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: _____

Dashley
PEDIATRIC DENTISTRY

Child's Name: _____ Birthdate: _____

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: _____

Dashley
PEDIATRIC DENTISTRY

Child's Name: _____ Birthdate: _____

Dental Insurance Information

Primary Dental Insurance

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

Secondary Dental Insurance

Name of Insured: _____
Relationship to Patient: _____
Address: _____
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 _____

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: _____

Dashley
PEDIATRIC DENTISTRY

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.

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: _____

Dashley
PEDIATRIC DENTISTRY

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.

General Media & Social Use

I understand that Dashley Pediatric Dentistry, Dr. Victoria Dashley, and staff may wish to use my child/children's name(s) and/or photographs in printed materials, advertising, the practice website, or social media.

☐ **I AGREE** to allow my/my child's name(s) and photographs to be used for these purposes. I waive any rights of privacy or compensation in connection with such use.

☐ **I DO NOT AGREE** to allow my child's name(s) and photographs to be used for these purposes.

Clinical & Educational Use

I understand that photographs and/or videos of my child's teeth, jaws, and face may be taken before, during, and after treatment. These may be used for educational purposes, professional presentations, advertising, the practice website, or social media.

☐ **I AGREE** to allow clinical photographs/videos of my child to be used as described above. I understand no compensation, financial or otherwise, will be provided.

☐ **I DO NOT AGREE** to allow clinical photographs/videos of my child to be used for educational or promotional purposes.

Child/Children's Full Name

Parent/Legal Guardian Name Relationship to Child

Signature Date

Dashley
PEDIATRIC DENTISTRY

CONSENT FOR USE & DISCLOSURE OF HEALTH INFORMATION

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

HIPAA NOTICE OF PRIVACY PRACTICES:

THIS NOTICE DESCRIBES HOW HEALTH 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 HEALTH INFORMATION IS IMPORTANT TO US.

Due to federal mandates called the Health Insurance Portability and Accountability Act (HIPPA); healthcare providers are required to obtain patient consent for the release of private health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. We reserve the right 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 the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new Notice available upon request. You may request a copy of our notice at any time. For more information about our privacy practices, or additional copies of this Notice, please contact us using the information listed at the end of this notice.

Healthcare information to be released to my primary care physician, specialist physicians directly involved in my care, referring dentist, insurance company, or other dental specialist involved in my dental care. For this purpose, private health information is defined as personal information, an examination finding, financial estimates, and/or treatment either proposed, underway or completed. I give consent to release private health information solely for the benefit of the patient's continued quality healthcare. I also give permission to leave reminders and/or pertinent messages at my contact phone number, answering machine/voicemail per my request, by mail, email, and/or text message.

Authority of Personal Representative to sign for patient (circle one):

Parent Power of Attorney Guardian Other

Signature: _____ Date: _____

Your Authorization:

In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you authorize us, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other people to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.
Persons Involved In Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your representative, or another person responsible for your care, of your location, your general condition, or death. If you are present, then before use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.
Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.
Required by Law: We may use or disclose your health information when we are required to do so by law.
Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, text messages, or email.)

PATIENT RIGHTS
Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. (You must request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice.)

Signature: _____ Date: _____

Dashley
PEDIATRIC DENTISTRY

Financial Responsibility Agreement

Patient Name (Child): _____
Date of Birth: _____
Parent/Guardian Name: _____
Date: _____

I understand that this practice is an out-of-network provider, and that I am responsible for all costs related to my child's dental care.

This includes any charges not covered or reimbursed by my insurance.

We are an opt-out provider and cannot submit claims to federally funded insurance (Medicare) or state-funded plans (CHP, Fidelis, Healthplex, Medicaid, UHC Community, etc.).
Patients with these plans may be seen in our office on a self-pay basis.

I understand that **insurance coverage is not guaranteed.** While the office may help submit claims, I am responsible for any balance not paid by insurance — including copays, deductibles, and denied services.

I agree that **payment is due at the time of service**, regardless of insurance status.

I agree to pay all charges promptly and authorize this practice to share necessary treatment information with my insurance company.

Parent/Guardian Signature: _____
Date: _____