Talia Pike DMD

Patient Information

Patient Name_____ Nickname_____
Birthdate_____ Age____ Sex_____
Address_____ Apt/Suite#_____
City_____ State_____ Zip_____ Home #_____
School/Grade_____

Parent Name_____ Birthdate_____
Employer_____ SSN: _____
Work #_____ Cell #_____
Email Address_____

Parent Name_____ Birthdate_____
Employer_____ SSN: _____
Work #_____ Cell #_____
Email Address_____

How did you hear about our office?_____
Is it ok to leave messages regarding confirming appointments, insurance questions, etc?_____
What is the reason for your child's visit today?_____

Dental Insurance Information (please fill out ONLY if insurance card not present)

Primary Policy Holder Name_____ Birthdate_____
SSN#_____

Employer's Name & Address _____
_____
_____

Insurance Name & Address _____
_____
_____

ID #_____Group #_____

I authorize my insurance to pay directly to Dr. Pike if my insurance plan is taken by Dr. Pike. If I am covered by any other plan, I will pay in full when services are rendered. I understand that all insurance policies are different and I am responsible for knowing my plan provisions. I understand I will be responsible for all co-payments, deductibles and any charges that are denied by my insurance plan.

Signature of Parent/Guardian:_____ Date:_____

2201 NW Corporate Blvd., Suite 103 Boca Raton, FL 33431
Phone: 561-347-7006 Fax: 561-347-7008
www.pikepediatricdentistry.com

Pike Pediatric
DENTISTRY

Health History

yes no Is your child in good health?
Child's doctor_____

yes no Has your child ever had a health problem?
If yes, please explain_____

yes no Are your child's immunizations up to date?

yes no Has your child had any operations?
If yes, please explain_____

yes no Is your child currently taking any medications?
If yes, please list_____

yes no Does your child have any known allergies?
If yes, please list_____

Please circle if your child has ever been diagnosed with or treated for any of the following:

ADD/ADHD	Cancer/Tumors	Heart Condition/Murmur	Psychiatric Care
AIDS/HIV	Cerebral Palsy	Hepatitis	Rheumatic Fever
Anemia	Cleft Lip/Palate	Kidney Disease	Sinus Problems
Asthma	Diabetes	Liver Disease	Social Delays
Autism	Epilepsy/Seizures/Convulsions	Mental Delays	Speech/Hearing Problems
Birth Defects	Excessive Bleeding	Measles	Stomach/GI Disease
Bladder Problems	Fainting	Mumps	Tuberculosis
Blood Disorder/Transfusion	Frequent Headaches	Physical Delays	Other

Please describe anything circled above_____

Any habits? (finger/thumb sucking, pacifier use, biting nails, etc.)_____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform Pike Pediatric Dentistry if my child ever has a change in health.

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Dental History

yes no Has your child ever been to the dentist?
Date of last visit_____
Name of previous dentist_____

yes no Has your child ever had dental x-rays?

yes no Do you think your child will react well to dental treatment?
If not, please explain_____

yes no Does your child use fluoride toothpaste?

yes no Do you give your child any fluoride supplements?

yes no Have your child's teeth ever been injured?
If yes, when?_____

How many times a day are your child's teeth brushed? _____

How many times a week are your child's teeth flossed? _____

Please circle if your child has any of the following:

Cavities	Gum Infection	Sensitive Teeth
Braces	Discolored Teeth	Jaw Sounds
Toothache	Grinding	Loose Teeth

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform Pike Pediatric Dentistry if my child ever has a change in health.

Signature of Parent/Guardian:_____ Date:_____

Consent for Dental Treatment

I request and authorize Dr. Pike and her staff to examine and provide my child with comprehensive dental treatment including, but not limited to cleanings, fillings, crowns, extractions, and nitrous oxide, if required. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Pike to diagnose and/or treat my child's dental condition. I understand that I will be responsible for any charges incurred on this child for dental treatment. I will allow photographs to be taken of my child and/or my child's teeth for diagnostic or educational purposes. 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. Dr. Pike will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone.

Signature of Parent/Guardian:_____Date:_____

Non-Guardian Consent

I give my permission for the following person(s) to accompany my child to his/her dental visits. All person(s) listed below must be over the age of 18. This includes making decisions regarding treatment that may arise during the scheduled appointment. This also gives Dr. Pike and her staff permission to discuss treatment and conditions with the person(s) listed below. I understand that I am responsible for payment at the time of services and should someone accompany my child other than myself, arrangements for payment must be made **before the scheduled appointment time.**

Name	Relationship to child
_____	_____
_____	_____

Signature of Parent/Guardian: _____ Date:_____

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DENTISTRY

Financial Policy

Please understand that financial arrangements are made directly with you. For your convenience, the following outlines our financial policies:

1. **Payment is due in full** for each appointment as services are rendered and is to be paid by the person accompanying the child. We accept cash, MasterCard, Visa, Discover and Care Credit. You will be responsible for payment of all costs and fees incurred, including attorney's fees, should collection efforts be made in order to fulfill a debt.

2. **Dental Insurance:** Please check with our staff to make sure that we accept your child's insurance plan. For all insurances that we do not accept, we will be happy to submit a claim to your insurance electronically, however payment is due in full at time of service. The type of plan chosen by you and/or your employer determines your insurance benefits. As such, we have no control over the terms of your contract, the method of reimbursement or the determination of your insurance benefits. Any reimbursements by your insurance company other than those we directly participate with should be made directly to you according to the terms of your contract with them.

3. **Pre-treatment Authorization:** Some insurance companies recommend an estimate of the work to be done and the fees to be charged before determining their benefits to you. If so, we will provide you with the pre-treatment fee estimate. In this case, it will be up to you to determine if you wish to proceed with the treatment before the insurance benefit is determined.

4. **Fillings:** Our dental material of choice is a white (composite resin) filling. Please be aware that your insurance company may not pay for a resin filling at the same level as a silver (amalgam) filling. The co-payment is your responsibility. In some cases, Dr. Pike may recommend placing a silver crown instead of a resin filling.

5. **Nitrous Oxide / Analgesia:** Our office uses Nitrous Oxide Analgesia (Laughing Gas) for the comfort of our young patients. This fee is not always covered by dental insurance. We thank you for your payment on the date of service.

6. **Appliances:** The entire cost of the appliance must be paid on the day your child's impressions are taken. This is necessary because our office must pay the laboratory bills when appliances are ordered, not when they are completed.

7. **Emergency Treatment:** All emergency treatment must be paid in full at the time the service is rendered.

Please remember, even if you have insurance coverage, **you are responsible for payment of your account.** *Understand 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. Past due accounts are subject to a monthly service charge and will be turned over for collection by an outside agency .If your account is turned over to a collection agency, all court costs and attorney fees will be applied.* ***I have read and understand my obligation.***

Signature of Parent/Guardian: _____ Date:_____

Notice of Privacy Practices-HIPAA

I had the opportunity to read over the HIPAA guidelines and ask any questions that I had regarding HIPAA.

Signature of Parent/Guardian:_____Date:_____

Office Policies

The office attempts to schedule appointments at your convenience and when time is available. If your child is under the age of 5, we recommend that you schedule a morning appointment for your child. Younger children are more cooperative when they are well rested.

Since appointed times are reserved exclusively for each child, we ask that you please notify our office 24 business hours in advance of your scheduled appointment time if you are unable to keep your appointment. We realize that unexpected things can occur, but we ask for your assistance in this regard. If your child misses an appointment without notifying us 24 business hours in advance, a cancellation fee will be applied to your account. This fee will vary depending on the length of time reserved for your child. We try our best to accommodate our patients, so please be courteous and let us know if you cannot make it to your child's scheduled appointment. As a courtesy, our office calls to confirm all scheduled appointments.

We kindly ask that **only 1** (one) parent &/or guardian accompanies the child in the treatment room for any dental treatment needed (ex. fillings, extractions etc.). Siblings are **not** permitted to sit on their parent's lap.

I have read and understand the Office Policies and agree to abide by its contents:

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Consent for Attempted Treatment

To all patients where treatment is attempted, but not completed due to lack of cooperation or other unforeseen circumstances, a fee based upon time and materials used will be charged (ex. chair time, nitrous oxide, local anesthesia). Please understand that time was set aside for your child in order for treatment to be performed. If your child is uncooperative, we reserve the right to charge for our time and materials used/opened. Thank you for understanding!

Attempt Treatment (chair time for treatment) (DATTX)	$50.00
Nitrous Oxide (D9230)	$75.00
Temporary Filling (in case treatment is started, but cannot be completed) (D2940)	$85.00

*Please note: if the patient has insurance, the temporary filling (D2940) will be billed out and **may** be covered. Co-insurance deductible and co-pay will apply. In some instances, nitrous oxide (D9230) **may** also be covered. IF YOU DECIDE TO CHOOSE IV TREATMENT IN OUR OFFICE, WE WILL PUT THESE CHARGES PAID TOWARD THE IV TREATMENT.

Signature of Parent/Guardian: _____ Date:_____

Confirmation of Appointments

We have an automated system that confirms appointments by email and text. If the appointment is not confirmed, the office will also attempt to call you to confirm the appointment.

EMAIL
Address: _____@_____.com

TEXT
Best number to text: _____

PHONE CALL
Best number to call: _____

Updated address (if moved): _____
_____
_____