Dr. Maggie Davis & Associates
PEDIATRIC DENTISTS

Maggie Davis, D.M.D.
Lorielle Alter, D.M.D.

Board Certified Pediatric Dentists

Phone: 727.786.7551
Email records to: info@drmaggiedavis.com

Patient Information

Patient:_____Today's Date:_____
Preferred Name: _____Date of Birth: _____Age: _____Sex: M / F (Gender Identity: M / F)
School:_____Grade:_____
Home Address:_____City:_____Zip:_____
May we text message appointment confirmation? If so, which cell phone number?_____
Email address:_____
Who has legal custody of this patient?_____
Person responsible for payment of account:_____DOB:_____
How did you hear about our dental practice?_____
Reason for today's visit:_____
How do you think your child will respond to dental treatment?_____

Parent 1 Information - Relationship to patient: ☐ Mother ☐ Father ☐ Grandparents ☐ Other:_____
Name:_____Date of Birth:_____
Occupation:_____Employer:_____
Driver's License #:_____ Social Security Number:_____
Cell Phone #:_____Home Phone #:_____Work Phone #:_____
Home Address:_____City:_____Zip:_____

Parent 2 Information - Relationship to patient: ☐ Mother ☐ Father ☐ Grandparents ☐ Other:_____
Name:_____Date of Birth:_____
Occupation:_____Employer:_____
Driver's License #:_____ Social Security Number:_____
Cell Phone #:_____Home Phone #:_____Work Phone #:_____
Home Address:_____City:_____Zip:_____

Financial & Insurance Information

*****Important Note Regarding Insurance*****
Dr. Maggie Davis & Associates office will gladly help file insurance estimates & forms, but we are not a 'Participating Provider' for any Insurer and we are considered 'Out of Network'.
Balances not paid by your insurer are your responsibility.
Initial here to acknowledge: ☐

Person Financially Responsible for Account

Name:_____Relationship to Patient:_____
Billing Address:_____City:_____Zip:_____
Cell Phone #:_____Home Phone #:_____Work Phone #:_____

Insurance Information

Dental Insurance Company: _____Insurance Phone #:_____
Insurance Company Address:_____
Policy Holder Name: _____Policy Holder SSN/ID#:_____Policy Holder DOB:_____
Group/Policy #:_____Employer:_____

Patient Name: _____Date of Birth:_____

Patient Medical Questionnaire

Pediatrician:_____Phone #:_____

Y N Has your child ever been hospitalized or treated in the ER? If yes, please describe when & why:_____

_____

Y N Has your child ever had surgery? If yes, please describe when & why:_____

Y N Has your child ever had pre-medication with antibiotics before dental appointment?

List all current medications the patient is taking (prescription & over the counter), including the reason for taking the medication:

_____

_____

Please list any known allergies:_____

Has your child ever been diagnosed with or treated for the following?

Y N Acid Reflux	Y N Cancer/Tumor/Malignancy	Y N Heart Murmur	Y N Seizure/Epilepsy
Y N ADHD/ADD/Hyperactivity	Y N Cerebral Palsy	Y N Hepatitis	Y N Sensory Issues
Y N Allergies	Y N Chemotherapy/Radiation	Y N HIV/AIDS	Y N Sickle Cell Disease
Y N Anemia	Y N Cleft Lip/Palate	Y N Kidney Disease	Y N Sinus Problems
Y N Arthritis	Y N Developmental Delay	Y N Latex Sensitivity/Allergy	Y N Sleep Apnea/Snoring
Y N Asthma	Y N Down Syndrome	Y N Liver Disorder	Y N Speech Delays
Y N Autism/Spectrum Disorder	Y N Diabetes	Y N Premature Birth	Y N Transplant
Y N Birth Defects	Y N GI/Stomach Disease	Y N Profound Mental Impairment	Y N Tuberculosis
Y N Bleeding Problems	Y N Hearing Impairment	Y N Psychologic/Nervous Disorder	Y N Vision Problems
Y N Breathing Problems	Y N Heart Condition/Disorder	Y N Rheumatic Fever	Y N Other

If other, please specify:_____

Please provide more information on any of the above marked yes:_____

_____

_____

Patient Dental Questionnaire

What is your main concern about your child's teeth?_____

Y N Do you assist your child in brushing his/her teeth?

Y N Does your child use dental floss?

Y N Was your child bottle fed? Until what age?_____

Y N Was your child breast fed? Until what age?_____

Y N Do you or your child have any concerns about the appearance of his/her teeth? Describe:_____

Y N Does your child have a current or previous pacifier or thumb/finger sucking habit?_____ Until what age?_____

Y N Has your child ever had an accident or injury involving the teeth/jaws? When & where?_____

Please check below if your child has had problems or concerns with any of the following:

☐ Cavities	☐ Gum Infection	☐ Grinding/Bruxism	☐ Tooth Sensitivity	☐ Crooked Teeth
☐ Toothache	☐ Canker sores	☐ Jaw Pain	☐ Tooth Color	☐ Missing Teeth

When was your child's last dental visit?_____ When was your child's last dental x-rays?_____

Previous dentist's name and phone #:_____

Why did your child leave his/her previous dentist?_____

Is there something in particular that we should know about your child that may guide us in rendering care for them?_____

_____

Fluoride Exposure

Your child drinks water primarily from: ☐ Tap Water [County?_____] ☐ Well Water ☐ Bottled Water [Brand?_____]

Y N Does your child use toothpaste with fluoride?

Y N Does your child use a fluoride rinse?

Y N Do you have a reverse osmosis water filter?

Y N Does your child take prescription fluoride tablets/drops?

The information provided in this form is complete to the best of my knowledge. I will notify Dr. Maggie Davis & Associates at future visits if any of the information changes. Person completing this form please print name & relationship to patient.

Print Name:_____ Relationship:_____

Signature:_____Date:_____

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TELL US ABOUT YOU

Would you describe yourself as someone who prefers a lot of detail when communicating your child's dental needs or are you more of a bottom line type of communicator. Select **one**:

☐ Details ☐ Bottom Line

YOUR GOALS

Among our Team we have four goals that drive our practice and quality of care. All of these are extremely important to us. We would like to know which **one** is most important to you.

*Please **put in order** from one to four*

_____**Comfort**-Your child feeling at ease during and after their visit

_____**Longevity**-Your child maintaining a long-lasting healthy smile

_____**Aesthetics**-Your child having a bright smile that they are proud of

_____**Function**-Your child eating and speaking without restrictions

We have found that some of our parents have barriers that may prevent them from getting their child the treatment they need. Some parents do not have any barriers. In order to serve your family to the best of our ability, would any of the following be a potential barrier to dental care?

Please put an **X** next to any barriers you may have:

_____**Time**

_____**Money**

_____**Fear**

_____**Trust**

What would be a tangible solution to overcome the barrier?

_____

_____

_____

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PARENT/GUARDIAN CONSENT FOR NON-PARENT TO BRING YOUR CHILD TO OUR OFFICE

WHENEVER WE PROVIDE YOUR CHILD WITH DENTAL CARE WE REQUIRE YOUR PERMISSION. IF YOU ARE NOT WITH YOUR CHILD THEN WE NEED YOUR SIGNED AUTHORITY TO RELY ON YOUR DESIGNATED PERSON(S) TO SEEK DENTAL CARE FOR YOUR CHILD IN YOUR ABSENCE. THOSE NAMED HERE ARE ALSO ELIGIBLE FOR PATIENT INFORMATION AS DESCRIBED IN THE NOPP/PHI ACKNOWLEDGEMENT.

LET US KNOW WHO YOU DESIGNATE BY COMPLETING THIS FORM.

As _____'s parent/legal guardian, I give permission for Dr. Maggie Davis and Dr. Lorielle Alter, DMD to accept the authority of the following person(s) in my absence for dental treatment of my minor child. I understand that no treatment can be given in my absence without this statement or a similar written statement of permission. I hold Dr. Maggie Davis DMD LLC harmless in using this consent for treatment, and acknowledge that this is valid until revoked by me in writing. I am responsible for all charges in connection with the treatment rendered. With this consent Dr. Davis and Dr. Alter are also authorized to share medical and /or billing information with these same individual(s)

I authorize:_____ Relationship_____

I authorize:_____ Relationship:_____

I authorize:_____ Relationship:_____

I authorize:_____ Relationship:_____

Date:_____ Signature: _____

(circle one): parent legal guardian other: _____

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Parent Information

Thank you for choosing our pediatric dental office for your child's care. It is our goal to make each child's dental visit a positive experience and to treat every child as our own. Parents are welcome to come back to our treatment area, but both as experienced dental professionals, and—most importantly—as parents ourselves, we recommend parents wait in our reception area as we guide your child through his or her appointment. Similar to a learning environment at school, children are more likely to socialize and interact without a parent present. Dr. Maggie, Dr. Lorielle and their staff have excellent communication skills to help your child feel relaxed and we would like the best opportunity to explain, complete, and celebrate your child's successful dental appointment while having fun! With that being said, we understand that every child is unique and we encourage your presence if your child is very young, has special needs or you simply feel your child needs you present. Please let us know at check-in if you wish to come back, as we are happy to accommodate. We only ask that you act as a silent observer and other siblings wait in the reception play area. Should you decide to wait in the reception area but want to check on all the fun your child is having, please ask our front desk staff to bring you back for a 'peek-a-boo' visit where you can observe your child without being in their direct line of sight. At the end of every visit we will always discuss your child's oral hygiene with you and you will have the opportunity to ask as many questions as you would like.

Name of Guardian:_____ Signature:_____

Appointment Policy

We reserve your appointment time specifically for you! If you need to reschedule, please give us at least 48 hours notice so that we may give someone else the opportunity to use that time. A fee may be charged for late cancellations (less than 48 hour notice) and/or missed appointments. This fee must be paid before a new appointment is scheduled. After three broken appointments within one year's time, we unfortunately will need to assist you in transferring the patient's records to another dentist. If your child is under the age of 6, we ask that you schedule a morning appointment. Younger children often respond better to new environments when they are well rested.

Name of Guardian:_____ Signature:_____

Consent for Treatment

I, the undersigned parent/legal guardian, authorize Dr. Maggie Davis, Dr. Lorielle Alter, and their staff to examine this child, clean his/her teeth, apply topical fluoride, perform necessary dental treatment, and obtain other records necessary for an accurate diagnosis for my child. I further request and authorize the taking of dental radiographs (x-rays) as may be considered necessary by our Doctors to diagnose and/or treat my child's dental condition. I will allow photographs to be taken of my child and/or my child's teeth for diagnostic or educational purposes only. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Our Doctors will provide an environment likely to help children learn to cooperate during treatment by using praise, distraction and story telling techniques, & child-friendly demonstration of procedures and instruments.

Name of Guardian:_____ Signature:_____

Financial Policy and Payment Options

We offer several flexible payment arrangements for our patients. We do not want financial considerations to be an obstacle to your child's care. Please select the **ONE** most appropriate financial option by **INITIALING** below.

_____ Self-pay. Payment in full at time of service.

_____ Self-pay. Payment in full at time of service and you chose to file your dental insurance independently with copy of receipt that we can provide after treatment has been completed.

_____ Discounted rate utilizing Dental Membership Club.

**One-time lifetime activation fee with monthly installments thereafter. Ask a Team member for details.*

_____ 6-Month payment plan through Care Credit (Services over $200) .

Care Credit Account # _____ Exp: _____

** Deferred interest for first six month, as dentist pays these fees for you. Ask a Team member for details.*

_____ Dental insurance benefits with credit card kept on File.

Regardless of our office's insurance network status, we will as a courtesy, process your insurance benefits in our office, relieving you of this time consuming and complicated burden. *By selecting this option, you agree to provide a credit card to be kept on file with our office.* **Insurance benefits vary among dental insurance companies and any unpaid claim or balance thereof is the responsibility of the parent/guardian.** *Permission is granted to charge your credit card for any un paid balance still due thirty (30) days after treatment is rendered and your dental insurance company has processed the claim. Outstanding balances will be assessed at a rate of 1.5% monthly percentage (18.00% APR) to accounts over 30 days past due.*

Name on Card: _____ Date: _____

Credit Card Number _____ Exp: _____ CVV:_____ Zip Code: _____

**By signing this form, you are authorizing our office to process your payment automatically.*

***For your security, your card information is electronically stored with the merchant processing company and is encrypted. Our office will assign a unique identification number to your payment option as your specific card information beyond the last four digits will not be accessible to anyone.*

Payment is due in full at the time service is provided. Please be aware that the adult accompanying the child to our office is responsible for payment of all charges. In situations of divorce we are unable to serve as a mediator to your financial arrangements, but will rely on you to handle discussion of parental payment responsibility outside of our offices. We are happy to provide a detailed statements and other financial information to help families work through such issues. Returned checks will be subject to additional fees. In the unfortunate event that it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection or legal fees including a surcharge of up to 35%.

Please remember, even if you have insurance coverage, you are responsible for payment of your account. Please realize that your insurance coverage is a relationship between you, the insured patient, and your insurance company. Your understanding and cooperation with this matter is greatly appreciated. Your understanding of our policies frees our staff to provide timely care to your child while keeping our fees as low as possible. We thank you for the opportunity to serve your child's dental health care needs and welcome any questions you may have concerning your child's care or our financial policy.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MAGGIE N. DAVIS, D.M.D., LLC. I UNDERSTAND THAT RESPONSIBILITY FOR PAYMENT FOR DENTAL SERVICES PROVIDED IN THIS OFFICE FOR MY DEPENDENT IS MINE, DUE AND PAYABLE AT THE TIME SERVICES ARE RENDERED. I FURTHER UNDERSTAND THAT A FINANCE, REBILLING, COLLECTION CHARGE AND/OR ATTORNEY FEE WILL BE ADDED TO ANY OVERDUE BALANCE.

Patient Name:_____Parent Name:_____

Date: _____Signature:_____

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HIPAA
Consent for Use and Disclosure of Protected Health Information (PHI)

Patient Name:_____ Date of Birth: _____

I, _____, the undersigned, and _____
(print name of Parent, Legal Guardian or Patient if 18) (Relationship to the Patient)

of the above named patient, herby authorize Maggie N. Davis, DMD, LLC (hereafter collectively referred to as the "Practice") to use and disclose the entire medical record concerning the above named patient (hereafter referred to as the "Patient") in accordance with the attached Notice of Privacy Practices (NOPP). I have reviewed the NOPP, been given an opportunity to ask questions about it, understand it and do hereby agree to its terms. A copy of this signed, dated Consent shall be effective as the original. I release, hold harmless and agree to indemnify Practice, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this Consent. I specifically authorize the Practice to use and disclose verbally, by mail, fax or unencrypted e-mail, the Patient's medical record.

Signature:_____Date: _____
(patient or guardian signature)

Release of Records [To be completed on an as needed basis]

1. Please send a copy of my records (including information from other health-care providers that it may contain) to:_____at_____. I understand that my records may be subject to re-disclosure by recipient(s) and unprotected by federal or state laws.
2. Please allow _____to pick up a copy of my records (including information from other health-care providers that it may contain).
3. Please send a copy of my records (including information from other health-care providers that it may contain) by unencrypted email to:_____. I understand it may be unprotected by federal or state law.

*****Release of Record is good 90 days from today's date.*****

Authorizing Signature:_____Date:_____

Print Name:_____Relationship to Patient:_____

Reason for Request: ☐ Moved ☐ Second Opinion ☐ Transfer Office ☐ Insurance ☐ Other: _____