Olen Ben Davis, DDS
Board Certified Pediatric Dentist
Boo Lee, DDS
Board Certified Pediatric Dentist

345 Earnie Ln
Holly Springs, NC 27540
Telephone: 919.762.7013
www.bluewaterpediatricdentisry.com

New Patient Information

A LEGAL GUARDIAN FOR THE CHILD MUST COMPLETE THIS FORM.
By completing this form thoroughly, you are assisting us to provide the safest, friendliest, and most efficient care for your child.

Person completing form _____ Relation to child _____ Date _____

Child Information

Child's name (First)_____ (Middle Initial)_____(Last) _____
Nickname _____Child's date of birth _____ **Male / Female**
Social security number _____ Home phone number _____
Home address _____
City _____State_____Zip Code_____
If your child attends school, where _____ Grade _____
Child's physician or pediatrician _____ Phone number _____
Siblings? If yes, please list name and age _____
Sometimes we make conversation with children by talking about upcoming holidays, cartoon characters, tooth fairy, etc. Is this okay with you? Yes _____ No _____
Is there a favorite something we can talk to your child about? _____

Parent Information

Parent#1 Name (First)_____ (Middle Initial)_____(Last)_____
Parent #1 Date of birth_____ Social Security #_____Mobile Number_____
Parent#1 Occupation _____Employer _____ Work phone # _____
Parent#2 Name (First)_____ (Middle Initial)_____(Last) _____
Parent #2 Date of birth _____ Social Security #_____ Mobile Number_____
Parent#2 occupation _____ Employer _____ Work phone number _____
Phone number to text confirming appointments _____and Email address _____
Who referred you to our office? _____ Family dentist name _____

Financial Information

Person responsible for child's account _____ Relation to child _____
Does the patient have dental insurance? Yes _____ No _____

I have provided dental insurance: Yes _____ No _____

Our office is not part of any private pay dental networks. Most insurance plans have out of network benefits that can be used for treatment in our office. Please check with your insurance plan administrator for more details. During your visit we will only collect what we estimate your insurance will not pay. Actual insurance reimbursement may vary from our estimate. You are responsible for the full balance on your account. In the case of divorce or separation the parent that brings the child in for the visit is responsible for payment at the time of the visit. Please see our insurance specialist or business manager with any questions. ***I have read and understand this insurance policy. I also hereby authorize my insurance company to send payments directly to Blue Water Pediatric Dentistry and understand that I am responsible for all remaining balances.***

X_____ _____
Signature Date

First Visit Expectations

Reason for visit _____
Is this your child's first dental visit? Yes or No If no, when was last visit? _____
Has your child had dental x-rays in the past six months? Yes or No
Who was your child's last dentist? _____
What is your main concern about your child's dental health? _____
Has your child ever complained about a dental problem, or had any unhappy dental experiences? Yes or No
If yes, please explain. _____
Is your child presently having any dental problems? Yes or No If yes, please explain. _____
_____
Do you have any other comments regarding your first visit here? _____

Medical History

Circle the answer that applies or fill in the blanks as needed.

Yes	*No*	Allergies to food or drugs _____	*Yes*	*No*	Headaches
Yes	*No*	Seasonal allergies	*Yes*	*No*	Kidney, GI or liver disease
Yes	*No*	Anemia	*Yes*	*No*	Lung or breathing problems
Yes	*No*	Asthma	*Yes*	*No*	Mental disorder
Yes	*No*	Bleeding disorder	*Yes*	*No*	Rheumatic fever
Yes	*No*	Cerebral Palsy	*Yes*	*No*	Seizures
Yes	*No*	Diabetes	*Yes*	*No*	Speech disorder
Yes	*No*	Epilepsy	*Yes*	*No*	Tonsil or adenoid problems
Yes	*No*	Frequent infections	*Yes*	*No*	Snoring
Yes	*No*	Hearing disorder	*Yes*	*No*	Congenital birth defects
Yes	*No*	Behavioral or learning problems	*Yes*	*No*	Mental or physical delays
Yes	*No*	Endocrine problems	*Yes*	*No*	Problems with sight
Yes	*No*	Cancer	*Yes*	*No*	Diseases of blood
Yes	*No*	Allergy to wool or lanolin	*Yes*	*No*	Blood transfusion
Yes	***No***	**Heart problems (including heart murmur)**	***Yes***	***No***	**Immunizations current**
Yes	***No***	**Latex allergy (reaction to balloons, pacifiers or any rubber goods). If yes, please explain** _____			

Yes *No* Any other medical issues. If yes, please describe _____

Yes *No* Hospitalized. If yes, please describe _____

Yes *No* Any family members have any of the problems listed above. If yes, please describe (and include the relationship to child) _____

Yes *No* I would consider my child to be in good health. If no, please explain _____

Yes *No* I expect my child to cooperate for dental treatment.

Please list any medications / Vitamin's (including dosage and frequency) your child takes _____

Please list any drugs that have caused adverse reactions in your child _____

Is there any other information that you feel might be of value to us in treating your child? _____

Dental History

Please be specific when marking the following information about your child. Circle the answer that applies or fill in the blanks as needed.

Yes	*No*	TMJ/TMD (clicking or "popping" in the jaw)	*Yes*	*No*	City water
Yes	*No*	Finger habit	*Yes*	*No*	Fluoride supplement dosage _____
Yes	*No*	Thumb habit	*Yes*	*No*	Fluoridated toothpaste
Yes	*No*	Other habit (_____)	*Yes*	*No*	Breastfed when stopped _____
Yes	*No*	Nail biting	*Yes*	*No*	Bottle when stopped _____
Yes	*No*	Mouth breathing	*Yes*	*No*	Pacifier when stopped _____
Yes	*No*	Has your child ever worn an orthodontic appliance?	*Yes*	*No*	Is your child assisted in brushing?
Yes	*No*	Has your child received any fluoride treatments?	*Yes*	*No*	Is your child assisted in flossing?
Yes	*No*	Does your child get "cold sores" or "fever blisters"?	*Yes*	*No*	Are disclosing solutions used?
Yes	*No*	Has your child inherited any dental conditions?			How often are your child's teeth brushed? _____
Yes	*No*	Does anyone in the family have missing teeth?			How often are your child's teeth flossed? _____
Yes	*No*	Does anyone in the family get "cold sores" or "fever blisters"?			

Yes *No* Has your child ever had a dental injury (bumped or chipped tooth, bruised lip, etc.)? If so, please explain _____

Is there any other information you would like us to know prior to your child's visit? _____

The information listed on both sides of this form is complete and accurate. I give consent for Dr. Lee or Dr. Davis, associates and staff to perform a dental examination, dental prophylaxis, fluoride treatment and take x-rays on my child.

X _____ _____

Parent or Guardian Date

Dentist notes: _____

Blue Water Pediatric Dentistry • 345 Earnie Ln, Holly Springs, NC 27540 • Tel: 919-762-7013 • Fax: 919-400-4323
info@BlueWaterPediatricDentistry.com

Olen Ben Davis, DDS
Board Certified Pediatric Dentist
Boo Lee, DDS
Board Certified Pediatric Dentist

345 Earnie Ln
Holly Springs, NC 27540
Telephone: 919.762.7013
www.bluewaterpediatricdentisry.com

A LEGAL GUARDIAN FOR THE CHILD MUST COMPLETE THIS FORM.

REQUEST AND CONSENT FOR DENTAL TREATMENT

Please read this form *carefully*. If you do not understand something to your satisfaction, please ask questions. We will be pleased to explain it.

1. I request and authorize the dental treatment by Blue Water Pediatric Dentistry Associates and staff.

   Patient Name: _____

2. I am the **legal guardian** of the child named above. _____(**Initials**)

3. I further request and authorize the taking of dental x-rays and the use of such anesthetics as may be considered necessary to treat my child's dental need(s).

4. Drs. Davis and/or Lee, Associates and staff, will have sufficient opportunity to discuss the patient's dental condition/problem(s), the planned procedures and treatment, and the benefits to be reasonably expected from this treatment plan, compared with alternative approaches and/or no treatment.

5. It is unusual for any of the following risks or complications to occur. These risks or complications include but are not limited to, the possibility of pain or discomfort during the treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of a temporomandibular joint disorder, temporary or permanent numbness, and allergic reactions.

6. **I understand** that during the course of the patient's dental treatment, something unexpected may arise that may necessitate procedures in addition to or different from those listed on the patient's treatment plan and that I will be consulted *prior to initiation of treatment procedures* not listed. I am aware that the practice of dentistry is not an exact science and acknowledge that no guarantees have been made to me concerning the results of the dental treatment that the patient receives in our office.

7. **I understand** it is the goal of this dental office to accomplish dental treatment by the use of warmth, friendliness, persuasion, humor, charm, gentleness and kindness and understanding. **I understand** that treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Behavior will be guided using praise, explanation and demonstration of procedures and instruments, using variable voice tone and loudness.

8. **I understand** that should the patient become uncooperative during dental procedures with movement of the head, arms and/or legs, dental treatment cannot be safely provided. During such disruptive behavior, it may be necessary for the assistant(s) and or doctor to hold the patient's hands, stabilize the head and/or control leg movements for their safety. I also understand the routine use of "tooth pillows" (mouth props) may be necessary to be sure a child does not accidentally close their teeth while an instrument is in their mouth that could harm them. I also understand that mouth props are sometimes necessary if a child refuses to open their mouth.

OVER PLEASE!

_____
Initials

9. **I understand** that it is not an uncommon response for children to cry before or during dental treatment or directly afterward when they see their parent. **I understand** the only way I can guarantee my child will not cry or be unhappy during dental treatment is if I elect to have their treatment completed in the operating room under general anesthesia. I also know conscious sedation is an option for some children.

10. **I further understand** that should the patient become uncooperative during dental procedures with excessive body movements, the patient may need to be wrapped in a "hug blanket" called a pediwrap to prevent injury and enable Blue Water Pediatric Dentistry to safely provide the necessary treatment. *I will be consulted prior to the use of the pediwrap.*

11. For the purpose of advancing medical-dental education, I give permission for the use of clinical photographs of the patient for diagnostic, scientific, educational or research purposes.

12. All of my questions have been answered to my satisfaction and I consent to the treatment and procedures prescribed for the patient on the treatment plan.

13. **I understand** that I may revoke this consent to treatment at any time and that no further action based on this consent will be initiated except to the extent that treatment and procedures have already been performed or initiated.

14. **I confirm** that I am a legal guardian to the child referenced on the opposite page. **I also confirm** that I have read and understand this form or it was read to me, and that all blanks were filled in and all inapplicable paragraphs, if any, were stricken before I signed below.

X

Signature of Person Consenting to Treatment **Date**

Signature of Doctor Date

Witness Certification Date

Do not complete the information below unless requested to do so by doctors or staff of Dr. O. Ben Davis, DDS, or Dr. Boo Lee, DDS.

I give consent for the use of immobilization of my child by use of a pediwrap. All my questions have been answered concerning this method of immobilization.

X

Signature of Person Consenting to Treatment **Date**

Signature of Doctor Date

Witness Certification Date

Olen Ben Davis, DDS
Board Certified Pediatric Dentist
Boo Lee, DDS
Board Certified Pediatric Dentist

345 Earnie Ln
Holly Springs, NC 27540
Telephone: 919.762.7013
www.bluewaterpediatricdentisry.com

Authorization for Release of Information

Name of Patient _____ **Date of Birth** _____

Blue Water Pediatric Dentistry is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
❑ Parents (provide names) _____ Voice Mail ❑	❑ Results of lab tests/x-rays ❑ Financial ❑ Medical
❑ Step-Parent (provide name)_____ Voice Mail ❑	❑ Financial ❑ Medical as follows:_____
❑ Grand-Parents (provide names)_____ Voice Mail ❑	❑ Financial ❑ Medical as follows:_____
❑ Other (provide name) _____ Voice Mail ❑	❑ Financial ❑ Medical as follows _____

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the parent or guardian.

X_____Date_____

Signature of Parent, Guardian or Personal Representative

Description of Personal Representative's Authority (attach necessary documentation)

_____

Olen Ben Davis, DDS
Board Certified Pediatric Dentist
Boo Lee, DDS
Board Certified Pediatric Dentist

345 Earnie Ln
Holly Springs, NC 27540
Telephone: 919.762.7013
www.bluewaterpediatricdentisry.com

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I have received this office's Notice of Privacy Practices. Specifically I understand that my protected health information will be used to:

- Conduct, plan and direct my (or my child's) treatment and follow-up among other healthcare providers who may be involved in that treatment
- Obtain payment (e.g. insurance companies, collection agencies, check processing companies)
- Conduct normal healthcare operations such as quality assessment

I also understand that the usual business practice of this office is to use an open bay for most treatment, to send recall postcards for six-month appointments, and to call to confirm appointments two days prior to most appointments. Please check the appropriate boxes below if you want something other than our usual business practice:

☐ Do not use an open bay for patient treatment. Schedule all appointments for the VIP room. I understand that this may limit my ability to schedule appointments as there is only one private treatment room in this office.

☐ Do not send recall postcards. I understand that missing appointments may result in dismissal from the office.

☐ Do not call to confirm appointments. I understand that missing appointments may result in dismissal from the office.

☐ Do not Email to confirm appointments. I understand that missing appointments may result in dismissal from the office.

Patient Name: _____

Print Your Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

FOR OFFICE USE ONLY

I attempted to obtain the patient's (or parent's) signature in acknowledgement of this Notice of Privacy Practices, but was unable to do so as documented.

☐ Patient or parent was given notice, but forgot to sign before leaving the office.
☐ Patient or parent refused to sign.
☐ Notice was mailed to patient or parent.

Staff Member: _____ Date: _____

Olen Ben Davis, DDS
Board Certified Pediatric Dentist
Boo Lee, DDS
Board Certified Pediatric Dentist

345 Earnie Ln
Holly Springs, NC 27540
Telephone: 919.762.7013
www.bluewaterpediatricdentisry.com

OFFICE SCHEDULING POLICY

We request that you contact us **AT LEAST 24 HOURS PRIOR TO YOUR APPOINTMENT** in order to cancel or reschedule any appointment.

- If you miss an appointment, there is a $25 fee.
- If a second appointment is missed, your child and/or family may be dismissed from our office.
- *Please note that each child's appointment is counted as a separate appointment.*

If you arrive over 15 minutes late to your child's appointment you maybe asked to reschedule as the delay affects not only the physician, but other patients scheduled after you.

You are required to bring the patient's most current insurance card to **every** appointment.

I have read the above statement and agree to comply by this policy, understanding that if my child misses an appointment I will be responsible for any fees accrued. These fees must be paid before next services can be completed.

Child(ren)'s Name(s): _____

Parent/Guardian's signature	DATE	Print Name	DATE
Witness Signature	DATE	Print Witness Name	DATE