
Nestor D'alessandria DMD

Today's Date:_____

**Childs Name**_____**Nickname**_____
**Sex: F** ☐ **M**☐ **Birth Date:**_____ **Age**_____ **Reason For Visit?**_____
**Is this your child's first dental visit?** _____**Date of last visit** _____**Previous Dentist**_____
**Your child's attitude towards previous dental care?**_____
**Social Security**_____ **Race**_____**School**_____
**Religion**_____ **Name of Insurance Plan:**_____
**Is your child adopted?**_____ **Who has legal Guardianship of your child?**_____
**How did you hear about our office?**_____
**Languages Spoken:** ☐ **English** ☐ **Spanish**☐ **Portuguese** ☐ **Creole**☐ **Other:** _____

***Medical Information**

**Dr.'s Name**_____**Address**_____**Phone:**_____
Is your child taking any medication? _____What Kind?_____
Reason_____
Has your child ever been hospitalized?_____When?_____Reason_____

**Has your child had difficulty with any of the following:**

| Yes/No | | Yes /No | | Yes /No | |
|---|---|---|---|---|---|
| ◯◯ | Seasonal Allergies | ◯◯ | Seizures/Epilepsy | ◯◯ | Heart Murmur |
| ◯◯ | Autism | ◯◯ | Convulsions | ◯◯ | Bone Marrow Transplant |
| ◯◯ | Cancer/Tumors | ◯◯ | Arthritis | | |
| ◯◯ | Developmental | ◯◯ | Bones | ◯◯ | Sickle Cell Disease |
| ◯◯ | Hearing | ◯◯ | Ears Nose | ◯◯ | Organ Transplant |
| ◯◯ | Hepatitis | ◯◯ | Eyes | ◯◯ | Hemophilia/ Thalassemia |
| ◯◯ | General Anesthesia | ◯◯ | Throat | | |
| ◯◯ | Surgery | ◯◯ | Kidney/Liver | ◯◯ | Dialysis/ Blood transfusion |
| ◯◯ | Anemia/Bleeding | ◯◯ | Stomach/Intestinal | | |
| ◯◯ | Cerebral Palsy | ◯◯ | Cleft Lip/Palette | ◯◯ | Spina Bifida |
| ◯◯ | Diabetes | ◯◯ | Rheumatic Fever | ◯◯ | Sleep Apnea |
| ◯◯ | Heart | ◯◯ | Asthma/Breathing Problems | ◯◯ | Down 's syndrome |
| ◯◯ | Immune Deficiency | | | ◯◯ | ADHD |

Other: (please specify):_____
Comments/Details_____
Does your child have any emotional or school problems?_____
**Allergies to food or Medication**? Y/N_____

**Parents signature:**_____**Date:**_____

**Doctor's signature**_____**Date:**_____

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## Dental Information

Was your child bottle fed? _____Until what age? _____or breast fed? _____until what age?_____
Does your child has any mouth habits such as: finger/thumb sucking_____Pacifier_____other_____
Has your child had any injuries to his/her teeth, mouth or head?_____when?_____
Details_____
Does your child brush regularly?_____Does an adult assist with brushing?_____
Does your child floss?_____ Does and adult assist with flossing?_____
Has either parent or child been treated orthodontically? _____Name of Orthodontist_____
How would you expect your child to behave in our office?_____
Describe your child: Outgoing ◯ Shy ◯ Stubborn ◯ Anxious ◯ Frightened ◯ Age appropriate ◯

## Responsible party ( Parent/ Legal Guardian) :

First Name _____Last Name _____Middle Int_____

Address _____City, State, Zip_____

Home Phone_____ Work Phone_____ Cell_____

Birth Date_____ Soc Sec _____Email_____

Occupation _____Relationship to Patient_____

**Financial Policy**

Your child's estimated share of cost is due and payable on the day the treatment is performed. Unless prior approved financial arrangements are made. Understand that dental insurance may cover only part of your child's dental treatment based no your specific dental benefit plan. We will do our best to provide you with an estimate based on your plan. Please understand that the contract for dental insurance is between you and your insurance company. Any disputes of coverage need to handle through the insurance company directly by you. I (Parent/Guardian) _____ accept as my personal responsibility all charges to my child's account regardless to any insurance coverage.

*To Avoid missed appointment charges we request that you cancel at least 24 hours prior to the appointment, so that we can offer the appointment to another child. If you have 2 broken appointments, you will be automatically charged $50.oo for your missed appointments. A broken appointment is considered a "no show" or cancelling an appointment the same day.

**Signature_____ Relationship to Child _____Date_____**


# Pediatric Dental Land, Inc.
## Consent

Dear Parent or legal guardian,

Since my child_____ is a minor,

(Patient name)

It becomes necessary that a signed permission is obtained from a parent or legal guardian before any dental services can be started and accomplished by either Dr. Nestor D'alessandria and or any Doctors associated with Pediatric Dental Land, Inc. Authorization is hereby granted to do an examination, take X-rays, clean teeth, give fluoride treatment, and provide oral hygiene instructions if deemed necessary. Following a consultation, authorization is hereby granted to administer any treatment, anesthetics, extractions, and perform such operations or otherwise treat my child as it may be deemed necessary and or advisable. I also give permission to provide my child with emergency care if needed. I authorize my pediatrician or other physician(s)/medical facilities to release any and all pertinent medical information regarding my child. I further understand that this consent will remain in effect until such time that I choose to terminate it. I understand that I accept responsibility for payment of services rendered. I certify the truth of the information given. I also authorize the release of pertinent information to those persons requiring it for treatment of my child or for the purpose of payment of the account or credit references. I certify the truth of the information given. I also authorize the release of pertinent information to those persons requiring it for the treatment of my child or for the purpose of payment of the account or credit references.

Signed:_____ Date:_____

(Parent or legal guardian)


# HIPAA Acknowledgement and Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have Certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

*Conduct, plan and direct my treatment and follow-up care among the multiple healthcare Providers who may be involved in that treatment directly or indirectly.

*Obtain payment from designated third-party payers.

*Conduct normal health care operations such as quality assessments or evaluations, and Physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information (available in office in print form)

I have been given the right to review such Notice of Privacy Practices prior to signing this consent.

I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address(s) below to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

Patients Name: _____ Date of Birth (MM/DD/YYYY): _____

Signed (Patient or Legal Representative for Patient) _____ Date_____

Legal Representatives Relationship to Patient: _____

Pediatric Dental Land, Inc.
Nestor H D'alessandria, DMD.
8320 W Sunrise Blvd Suite 210
Plantation, Florida, 33322
(954) 414-8018

Nestor D'alessandria DMD

**NOTE : Parent/Patient Giving consent: { on this page by the marked arrow you may authorize another person or family member to bring the child to their appointment in the case that the Parent/ Guardian listed previously may not attend }**

Patient name: _____

Address:_____
Telephone:_____

Patient DOB:_____ Patient Social Security Number:_____

**I, _____ understand that by signing this consent form I am giving my consent to Pediatric Dental Land to disclose and discuss my child's protected health information to carry out treatment, payment activities and health care operations with the following family member:**

→ Name of Authorized Adult :_____

Relationship to Patient:_____

I understand that I have the right to revoke this consent at any time by giving written notice to Pediatric Dental Land of my revocation.

Parent/Guardian signature_____Date_____

Witness_____ Date_____

***Patient/Relative HIPPA consent***

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# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You may refuse to sign this Acknowledgement*

I _____, have received a copy of this office's (Pediatric Dental Land) Notice of Privacy Practice.

Please Print
Name:_____

Signature:_____Date_____

*FOF OFFICE USE ONLY*

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other ( Please specify below)

_____
_____
_____

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## FINANCIAL POLICY

We are committed to providing you and your child the best possible care. If you have dental insurance, we will help you receive your maximum allowable benefits. In order to do this, we need your assistance and understanding of our financial policy.

The parent/legal guardian accompanying a minor (under 18 years old) is responsible for the full payment. Payment methods are cash, Check,Visa, MasterCard, or debit card. Information regarding outside extended payment plans is also available.

Regarding Non-Insured Patients
Full payment is due at the time of service. We are able to give our non-insured patients a ten percent fee reduction.

Regarding Insured Patients
The portion of dental service fees not covered by insurance is your (patient or patient representative) responsibility and is due at the time of service. If your insurance company has not paid for rendered dental treatment in full within 30 days, the balance will be your responsibility and due at that time.

We will gladly discuss and answer to the best of our ability any questions regarding the financial aspects of dental treatment. However, please
understand:
– At times, your insurance company does not pay for 100% for service. Any discrepancies or questions between your expected insurance
coverage, and what the insurance company has actually covered, should be directed to your insurance company.
– Your insurance coverage is a contract between you and your insurance company. The extent of coverage or any other details of that contract cannot be influenced by us.

We must emphasize that as dental care providers, our relationship is with you and your child. While we file insurance claims as a courtesy to our patients, all charges are your responsibility from the date of service.

Returned checks will incur an additional $25.00 charge. Balances older than 30 days will be subject to additional collection fees and interest charges of 1.5% per month.
A charge of $25.00 may also be applied to broken or cancellations without a 24 hour advanced notice.

The responsible party is the parent that brings the child in for the dental visit, independent of what a divorce decree may state. Reimbursement must be made between the divorced parties. We will not intervene.

If you have any questions about the above information or the financial aspect of your dental care, please do not hesitate to ask us. We are here to help you.

CONSENT FOR INSURANCE SUBMITTAL:
I authorize the Dentist to release any information, diagnosis and the records of treatment to
third party payers 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 insurance carrier may pay less than the actual bill for services.

_____

I have Read all the information on this sheet. I understand and agree to Pediatric Dental Land, Inc. financial policy.

Name (please print): _____

_____ _____
Signature of Patient/ (parent or guardian) Date