

**Southern Illinois Pediatric Dentistry of Edwardsville
New Patient Form**

Patient (Child) Information:

Name: _____ D.O.B.: _____
First M.I. Last

Address: _____
City, State, Zip

Responsible Party (Parent/Legal Guardian) Information:

Name: _____ D.O.B.: _____

Relationship to patient: _____ Home Phone: _____

Address: _____ Cell Phone: _____

Email: _____

Spouse's name: _____

Whom may we thank for referring you: _____

Emergency Contact: _____ Phone: _____

Insurance Information:

Name of Insured: _____ D.O.B.: _____

Relationship to patient: _____ SSN: _____

Insurance Company: _____

Policy #: _____ Group #: _____

Insurance Telephone #: _____

Employer Name: _____

IF YOU HAVE SECONDARY INSURANCE - PLEASE INFORM THE FRONT DESK

*We do **NOT** accept Medicaid as secondary insurance*

Parent or Legal Guardian's Signature Date

**Southern Illinois Pediatric Dentistry of Edwardsville
New Patient Medical & Dental History**

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

Gender: M / F Height: _____ Weight: _____ Date of last physical exam: _____ / _____ / _____

Name/Address/Phone # of Primary Physician: _____

Name/Address/Phone # of Medical Specialist: _____

Is your child being treated by a physician at this time? Reason: _____ YES / NO

Is your child taking any medication, Vitamins or supplements? (Prescription or over the counter) YES / NO

List name, dose & date started: _____

Has your child ever been hospitalized, had surgery or been treated in the ER? YES / NO

List date & Describe: _____

Has your child ever had a problem with an anesthetic? Describe _____ YES / NO

Has your child ever had a reaction or allergy to an antibiotic or medication? List: _____ YES / NO

Is your child allergic to latex or anything else such as metals, acrylic etc.? List: _____ YES / NO

Is your child up to date on immunizations against childhood diseases? YES / NO

Please mark YES or NO for the following medical conditions:

Abnormal bleeding/ Hemophilia	YES / NO	Heart Murmur	YES / NO
Anemia	YES / NO	Hepatitis / Liver Problems	YES / NO
Asthma	YES / NO	Hydrocephaly / Shunt Problems	YES / NO
Autism	YES / NO	Hypertension	YES / NO
Complications at birth	YES / NO	HIV / AIDS	YES / NO
Cancer	YES / NO	Kidney / Bladder Problems	YES / NO
Congenital Heart Defects	YES / NO	Neurological Disorder	YES / NO
Cystic Fibrosis	YES / NO	Pneumonia	YES / NO
Developmental Disorders	YES / NO	Seizures	YES / NO
Gastroesophageal / Acid Reflux	YES / NO	Sinus Problems	YES / NO

Please list any other medical considerations our office should be aware of: _____

DENTAL HISTORY

Has your child ever been to the dentist? YES / NO

Do you help your child brush & floss? YES / NO

Has your child ever had a bad experience at the dentist? Explain: _____ YES / NO

Does your child use a mouth rinse? What kind: _____ YES / NO

Does your child brush with fluoridated toothpaste? How often: _____ YES / NO

Does your child floss? How often: _____ YES / NO

- Cavities Toothache Sensitive Teeth Trauma
 Color of Teeth Orthodontics Jaw Sounds Gum Infection Other: _____

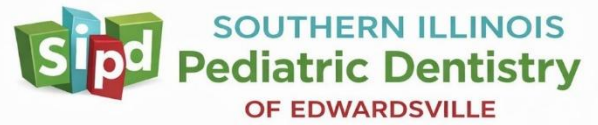
Parent or Legal Guardian Signature

Date

Doctor Signature

Date

**Southern Illinois Pediatric Dentistry of Edwardsville
Guardianship Form**



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 with 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 _____

TO DENY PERMISSION - CHECK BELOW & SIGN

I do hereby **DENY** permission for anyone other than a **parent or legal guardian** to bring my child to Southern Illinois Pediatric Dentistry for dental treatment and/or to receive or release dental information.

Southern Illinois Pediatric Dentistry of Edwardsville

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

NOTICE OF PRIVACY PRACTICES

Southern Illinois Pediatric Dentistry of Edwardsville

Effective Date: February 01, 2026

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

CONTACT INFORMATION

For more information about our privacy practices, to discuss questions or concerns, or to get additional copies of this notice, please contact our Privacy Officer.

Telephone: 618-655-3272

1419 Lewis Road Suite 2

Edwardsville, IL 62025

OUR LEGAL DUTY

We are required by law to protect the privacy of your protected health information (“medical information”). We are also required to send you this notice about our privacy practices, our legal duties and your rights concerning your medical information.

We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect on the date set forth at the top of this page and will remain in effect unless we replace it. We reserve the right at any time to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make any change in our privacy practices and the new terms of our notice applicable to all medical information we maintain, including medical information we created or received before we made the change in practices.

We may amend the terms of this notice at any time. If we make a material change to our policy practices, we will provide to you, the revised notice. Any revised notice will be effective for all health information we maintain. The effective date of a revised notice will be noted. A copy of the current notice in effect will be available in our facility and on our website. You may request a copy of the current notice at any time. We collect and maintain oral, written and electronic information to administer our business and to provide products, services and information of importance to our patients. We maintain physical, electronic and procedural safeguards in the handling and maintenance of our patients’ medical information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction and misuse.

USES AND DISCLOSURES OF YOUR MEDICAL INFORMATION

Treatment: We may disclose your medical information, without your prior approval, to another dentist or healthcare provider working in our facility or otherwise providing you treatment for the purpose of evaluating your health, diagnosing medical conditions and providing treatment. For example, your health information may be disclosed to an oral surgeon to determine whether surgical intervention is needed.

Payment: We provide dental services. Your medical information may be used to seek payment from your insurance plan or from you. For example, your insurance plan may request and receive information on dates that you received services at our facility in order to allow your employer to verify and process your insurance claim.

Health Care Operations: We may use and disclose your medical information, without your prior approval, for health care operations. Health care operations include:

- healthcare quality assessment and improvement activities;
- reviewing and evaluating dental care provider performance, qualifications and competence, health care training programs, provider accreditation, certification, licensing and credentialing activities;
- conducting or arranging for medical reviews, audits and legal services, including fraud and abuse detection and prevention; and

- business planning, development, management and general administration including customer service, complaint resolutions and billing, de-identifying medical information, and creating limited data sets for health care operations, public health activities and research.

We may disclose your medical information to another dental or medical provider or to your health plan subject to federal privacy protection laws, as long as the provider or plan has had a relationship with you and the medical information is for that provider's or health plan's care quality assessment and improvement activities, competence and qualification evaluation and review activities, or fraud and abuse detection and prevention.

Your Authorization: You (or your legal personal representative) may give us written authorization to use your medical information or to disclose it to anyone for any purpose. Once you give us authorization to release your medical information, we cannot guarantee that the person to whom the information is provided will not disclose that information. You may take back or "revoke" your written authorization at any time, except if we have already acted based on your authorization. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us written authorization, we will not use or disclose your medical information for any purpose other than those described in this notice. We will obtain your authorization prior to using your medical information for marketing, fundraising purposes or for commercial use. Once authorize, you may opt out of these communications at any time.

Family, Friends and Others involved in your care or payment for care: We may disclose your medical information to a family member, friend or any other person you involve in your care or payment for your health care. We will disclose on the medical information that is relevant to the person's involvement.

We may use or disclose your name, location and general condition to notify, or to assist an appropriate public or private agency to locate and notify, a person responsible for your care in appropriate situations, such as a medical emergency or during disaster relief efforts.

We will provide you with an opportunity to object to these disclosures, unless you are not present or are incapacitated or it is an emergency or disaster relief situation. In those situations, we will use our professional judgment to determine whether disclosing your medical information is in your best interest under the circumstances.

Health-Related Products and Services: We may use your medical information to communicate with you about health-related products, benefits, services, payment for those products and services and treatment alternatives.

Reminders: We may use or disclose medical information to send you reminders about your dental care, such as appointment reminders via US Mail, email and telephone. By providing your cell phone number and email address to us, you agree that you may receive reminders and breach notifications via text and email as a possible alternative to US Mail. It is the policy of our office to leave a message on any voicemail or answering machine that may be attached to a number that you provide (home, cell or work).

Plan Sponsors: If your dental insurance coverage is through an employer's sponsored group dental plan, we may share summary health information with the plan sponsor.

Public Health and Benefit Activities: We may use and disclose your medical information, without your permission, when required by law and when authorized by law for the following kinds of public health and public benefit activities;

- for public health, including to report disease and vital statistics, child abuse, adult abuse, neglect or domestic violence;
- to avert a serious an imminent threat to health or safety;
- for health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities and fraud prevention agencies;
- for research;
- in response to court and administrative orders and other lawful process;
- to law enforcement officials with regard to crime victims and criminal activities;
- to coroners, medical examiners, funeral directors and organ procurement organizations;
- to the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; and
- as authorized by state worker's compensation laws.

Special protections for SUD records: Substance Use Disorder (SUD) Treatment records have enhanced protections. They cannot be used in legal proceedings without your consent or court order.

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Business Associates: We may disclose your medical information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Data Breach Notification Purposes: We may use your contact information to provide legally required notices of unauthorized acquisition, access or disclosure of your health information.

Additional Restrictions on use and disclosure: Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. "Highly Confidential Information" may include confidential information under Federal laws governing reproductive rights, alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information:

- 1) HIV/AIDS;
- 2) Mental Health;
- 3) Genetic Tests (in accordance with GINA 2009);
- 4) Alcohol and drug abuse;
- 5) Sexually transmitted diseases and reproductive health information; and
- 6) Child or adult abuse or neglect, including sexual assault.

YOUR RIGHTS

- 1) You have a right to see and get a copy of your health records.
- 2) You have a right to amend your health information.
- 3) You have a right to ask to get an Accounting of Disclosures of when and why your health information was shared for certain purposes.
- 4) You are entitled to receive a Notice of Privacy Practices that tells you how your health information may be used and shared.
- 5) You may decide if you want to give your Authorization before your health information may be used or shared for certain purposes, such as marketing. It is the policy of our office NOT to sell or disclose your information to any outside firms or business partners. Your information may be used, only within our office, for the purposes of presenting to you certain products or services which our dentist(s) or staff feel may present a benefit for you, your oral health or happiness with your smile.
- 6) You have the right to receive your information in a confidential manner and restrict certain communication methods.
- 7) You have a right to restrict who receives your information.
- 8) You have a right to request amendment to be made to your health records by submitting the request in writing to our privacy officer. Your request does not guarantee the amendment, but does guarantee that it will be reviewed and considered.
- 9) If you believe your rights are being denied or your health information is not being protected, you can:
 - a. File a complaint with your provider or health insurer
 - b. File a complaint with the U.S. Government
- 10) Right to opt out of fundraising activities.

COMPLAINTS

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, about amending your medical information, about restricting our use or disclosure of your medical information, or about how we communicate with you about your medical information (including a breach notice communication), you may contact our Privacy Officer to register either a verbal or written complaint. You may also submit a written complaint to the Office for Civil Rights of the United States Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, Washington, DC, 20201. You may contact the Office for Civil Rights' hotline at 1-800-368-1019. We support your right to privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the US Department of Health and Human Services.

Acknowledgment of HIPAA Notice of Privacy Practices

I, _____, acknowledge that I have been informed of and received a copy of the dental practice's Notice of Privacy Practices.

You may refuse to sign this acknowledgement

Patients' name (please print)

Parent/Guardian signature Date

Relationship to patient

OFFICE USE ONLY BELOW THIS LINE

We were unable to obtain written acknowledgement of receipt of our Notice of Privacy Practices because:

_____ Parent or guardian was unwilling to sign

_____ A communication barrier prevented us from obtaining acknowledgement

_____ An emergency prevented us from obtaining acknowledgement

_____ Other: _____

Staff Signature Date

General Consent

State law requires us to obtain your consent for your child’s contemplated dental treatment or oral surgery. Please read this form carefully and feel free to ask any questions that you may have. We will be happy to explain anything that you do not understand.

I hereby authorize and direct Dr. Adam Snyder, Dr. Christine Wohlford, Dr. Austin LaMay or other associate dentists and/or dental auxiliaries of their choice, to perform upon my child (or legal ward) the following dental treatment(s) or oral surgery procedure(s), including the use of any necessary or advisable anesthetic and/or diagnostic aids (including radiographs, or “x-rays”). You have a right to refuse consent to a procedure before it is performed. In general terms, the dental procedure(s) may include one or a combination of the following:

- Cleaning of the teeth and the application of topical fluoride
- Dental radiographs and/or intraoral photographs
- Application of sealants for posterior teeth that are deemed susceptible to decay
- Treatment of infected or injured oral hard and/or soft tissues including the placement of any restorative materials and/or medicaments deemed necessary, including but not limited to resin (tooth-colored) restorations, amalgam (silver) restorations, stainless steel crowns, temporary restorative materials, and pulpotomies (pulpal therapy)
- Extraction (removal) of one or more teeth
- Replacement of missing teeth with dental prosthesis
- Space maintenance and/or appliance therapy
- Use of nitrous oxide
- Use of physical restraint device (papoose board) in order to safely and adequately complete the necessary dental procedure – typically only in the case of emergency dental treatment

This treatment has been explained to me, and I have the opportunity to ask as many questions as possible. Alternative methods of treatment, if any, will also be explained to me along with the advantages and disadvantages of both. I am advised that although excellent results are to be expected, the possibility and nature of complications cannot be accurately anticipated and that therefore there can be no guarantee as expressed or implied either as to the result of the treatment or as the cure.

I hereby state that I have read and understand this consent, and that all questions about the procedure(s) have been adequately answered to my satisfaction. I understand that I have the right to be provided with answers to questions that may arise during the course of treatment. I further understand that this consent will remain in effect until such time that I choose to revoke it.

Patient’s name

D.O.B

Signature of parent/guardian

Relationship to patient

Date

Witness

Date

Signature of Dentist

Date