleeding	☐ Yes					

If you answered yes to any of these, please explain: _____

Does your child have a Heart Condition?	☐ Yes	☐ No	If you chose yes, please check the box that applies.			
Artificial Valve	☐ Yes		High Blood Pressure	☐ Yes		
Congenital Heart Defect	☐ Yes		Low Blood Pressure	☐ Yes		
Heart Disease	☐ Yes		Heart Attack (Myocardial Infarction)	☐ Yes		
Heart Murmur (Irregular Heart Beat)	☐ Yes		Pacemaker	☐ Yes		
Rheumatic Fever	☐ Yes		Infective Endocarditis	☐ Yes		
Angina (Chest Pains)	☐ Yes		Mitral Valve Prolapse	☐ Yes		

If you answered yes to any of these, please explain: _____

Does your child have a Respiratory Diseases/ Lung Disorder?	☐ Yes	☐ No	If you chose yes, please check the box that applies.			
Asthma	☐ Yes		Persistent Cough	☐ Yes		
Breathing Difficulty	☐ Yes		Shortness of Breath	☐ Yes		
COPD	☐ Yes		Sleep Apnea	☐ Yes		

If you answered yes to any of these, please explain: _____

Does your child have Special Needs?	☐ Yes	☐ No	If you chose yes, please check the box that applies.			
ADHD	☐ Yes		Wheelchair	☐ Yes		
Behavior Disorder	☐ Yes		Hearing Impairment	☐ Yes		
Autism	☐ Yes		Head Injury	☐ Yes		
Depression	☐ Yes		Developmental Challenges	☐ Yes		
Down Syndrome	☐ Yes		Nervous Disorders	☐ Yes		
Cerebral Palsy	☐ Yes		Psychological Disorders	☐ Yes		
Vision Impairment	☐ Yes		Bipolar Depression	☐ Yes		
Spina Bifida	☐ Yes					

If you answered yes to any of these, please explain: _____

Please Turn Over

Cont. HEALTH HISTORY (CONFIDENTIAL)

Does your child have an Infectious Disease?	☐ Yes	☐ No	If you chose yes, please check the box that applies.

HIV/AIDS	☐ Yes		STD	☐ Yes	
Hepatitis	☐ Yes		Tuberculosis	☐ Yes	
Herpes	☐ Yes				

If you answered yes to any of these, please explain: _____

Does your child have Stomach Problems?	☐ Yes	☐ No	If you chose yes, please check the box that applies.

Reflux	☐ Yes		Ulcers	☐ Yes	

If you answered yes to any of these, please explain: _____

Does your child have Ear Problems?	☐ Yes	☐ No	If you chose yes, please check the box that applies.

Ear Tubes	☐ Yes		Recurrent Ear Infections	☐ Yes	
Hearing Loss	☐ Yes				

If you answered yes to any of these, please explain: _____

Does your child have/ had Cancer?	☐ Yes	☐ No	If you chose yes, please check the box that applies.

Chemotherapy	☐ Yes		Remission	☐ Yes	How Long?
Radiation	☐ Yes		Leukemia	☐ Yes	
Tumors	☐ Yes				

If you answered yes to any of these, please explain: _____

Does your child have history of any of the conditions listed below?	☐ Yes	☐ No	If you chose yes, please check the box that applies.

Arthritis/Rheumatism	☐ Yes		Liver Disease	☐ Yes	
Cleft Palate	☐ Yes		Pregnancy	☐ Yes	What Trimester: _____
Diabetes	☐ Yes		Seizures	☐ Yes	
Dialysis	☐ Yes		Sinus Problems	☐ Yes	
Epilepsy	☐ Yes		Stroke	☐ Yes	
Dizziness/Fainting	☐ Yes		Tobacco Use	☐ Yes	
Joint Replacement	☐ Yes		Drug Use	☐ Yes	
Kidney Disease	☐ Yes		Eating Disorder	☐ Yes	
Thyroid Disorder	☐ Yes		Skin Rash	Yes	
			Artificial Joint	☐ Yes	

If you answered yes to any of these, please explain: _____

Does your child have anything that has not been previously mentioned?	☐ Yes	☐ No

If you answered yes, please explain: _____

_____

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PEDIATRIC DENTISTRY

Wonderland Pediatric Dentistry

AUTHORIZATION FOR CARE & TREATMENT: I hereby agree that Wonderland Pediatric Dentistry may perform care and treatment, and may conduct such examinations, laboratory tests and procedures (including x-rays), administer such local anesthetics, analgesia, medication and treatment, as may be directed by my treating practitioner. I acknowledge that no guarantees have been made to me as to the effect of such examinations, tests, procedures or treatment of my condition.

I certify that I have read and understand the above. I acknowledge that my questions, if any about the inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any member of his/her staff, responsible for any errors or omissions that I have made in the completions of this form.

CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION: I consent to the use and disclosure of my Protected Health Information by Wonderland Pediatric Dentistry for purposes of treatment, payment, and health care operations. For example, my treating practitioner at Wonderland Pediatric Dentistry may furnish Protected Health Information maintained by Wonderland Pediatric Dentistry in the course of my care and treatment. Also, as Wonderland Pediatric Dentistry is a teaching practice, I consent to the use and disclosure of my Protected Health Information (i) for training and educational purposes to faculty dentists, residents, and dental students in health-related professions from local colleges and universities affiliated with Wonderland Pediatric Dentistry, and (ii) for review in preparation for possible research. Release of medical records and information will be made according to state and federal regulations. I understand that Wonderland Pediatric Dentistry may release medical information to any third party, including my employer, which may be responsible for payment of my hospital and medical expenses. (Release of medical information to employers is limited to those employers who are directly liable for the costs of the patient's health care benefits through an employer self- insured group health plan or worker's compensation, or in other circumstances in which such disclosure is legally allowed).

INSURANCE AUTHORIZATION: I understand that I am responsible for knowing the terms and conditions of my insurance coverage. I further understand that I may be responsible for obtaining prior authorization for certain services in order for my insurance company to pay for those services and I understand that I may be personally responsible for payment if I do not obtain any necessary prior authorization or my insurance benefits are denied, reduced, or terminated.

ASSIGNMENT OF BENEFITS, INSURANCE PROCEEDS, and SETTLEMENTS: If I am entitled to health care services under any insurance policy from any person or organization which may become liable to me to provide such benefits, I assign such benefits to Wonderland Pediatric Dentistry and practitioners employed by the practice who render such services to me. I further authorize payment directly to Wonderland Pediatric Dentistry and such practitioners of all such insurance benefits payable to me. Such insurance may include, but is not limited to, private commercial insurance, auto liability insurance, worker's compensation, programs such as Medicare and Medicaid, or other government sources.

I certify that the information given regarding my insurance in accurate and current to the best of my knowledge.

I further assign to Wonderland Pediatric Dentistry any payments for medical benefits payable to me as a result of any settlement or judgment in a lawsuit.

FINANCIAL AGREEMENT: In consideration for services rendered by Wonderland Pediatric Dentistry and practitioners employed by Wonderland Pediatric Dentistry, I guarantee prompt payment of all such services not paid by insurance carriers or third parties within thirty (30) days. I understand that any amount not covered by my insurance carrier or other third party payer is my person responsibility, and I agree to make payments for any such amount. If Wonderland Pediatric Dentistry does not receive such payment within thirty (30) days from the date such balance is due, the bill may be turned over to an attorney or a collection agency and, if so, I agree to pay all reasonable collection cost including attorney's fees and/or collection fees in addition to the payment owed. I give Wonderland Pediatric Dentistry the right to examine my consumer credit report for financial information relation to my responsibility to pay for medical services.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE: I acknowledge that I have received the Wonderland Pediatric Dentistry Health Notice of Privacy Practices. A copy is available upon request.

PHOTOS AND VIDEO: Please note, to protect the privacy of our staff and other patients, we would ask that you refrain from taking any forms of photography or videography in our offices. Should you like a photo of your visit to the dentist, please ask a staff member. He/she will attempt to accommodate your request.

DISCLOSURE TO FAMILY OR FRIENDS INVOLVED IN MY CARE: I understand that I may limit the disclosure of my health information to family members, or other close relatives or close personal friends by notifying a member of the staff assigned to care for me.

I have read all the above statements and accept the terms and conditions as stated.

Patient/Parent/Agent/Guardian Signature	Witness Signature	Date
Interpreter (if used) Signature	Witness Signature	Date