MEDICAL HISTORY UPDATE

Child's Full Name: _____ Date of birth: _____/_____/_____

Home Address: _____

Telephone Number: _____

Email Address: _____

Name of Dental Insurance: _____

Subscriber's Name/D.O.B. _____

Subscriber's Social Security Number or Member ID: _____

CHECK ONE:

☐ There have NOT been any significant changes in my child's health since their last dental visit.

☐ There HAVE BEEN changes in my child's health, new diagnoses, and/or new medications since their last regular dental check-up.

Please list any changes in health or new medications below.

_____

_____

_____

_____

Parent or Legal Guardian's Name Printed

_____

Parent or Legal Guardian's Signature Date

Financial Policy:

Payment Policy:

The parent or guardian who brings the child to their visit is responsible for payment.

Payment is due at time of service. This includes any co-pays or deductibles or any fee that may not be covered by insurance.

We accept: Visa, Master Card, American Express, Discover, debit cards, and cash.

- There will be a $25 charge for any returned checks

We also accept Care Credit as a way to help finance your child's dental needs.

We are in network with many insurance providers. We will always do our best to give you the most accurate estimate before each appointment so that there are no surprises. In order to facilitate this, we request that **ALL** information is submitted to the insurance company and provided to SIPD prior to your appointment. In such cases when accurate documentation is not provided, you will be responsible for all charges.

If you happen to be out of network, most likely there are still benefits to you. For your convenience, our business staff will file the insurance claim for you.

Cancellation/No-Show Policy:

$25 charge for less than 24 hours' notice and for no show checkup hygiene appointments

$100 charge for less than 24 hours' notice and for no show treatment appointments

We kindly request 2 working-days' notice to cancel or change appointment times. We understand that unforeseen circumstances can arise.

Late afternoon appointments are highly requested, if you miss (or late cancel) one of these appointment times you may not be allowed to schedule late afternoon appointments in the future.

We would be happy to answer any questions that you may have regarding our payment/No-Show policy. Any questions should be directed to our Operations Manager Ashley Moorman.

I have read and understand the Payment Policy of Southern Illinois Pediatric Dentistry and any questions that I have had have been answered to my satisfaction.

Print Name

Parent or Legal Guardian's Signature Date

• SOUTHERN ILLINOIS •
Pediatric Dentistry

DESIGNATION OF AUTHORIZED ADULT REPRESENTATIVE(S) AND HIPAA RELEASE

In my absence, I do hereby give permission to the following individual(s) to bring my child or children to Southern Illinois Pediatric Dentistry to seek dental care and release dental information. This includes account information, outstanding or current treatment and or upcoming appointment dates/times.

Any of the areas being released that should *not* be, please notify the office and describe restrictions below:

_____

Patient name: _____ D.O.B.: _____

Name	Relationship to child	Phone

I understand that care will be provided by the hygienists and the dentist, including administration of treatment or antibiotics as deemed necessary by the dentist at the time. I will make every effort to call Southern IL Pediatric Dentistry office with any questions I have about my child's care following any visit I am not present. I understand that until I provide written notice to the practice of any changes to the designation of authorized adult representatives, Southern IL Pediatric Dentistry may rely on the consent to provided herein.

I authorize the release of my child or children's confidential protected dental information. I understand that this authorization is voluntary and that the information to be disclosed is protected by law. The information that is used and or disclosed associated to this authorization may be redisclosed by the recipient unless the recipient is covered by state laws that limit the use or disclosure of my confidential protected dental information.

Print Name Relationship to patient

Parent or Legal Guardian's Signature Date

NITROUS OXIDE INFORMED CONSENT

I hereby authorize Southern Illinois Pediatric Dentistry to administer nitrous oxide for my child:

_____

(child's name)

1. I accept and understand that nitrous oxide (commonly referred to as "laughing gas") provides relaxation and reduction in anxiety.
2. I accept and understand that nitrous oxide is an elective procedure and is not required for the necessary dental treatment. However, other alternatives that may be required to safely and adequately complete the necessary dental procedure(s) include restraint (papoose board) or general anesthesia.
3. Please advise the doctor and staff of your child's complete medical history, including any surgeries. Advise them of any changes in your child's medical history including if your child is currently ill.
4. Nitrous oxide is useful not only for anxiety control, but can also be effective in controlling some mild to moderate gag-reflexes.
5. Nitrous oxide can have some (temporary) side effects including, but not limited to:
    a. Nausea and vomiting- although very rare, it may occur. It is not necessary to avoid eating leading up to the procedure, but would not be advisable for eating a large meal immediately before the procedure. Remember that your child will likely be numb for 1-2 hours following the procedure and will be unable to chew any food during that time.
    b. Tingling of fingers and toes
    c. Feeling of warmth throughout the body
    d. Feeling of euphoria/uncontrollable laughing
6. Nitrous oxide is very effective for many children. However, it does not guarantee successful completion of all dental treatment if the child remains too active throughout the procedure.

I hereby certify that I understand this authorization and the reasons for the use of nitrous. I acknowledge that every effort will be made to ensure a positive outcome for my child's dental treatment. I further acknowledge that I have had the opportunity to discuss the use of nitrous oxide and that all questions have been answered to my satisfaction.

Date Parent/Guardian Signature

Date Witness