Dashley
PEDIATRIC DENTISTRY

Patient Information:

Child's Full Name: _____ **Nickname:** _____
Date of Birth: _____ **Age:** _____ **Gender:** □ Male □ Female
Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____
Parent/Guardian Name(s): _____
Cell Phone: _____ **Home Phone:** _____
Email Address: _____

Emergency Contact Name/Relationship: _____
Emergency Contact phone number: _____

Dental History:

Reason for todays visit?
□ First dental visit □ Routine check-up/Cleaning □ Referral for treatment □ Emergency care

Who was your child's previous dentist? _____
When was your child's last dental visit? _____
When were their last X-rays taken?_____

Do you have any concerns about your child's teeth or mouth? □ Yes □ No
If yes, please explain: _____
Does your child currently have any dental pain or discomfort? □ Yes □ No
If yes, please describe: _____
Has your child ever had a serious injury to the head, mouth, or teeth? □ Yes □ No
If yes, please describe: _____

Has your child had any previous dental treatments? □ Yes □ No
If yes, please explain: _____
Does your child have any specific dental fears or anxieties? □ Yes □ No
If yes, please explain: _____

Has your child seen an orthodontist? □ Yes, currently in treatment □ Yes, monitoring growth □ No
If yes, name of orthodontist: _____

Does your child brush their teeth regularly? □ Yes □ No **How often?** _____
Does your child use fluoride toothpaste? □ Yes □ No **Does your child floss regularly?** □ Yes □ No

Is your child currently bottle feeding or breastfeeding? □ Yes □ No
If no, what age did they stop? _____
Does/did your child use a pacifier or suck his/her thumb or fingers? □ Yes □ No
If yes, what age did they stop? _____

Does your child grind their teeth at night? □ Yes □ No
Has your child ever experienced any sleep-related breathing disorder?
□ None □ Mouth breathing □ Snoring □ Trouble breathing during sleep

How did you hear about us?
□ Social Media □ School Visit
□ Referral from: _____
□ Other: _____

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Medical History:

Primary Care Doctor's Name:_____ **Phone number:** _____

Does your child see any medical specialists? ☐ Yes ☐ No
If yes, please explain: _____

Has your child ever been diagnosed with any of the following? (Check all that apply)
☐ Asthma ☐ Heart Disease or Heart Murmur ☐ Diabetes ☐ Epilepsy/Seizures ☐ High Blood Pressure
☐ Liver Disease ☐ Kidney Disease ☐ Bleeding Disorder ☐ Bone or Joint Problems ☐ Cancer
☐ Autism Spectrum Disorder ☐ ADHD/ADD ☐ Down Syndrome ☐ Anxiety ☐ Depression
☐ Growth Problems ☐ Hearing Problems ☐ Other: _____
If you checked any boxes please provide any additional details:
_____

Has your child been diagnosed with any genetic (inherited) conditions? ☐ Yes ☐ No
If yes, please explain: _____

Has a physician or dentist ever suggested that your child take antibiotics before dental appointments? ☐ Yes ☐ No
If yes, please explain: _____

Does your child take any medications? ☐ Yes ☐ No
If yes, please list: _____
_____

Has your child ever had an allergic reaction to any of the following? (Check all that apply)
☐ Local Anesthetic ☐ Antibiotics (e.g., penicillin) ☐ Latex ☐ Food (e.g., peanuts, dairy) ☐ Other
Please list allergies: _____

Has your child ever been hospitalized or had surgery? ☐ Yes ☐ No
If yes, please provide details: _____

Does your child have any other health conditions or special needs? ☐ Yes ☐ No
If yes, please explain: _____

Consent & Signature:

I, the undersigned, consent to the treatment of my child as deemed necessary by the dental professionals at this office. I understand that all information provided is correct to the best of my knowledge, and I will notify the office of any changes to my child's health history.

Parent/Guardian Name: _____
Relationship to Child: _____
Signature: _____
Date: _____

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Patient Name _____ Birthdate _____

Dental Insurance Information

Primary Dental Insurance

Name of Insured: _____
Relationship to Patient: _____
Insured Date of Birth: _____
SS # _____
Employer: _____
Insurance Company: _____
Claims Address: _____
Group # _____
Employee ID # _____

Secondary Dental Insurance

Name of Insured: _____
Relationship to Patient: _____
Insured Date of Birth: _____
SS # _____
Employer: _____
Insurance Company: _____
Claims Address: _____
Group # _____
Employee ID # _____

Responsible Party - Who is responsible for payment?

Name _____ Relationship to Patient _____
Birthdate _____ SS # _____
Address _____City _____ State _____ Zip _____
Cell Phone _____ Home Phone _____

Authorization and Release

I authorize the release of any information including diagnosis and the records of any treatment or examination rendered to me or my child during the period of care to third-party payers and/or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____
Signature of patient or parent/guardian if minor

Communication Preferences

How would you like to receive appointment reminders and office updates?
□ Text Message (SMS) _____ □ Phone Call _____

By selecting text messaging, you consent to receive appointment reminders, follow-ups, and other important messages via SMS. Standard messaging rates may apply.
You may opt out at any time by replying "STOP"

Parent/Guardian Name: _____
Signature: _____ Date: _____

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PHOTOGRAPHY RELEASE/CONSENT

At Dashley Pediatric Dentistry, we make every effort possible to make our patients feel special. We love to share pictures of our patients' beautiful smiles on our social media pages, website, and other office related materials for our friends and family to see just how much fun a visit to the dentist can be!

Please check one of the following boxes and sign below.

☐ **I AGREE** and hereby grant full permission to Dashley Pediatric Dentistry, Dr. Victoria Dashley and staff to use either myself or my child/children's name(s) and photograph in any publication or advertising materials (printed or electronic), and social media. This consent serves to waive all rights of privacy or compensation which I may have in connection with the use of my photograph and/or my child's photograph or name.

☐ **I DO NOT AGREE** to have mine or my child/children's name(s) photograph used for public viewing.

AND

I hereby grant full permission to Dashley Pediatric Dentistry, Dr. Victoria Dashley and staff to use either myself or my child/children's name(s), to take photographs, and/or videos of my jaws and teeth, before, during and after treatment. (no full facial photos) for educational purposes.

☐ **I AGREE** to allow the photographs to be used for the following:
- Dental Education including lectures, seminars, demonstrations, professional publications such as journals or books

☐ **I AGREE** and understand that if the photographs and/or videos are used, my name or identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs

☐ **I DO NOT AGREE** to have mine or my child/children's photographs/videos to be used for educational purposes.

_____
Child/Children's Full Name

_____
Parent/Legal Guardian Name Relationship to Child

_____
Signature Date

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CONSENT FOR DENTAL TREATMENT OF MINORS IN ABSENCE OF PARENT/LEGAL GUARDIAN (Please fill out one form per child)

I, _____ give Dr. Victoria Dashley permission to treat my child, _____ while I am not present. The individual / individuals bringing my child to their appointment are listed below and are at least eighteen years of age.

PLEASE NOTE that if there are any medical changes, the parent or legal guardian MUST speak directly with Dr. Dashley.

I also understand that I need to be available by phone in case anything changes in the treatment plan OR in the event of an emergency.

Accompanying Adult: Relationship to child:

_____

_____

_____

_____

_____ My child is of legal driving age and may be unaccompanied to dental appointments. I give consent for any and all dental treatment that has been previously discussed.

I authorize the above named caregiver to consent for all dental treatment that has been previously discussed.

I agree to pay for all of the services provided to my child.

This authorization shall remain effective ONE (1) YEAR from the date signed below.

I understand that it is my responsibility to notify the office in writing in the event that I decide to revoke this form.

Parent / Legal Guardian signature: _____ Date: _____

Witness signature: _____ Date: _____

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CONSENT FOR USE & DISCLOSURE OF HEALTH INFORMATION

Leo A. Massaro DDS, Arthur J. Bigsby, III DDS
Maxillofacial Prosthodontist
Victoria L. Dashley, DDS
Pediatric Dentist

Section A: Patient Giving Consent

Patient Name: _____ Patient Date of Birth: _____
Address: _____ City, State, ZIP: _____
Phone Number: _____Email: _____

Section B: To the Patient – Please Read the Following Statements Carefully

- Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.
- Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, as well as the uses and disclosures we may make of your protected health information. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revision of our Notice, at any time by contacting:
Contact Person: Leo A. Massaro
Telephone: 315-451-5500
Fax: 315-451-5507
Address: 4820 W. Taft Rd, Liverpool, NY 13088

- **Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this Consent.
- **Fees & Payments:** Although we accept payments from your insurance company towards your account, you are responsible for your full account balance. I am aware that the office accepts MasterCard, Visa, Discover, American Express, and Care Credit. WE ARE A NON-PARTICIPATING PROVIDER FOR ANY INSURANCE COMPANY. We are also an OPTED-OUT MEDICARE PROVIDER as of 7/2015. I am also aware that my balance must be cleared within three (3) months from the day of treatment. If payment arrangements have been made, I understand that interest in the amount of 2% monthly will be charged on any balances over 90 days. I understand that in the event my account becomes past due and is turned over for collection, I agree to pay the collection fee of 35% based on the amount outstanding and any court costs if applicable. This signature on file is my authorization for the release of information necessary to process my claim, thereby authorizing payment to this doctor named of the benefits otherwise payable to me.

SIGNATURE OF GUARANTOR:

Signature: _____ Date: _____

Signature: I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Person we can share your protected health information with:

Name: _____ Relationship to Patient: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:
Personal Representative's Name: _____
Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

- Revocation of Consent: I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or continue to treat me after I have revoked my Consent. Any revocation does not change the terms of Fees & Payments listed above.

Patient, Parent, or Guardian Signature: _____
Date: _____