Child Medical History Update

Patient Name _____

□ Has there been any change in your child's health since your last dental appointment?
_____YES _____NO

For what conditions? _____

□ Is your child taking any kind of medication at this time? _____YES _____NO

If so, what? _____

_____

□ Does your child have any allergies (or adverse reactions) to any medications? _____YES _____NO

If so, what? _____

Pediatrician's Name: _____ Phone Number: _____

Parent Signature _____ **Date** _____

_____

Please Update Contact Info:

Parent/ Legal Guardian's Name (s):_____

Home address: _____

_____

Mom Home Phone: _____ Dad Home Phone: _____

Mom Cell Phone: _____ Dad Cell Phone: _____

Mom Email: _____ Dad Email: _____

Preferred Contact #_____ Like to get text? Y/ N Best time to contact:_____

Insurance Information: Any Changes? _____YES _____NO

If yes, please fill out the following:

Policy Holder Name: _____

Employer Name:_____

Insurance Co Name: _____

Insurance Phone: _____

SS#: _____ ID#: _____

Policy Holder DOB: _____ GRP#:_____

Parent/Guardian Signature **: _____Date:_____**

Dentist Signature: **_____*Date:*_____**

Pediatric Dental Land, Inc.
8320 W Sunrise Blvd, Suite 210
Plantation, FL. 33322
954-414-8018

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of Pediatric Dental land, Inc. Notice of Privacy Practices, which has an effective date of 07/15/2014, and which describes how my health information may be used and disclosed.

I understand that you have the right to change the Notice of Privacy Practices at any time, that I will be provided a copy of any updated version, and that I may contact you at any time to request a current Notice of Privacy Practices.

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices:

_____

Signature of Patient or Patient's Representative Date

_____

Print Name

_____

Relationship to Patient (If not signed by the Patient)

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) _____

_____ _____ DATE
SIGNATURE OF PATIENT (parent or guardian)

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH IMFORMATION (PHI)
ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICIES

*CONSENTIMIENTO DEL PACIENTE PARA USAR Y COMPARTIR INFORMACION PERSONAL DE SALUD Y CONFIRMACION DE RECIBO DE LA NOTA DE PRACTICAS DE PRIVACIDAD

I acknowledge that I have been provided with **PEDIATRIC DENTAL LAND.,** "Notice of Privacy Practices"., and I am giving my consent for the use and disclosure of Protect Health Information as required and / or permitted by law.

Confirmo que se me ha proveido con la "Nota De Practicas De Privacidad" de* **PEDIATRIC DENTAL LAND., *y doy mi consentimiento para usar y compartir Información Personal De Salud como lo permita y/o requiera la ley.*

Patient Name: *(please print)* _____

***Nombre Del Paciente:** *(nombre en letra de molde por favor*

Patient Signature *(or legal representative; proof may be requested)* _____

***Firma Del Paciente:** *(o representante legal; prueba puede ser requerida)*

Date: *(dd/mm/yy)* ____ / ____ / ____

***Fecha:** *(dd/mm/aa)*

EMAIL/TEXT MESSAGE TO MOBILE PHONE CONSENT FORM
*CONSENTIMIENTO DE CORREO ELECTRONICO/MENSAJES DE TEXTO A MOVIL

Purpose: This form is used to obtain your consent to communicate with you by email/mobile text messaging regarding your Protected Health Information. **PEDIATRIC DENTAL LAND., (PDL)** offers patients the opportunity to communicate by email/mobile text messaging. Transmitting patient information by /mobile text messaging has a number of risks that patients should consider before granting consent to use email/mobile text messaging for these purposes. **PDL** will use reasonable means to protect the security and confidentiality of email/mobile text messaging information sent and received. However, **PDL** cannot guarantee the security and confidentiality of email/mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email/mobile text messaging between **PDL** and me and consent to the conditions outlined herein. Any questions I may have had were answered.

***Propósito:** Esta forma es usada como consentimiento de usted para comunicarnos vía correo electrónico/mensaje de texto a móvil en referencia a su Información de Salud Protegida. **PEDIATRIC DENTAL LAND., (PDL)** ofrece a sus pacientes la oportunidad de comunicación vía correo electrónico/mensaje de texto a móvil. Trasmitir información vía correo electrónico/mensaje de texto a móvil tiene numerosos riesgos que el paciente debe considerar antes de otorgarnos este consentimiento para estos propósitos. **PDL** usara formas razonables de proteger confidencial y seguro la información mandada a usted vía correo electrónico/mensaje de texto a móvil. De todas formas, **PDL** no podrá garantizarle proteger confidencial y seguro la comunicación vía correo electrónico/mensaje de texto a móvil y no será en ninguna forma responsable si esta información confidencial es usada inadvertidamente por otros.

Yo comprendo haber leído y completamente entendido el consentimiento de esta forma. Yo comprendo los riesgos asociados con la comunicación vía correo electrónico/mensaje de texto a móvil entre **PDL** y yo y consentimiento a las condiciones que me han sido dadas. Cualquier pregunta que yo haya tenido me a sido respondida.

Patient Acknowledgment & Agreement / *Reconocimiento y Acuerdo del Paciente

My Consented Email Address is: _____
***Mi Correo Electrónico Consentido es:**

My Consented for Text Messaging to: _____
***Mi Mensaje de Textos consentido a:**

X _____ _____
Patient Signature *** Firma del Paciente** **Date** ***Fecha**

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