www.ZPD4KIDS.com

Consent to Communicate to Non-Parent

It is Patient/Parent's request that the practice communicate with a family representative on behalf of the parents/guardians

Patient Name (print):____

Patient Name (print):____

The following person(s) may attend visits and receive information regarding: check all that apply

◯ Treatment scheduled to be performed

◯ Future treatment planned for the above named child or children

Person Authorized_____________________________Relationship__________

Person Authorized_____________________________Relationship__________

◯ This authorization only valid for ______________________Date(s) of Service

◯ This authorization valid for any dates of service

Signature of Patient/Parent:_________________________ Date:__________

Relationship to the Patient:____

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55 Brendon Way, Suite 500 Zionsville, IN 46077 317.873.4186

Dr. Melissa McHenry DDS, MSD
55 Brendon Way, Suite 500
Zionsville, IN 46077
(317)873-4186

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

For the office of
ZIONSVILLE PEDIATRIC DENTISTRY
"You may refuse to sign this acknowledgement"

I, ______________________________, have received a copy of this office's Notice of Privacy Practices.

____
(Please Print Name)

____
(Signature)

____
(Date)

For 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
- Communication barriers prohibited the acknowledgment
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify)

____

____

____

____

Date:________________

Dr. Melissa McHenry DDS, MSD
55 Brendon Way, Suite 500
Zionsville, IN 46077
(317)873-4186

Tell Us About Your Child

Child's Name:______________________________Date of Birth:__________ Sex: M / F

______________________ ____________________ ______ ________
Street Address City State Zip

Home Phone:________________________

Nickname: ____________________ School:______________________________Grade: ______

Who is Accompanying the Child Today?

Name: ______________________________ Relation:________________________

Do you have legal custody of the child? Yes / No

Is the child adopted? Yes / No

Is the child in a foster home? Yes / No

Whom may we thank for referring you?______________________________________

Other siblIng(s) seen by us?____

Parents

Parent's Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Remarried ☐ Single

Mother

Name: ____Home Phone:__________________

______________________ ____________________ ______ ________
Street Address City State Zip

Social Security#: __________________________ Date of Birth:______________________

Employer: _______________________________ Work Phone #:______________________

Father

Name: ____Home Phone:__________________

______________________ ____________________ ______ ________
Street Address City State Zip

Social Security#: __________________________ Date of Birth:______________________

Employer: _______________________________ Work Phone #:______________________

Insurance Information

PRIMARY COVERAGE

Dental Coverage Yes / No Orthodontic Coverage Yes / No

Name of Insured: _________________________ Relation to Child:_________________

Social Security Number of Insured: ____________________ Date of Birth:_____________

Employer Name: __________________________Address:_________________________

Insurance Co. Name:___________________________ Phone#:____________________

Insurance Co. Address:____

Street *City* *State* *Zip*

Group I.D. #:______________________________

SECONDARY COVERAGE

Dental Coverage Yes / No Orthodontic Coverage Yes / No

Name of Insured: _________________________ Relation to Child:_________________

Social Security Number of Insured: ____________________ Date of Birth:_____________

Employer Name: __________________________Address:_________________________

Insurance Co. Name:___________________________ Phone#:____________________

Insurance Co. Address:____

Street *City* *State* *Zip*

Group I.D. #:__________________________________

Dental History

What is the primary reason for today's visit?______________________________

Is the child in pain? Yes / No

Previous / Present Dentist: ______________ Date of last visit: ________ Date of last x-rays? ________

Why did you leave your previous Dentist?______________________________

What did you like most about your previous Dentist? ______________Least?______________

Was the previous dental experience positive or negative? Explain:______________________

Is the primary source of water consumed by the child fluoridated? Yes / No

Is (was) the child breast-fed or bottlefed? ______________Until what age? ____________

How often does your child brush their teeth? Once or twice daily? ______

How often does your child floss? Zero or Once Daily? ______

Does your child: *(circle if yes)*

Suck Thumb / Finger	Tongue Thrust	Use Pacifier
Suck / Bite Lips	Bite / Chew Nails	Have Speech Problems or Impairment
History of Traumatic Injury	Tongue / Cheek Chewing	Clench / Grind Teeth
Mouth Breathe	History of T MJ/TMD	

Medical History

Are Immunizations Current? Yes / No

Child's Physician: ______________ Phone: (___) _______ Date Last Seen: __________

Address:____

Street *City* *State* *Zip*

Is the child currently under the care of a physician? Yes / No Please explain?____________

Please list all medications that your child is currently taking: ______________________

Please list all drug allergies and/or other reactions: ______________________________

Has the child had the following: *(circle if yes)*

Sickle Cell, Carrier or Trait?	Abdominal Bleeding/Hemophilia	AIDS / HIV+
Allergies / Latex Allergy	Anemia	Hospital Stays / Operations
Asthma/Lung Problems	Blood Transfusions	Cancer/Tumor
Cerebral Palsy	Congenital HearUBirth Defect	Convulsions/Seizures/Epilepsy
Cystic Fibrosis	Diabetes	Eating Disorder
Frequent Infections	Hearing/Sight Impairments	Heart Murmur
GI System Problems	Hepatitis/Liver Problems	Hives
Kidney Problems	Behavioral/Learning Problems	Tonsillitis
Tuberculosis (TB)		

If yes, to any. please explain:____

Financial Policy

PAYMENT IS DUE AT THE TIME OF SERVICE - The full balance of treatment is due at the time service is rendered. Payment plans are not available from our office. For your convenience we accept cash, check, Care Credit, Master Card, and Visa.

Assignment of Dental Insurance Benefits. Our office files insurance benefits as a courtesy. Claims unpaid by your insurance co. after 60 days are your responsibili ty and will be due in full. All deductibles, co-payments. and non-covered fees are due at the time of service. A CURRENT copy of your insurance card must be kept on file to utilize this service. Our office reserves the right to discontinue and I or refuse to file claims.

Service Charges - A rebilling fee of $3.00 may be applied to accounts with balances unpaid within 30 days of the statement date. A $25.00 fee will apply to all returned checks. A fee of $25.00 will be charged for appointments cancelled with less than 24 hours notice. Our office reserves the right to pursue any other remedy by law.

Delinquent Accounts - Account balances that exceed 90 days may be pursued through third party collections. All expenses incurred in the collection process will be the account holder's responsibility. Delinquent accounts will incur a charge of 8% interest.

How will you be paying?: CASH / CHECK / MASTER CARD / VISA / CARE CREDIT

Circle One

Authorizations

I affirm that the information I have given is correct to the best of my knowledge. II will be held in confidence and it is my responsibility to inform this office of changes in my child's medical status. I authorize the dental staff to perform all necessary dental treatment my child may need. I authorize the release of all information necessary to secure benefits otherwise payable to me. I assign directly to Zionsville Pediatric Dentistry, P.C. all insurance payments otherwise payable to me. I understand that I am responsible for the full balance, including but not limited to third party collection fees, court filing fees and attorney fees. I affirm that my signature represents my agreement to all the above mentioned terms.

Mother

______________________________ ______________

Signature of Parent or Guardian *Date*

Father

______________________________ ______________

Signature of Parent or Guardian *Date*

2.22.3 Agreement to Receive Electronic Communication

Patient Name: ________________________________ Date of Birth:______________
Patient Name: ________________________________ Date of Birth:______________
Patient Name: ________________________________ Date of Birth:______________
Patient Name: ________________________________ Date of Birth:______________

I agree that the dental practice may communicate with me electronically at the email or text address below.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails.

I am responsible for providing the dental practice any updates to my email address.

I can withdraw my consent to electronic communications by calling:

Privacy Official: Janice VanGorder
Address: ZIONSVILLE PEDIATRIC DENTISTRY
55 Brendon Way, Suite 500, Zionsville, IN 46077
Telephone Number: **317-873-4186**

Email Address (PLEASE PRINT CLEARLY):
____@________________________

Cell Phone____

Patient Signature:____

Date:______________________

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