Central Arkansas Pediatric Dentistry
Dr. Jana Barfield

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**Demographic Information**

Patient: _____ Today's Date: _____

Preferred Name: _____ Date of Birth: _____ Age: _____ Sex: _____ Ethnicity: _____

School: _____ Grade: _____

**Mother/Responsible Party (If Other Than Parent)**: _____ Relation to patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security No: _____ Date of Birth: _____ DL State & No.:_____

Employer: _____ Home Phone: _____ Work Phone: _____

Cell Phone: _____ **Text ok?** Yes □ No □ Email: _____

**Father/Responsible Party (If Other Than Parent)**: _____ Relation to patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security No: _____ Date of Birth: _____ DL State & No:_____

Employer: _____ Home Phone: _____ Work Phone: _____

Cell Phone: _____ **Text ok?** Yes □ No □ Email: _____

Names and ages of other children in family: _____

How did you hear about our office? _____

**Primary Dental Insurance**

Insurance Co: _____ Insurance Co. Address: _____

Insurance Phone: _____ Group #: _____ Member ID #:_____

Policyholder's Name: _____ Date of Birth: _____

Policyholder's Employer: _____ Relation to patient:_____

**Secondary Dental Insurance**

Insurance Co: _____ Insurance Co. Address: _____

Insurance Phone: _____ Group #: _____ Member ID #:_____

Policyholder's Name: _____ Date of Birth: _____

Policyholder's Employer: _____ Relation to patient: _____

# HEALTH HISTORY

**Has your child ever had any of the following? Circle all that apply & elaborate below.**

| | | |
|---|---|---|
| Heart Surgery/Problems | Congenital Heart Disease | Cancer or Tumor |
| Anemia, other Blood Disorders | Sickle Cell Anemia | Chemotherapy/Radiation |
| Frequent Infections/Immune Disorder | Chronic Steriod Usage | Transplant/Prosthetic Joints |
| Shunt Placement | Diabetes, Endocrine Disease | Seizures/Convulsions |
| Kidney Disease | HIV/Infectious Disease | High/Low Blood Pressure |
| Bone, Muscle, Joint Disease | Cerebral Palsy or Neurological Disease | GI/Liver Disease |
| Asthma/Reactive Airway Disease | Other Lung Problems/Disease | Has an Inhaler |
| Skin Disease | Speech/Hearing Disorder | Sight or eye disorder |
| Mental, Developmental Delays | Autism Spectrum/Asperger's | Learning Difficulties |
| Genetic Disorder/Syndrome | Behavioral Challenges | ADD/ADHD |
| Psychiatric, Mood disorders | Sensory Integration Disorder | Frequent headaches |
| Healthy, no problems | Allergies | |

**Please elaborate on any circled items below:** _____

_____

**Has your child had surgery or been hospitalized?** Reason & date _____

**Does your child have any conditions not listed above**?

☐ Yes, please explain _____

☐ No, my child is healthy

**Please answer the following concerning medication and other types of allergies…**

☐Yes ☐ No **Allergic to medicines?** _____

☐Yes ☐ No **Other allergies, specify** (Seasonal, food, tree nut, red dye, etc.) _____

**If your child has Asthma, Reactive Airway Disease, and/or has an Inhaler please answer the following questions concerning your child's medical history. Have they…**

☐Yes ☐ No Been hospitalized? Give reason and date _____

☐Yes ☐ No Has had an asthma attack? Give date and elaborate _____

☐Yes ☐ No Symptoms are caused by/made worse (time of year, allergens, exercise)? Explain _____

**Circle any of the following that apply:**

Uses rescue inhaler more than 2x week

Wakes up with symptoms at night more than 2x month

Has asthma symptoms with upper respiratory illnesses and colds

**What medicines does your child take regularly, including prescriptions and over the counter?**

_____

_____

**Patient's Physician/Pediatrician:** _____

Physician's Address & Phone Number: _____

# DENTAL HISTORY

☐Yes ☐No Has your child ever been to the dentist? Dentist name/date_____

**Does your child have or had a history of the following?**

☐Yes ☐No Pain? Since when?_____ What area?_____
☐Yes ☐No Previous dental treatment? If yes, did they tolerate it well?_____
☐Yes ☐No Injury to the mouth, teeth, or jaw? When?_____ What area? _____

**Please circle any of the problems/concerns that you want addressed today.**

| | | | | |
|---|---|---|---|---|
| Cavities | Toothache | Sensitive Teeth | Tooth Color | Trauma |
| Gum Infections | Crooked Teeth | Jaw Sounds | Mouth Ulcers | Fever Blisters |

Thumb, finger, or pacifier habit  Pain with Chewing, Yawning, Opening

**Please answer the following questions so that we best address your child's dental needs.**

***PATIENTS 7 YEARS AND YOUNGER***

| | | |
|---|---|---|
| Has 3 or more sugary or starchy snacks per day. | ***YES*** | NO |
| Goes to bed with milk, fruit juice or other sugary drink. | ***YES*** | NO |
| Drinks milk, fruit juice, or other sugary liquid in between meals. | ***YES*** | NO |
| Difficulty brushing/flossing due to cooperation/behavior level. | ***YES*** | NO |
| Has had cavities in the past. | ***YES*** | NO |
| Uses fluoride containing toothpaste. | YES | ***NO*** |
| Parent/caregiver brushes child's teeth at least 2x daily. | YES | ***NO*** |
| Parent/caregiver flosses child's teeth, at least 1x daily. | YES | ***NO*** |

***PATIENTS 8 AND UP***

| | | |
|---|---|---|
| Snacks frequently between meals on sugary or starchy foods. | ***YES*** | NO |
| Drinks milk, fruit juice, soda, or other sugary drink between meals. | ***YES*** | NO |
| Child has good oral hygiene and brushes at least 2 x daily. | ***YES*** | NO |
| Has had cavities in the past. | ***YES*** | NO |

# PERSONALITY AND TEMPERAMENT

**How does your child respond to new people**?_____

**New experiences?** _____

**Does your child have difficulty with any of the following?** Please circle.

Sensory issues  Certain textures  Sensitivity to light  Smells  Loud noises  Taste

Explain_____

**How do you expect your child to respond today?** Please circle all that apply:

Fearful  Shy  Anxious  Cooperative  Uncooperative  Needs Explanation  Combative  Interested
Other/Explain_____

Please feel free to offer any info you might think would be helpful to us in treating your child

_____

Please list any special interests or hobbies in which your child is involved _____

_____

# AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is also my responsibility to inform this office of any changes in my child's medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I also authorize the dental staff to perform the necessary dental services my child may need.

Signature of Parent/Guardian _____

The parent or guardian who accompanies the child is responsible for payment at the time of service unless prior arrangements have been approved.

# TREATMENT CONSENT AND INFORMATION RELEASE

Child's Name _____

I, being the parent or legal guardian of the above minor patient, hereby authorize and request the performance of dental services for this patient by Dr. Jana Barfield and staff or Central Arkansas Pediatric Dentistry.

I authorize Central Arkansas Pediatric Dentistry to:

- Perform diagnostic procedures, treatment, and behavior management techniques that are reasonable, necessary and advisable.
- Administer anesthetics and/or analgesics that may be deemed advisable.
- Release any information concerning my child's treatment for the purpose of insurance benefits.
- Release any information concerning my child's treatment to another dentist or physician.
- Receive payment of insurance benefits otherwise payable to me.

I understand that:

- My dental insurance carrier or payor of my dental benefits may pay less than the actual bill for services and that I am responsible for payment in full of all accounts.
- The treatment plan to be presented, along with the fees outlined could change depending upon the time elapsed since the initial examination and the extent of dental pathology.

Signed _____ Date _____

# NOTICE OF PRIVACY PRACTICES

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information over the last 6 years (but not before April 14, 2003). That list will not include disclosures for treatment, payment, health care operations, as authorized by you, and for certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for more information about fees.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. Your request is not binding unless our agreement is in writing.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. You must specify in your request the alternative means or location, and provide satisfactory explanation how you will handle payment under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why we should amend the information. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.

If you believe that:

- We may have violated your privacy rights,
- We made a decision about access to you health information incorrectly,
- Our response to a request you made to amend or restrict the use or disclosure of your health information was incorrect, or
- We should communicate with you by alternative means or at alternative locations,

You may contact us using the information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Central Arkansas Pediatric Dentistry
8000 Hwy 107, Suite 18
Sherwood, AR 72120

Patient: I have read and understand the above Patient Rights to Privacy Information.

Patient Signature (or Parent/Guardian if child) Date

# FINANCIAL AGREEMENT

This agreement addresses your financial responsibilities for the dental services we provide your child. We are committed to providing your child with personalized, compassionate care using the highest quality materials and the latest technology, and to providing you, the parent, with the educational tools needed to help maintain their oral health. In order for us to continue serving your family at the high standards we desire, our financial policy must ensure that we minimize our administrative costs.

All charges you incur are your responsibility regardless of your insurance coverage. As your dental care provider, our relationship is with you, not with your insurance company. Your insurance policy is an agreement between you, your employer, and the insurance company. Our practice is not a party to that agreement. As a courtesy to you we will help you process all your insurance claims. You may direct your insurance company to pay your benefits directly to our practice by signing the authorization on the Assignment of Benefits Agreement.

**Financial Policy**: The parent or guardian is responsible for their child's account. It is your responsibility to know their insurance contract benefits, assure collection of insurance payment to us and to negotiate with your carrier over any disputed claims.

- **Patients without insurance (Self-Pay):** Payment is due in full at the time of service. For patients paying 48 hours in advance of their appointment with cash or check, a 5% courtesy will be given.

- **New patient's first visit:** If we are unable to verify your insurance plan eligibility & benefits coverage, you will be expected to pay for your initial office visit & services in full that day.

- **Insurance Cards:** You must present your insurance card at the first appointment and may be asked at the time of any subsequent appointments so we may verify eligibility. Your must notify us immediately if you lose coverage, change health plans, or if there are any changes affecting your eligibility or coverage.

- **Co-payments:** If your insurance plan requires a co-payment for office charges, payment will be collected on the date of service. Your **estimated** copayment for treatment, which is the amount not covered by your insurance, is due at the time treatment is provided. Your **estimated** copayment may be adjusted after the time of treatment depending upon the final reconciliation of insurance payments. If payment from your insurance company is not received within 90 days from date of service, you will be expected to pay the balance in full.

- **Payment Methods:** Our practice accepts cash, personal checks, MasterCard, and Visa. Extended payment financing via Care Credit℠ is available upon request and approval. A returned check fee of $25.00 will be assessed to your account for every check returned for insufficient funds, stopped payment, or closed account.

- Balances older than 90 days will be subject to collection fees and finance charges at the rate of 1.5% per month (18% annually).

- The adult accompanying a child must be their parent, guardian, or listed as an adult authorized in the new patient paperwork. We are unable to provide non-emergency treatment unless payment has been pre-authorized by a parent or guardian before service.

Please do not hesitate to ask if you have any questions regarding this financial agreement. We are committed to providing you child with excellent care and a great experience.

_____
Print Name of Parent or Guardian

_____ _____
Signed Name of Parent or Guardian Date

# Late Arrival and Missed Appointment Policy

Your child's appointment time is specifically reserved for them. We carefully consider the amount of time needed and the time of day that best suits your child's dental needs. Before you arrive, we set aside time to prepare ourselves for your son or daughter's visit by reviewing our plans for them. We ensure the appropriate materials are available and readily accessible so that treatment flows smoothly. These preparations help facilitate the delivery of personalized, compassionate, high quality dental care that is positive and fun for our patients.

Persons arriving late and missed appointments without sufficient notice affect our ability to deliver the level of care we strive to provide. This affects both the offending patient and the other patients being seen that day.

Patients arriving 10 minutes late or more may need to be rescheduled. In order to avoid a possible missed appointment fee of $40, we request a 48 hour notice to change your appointment. After 2 missed appointments, we will be unable to reschedule your child for future dental care.

_____
Print Name of Parent or Guardian

_____ _____
Signature of Parent or Guardian Date

# ARKids and ConnectCare

Attending scheduled dental checkups and timely completion of recommended dental treatment is needed to keep your child healthy. Missed appointments and putting off treatment by rescheduling can cause dental problems to worsen, resulting in pain.

Due to the high rate of missed appointments and rescheduling for reasons other than illness, we are working with the ConnectCare program. ConnectCare works with ARKids patients, parents, and ARKids dentists. Their services include appointment reminders, and follow ups on failed and cancelled appointments. ConnectCare can also assist you in arranging transportation for dental appointments when necessary.

I understand that Central Arkansas Pediatric dentistry will be communicating with ConnectCare regarding my child's dental appointments and that ConnectCare will be following up with me if I miss or reschedule. I understand that if I do not have reliable transportation that ConnectCare can assist me in arranging transportation for my child's dental appointments, and that I need to call at least 2 full days (48 hours) before my appointment.

_____ _____
Signature of Parent or Guardian Date

**If you need assistance with getting a ride to your dental appointments, please contact NET (Non-Emergency Transportation) Program at 1-888-987-1200, Option #1.**

**If you need assistance with other services ConnectCare provides, please contact them at 1-800-322-5580.**

# Permission to Have Another Adult Accompany Child to the Dentist

I _____(parents name) authorize the following adults

1. _____ _____
   Name Relationship to patient
2. _____ _____
   Name Relationship to patient
3. _____ _____
   Name Relationship to patient

to bring my child _____(patients name) to his/her dental appointments at Central Arkansas Pediatric Dentistry.

The adults listed above are over the age of 18 and, in my absence, they are allowed to make dental and medical procedure decisions for my child until further notice.

**I understand it is my responsibility to accurately report my child's medical and dental history (including current medications) with Central Arkansas Pediatric Dentistry and the person accompanying my child. I understand that inaccurate medical or dental information may jeopardize my child's safety and compromise their quality of care.**

Signature_____Date_____