Amanda P. Velazquez, D.M.D
Diplomate, American Board of Pediatric Dentistry

Returning Patient

Patient: ____ Today's Date: ________________

Preferred Name: ________________________ Date of Birth : __________ Age: _____ Sex: M F

Home Address: ________________________________ City/State: _______________ Zip: ________

Phone Number: ____________________________ May we provide text reminders for appointments? Yes No

Parent/Guardian(s): ____

Reason for today's visit: ____

Patient Medical History

Pediatrician: ______________________________________ Phone #: ______________________

List all current medications the patient is taking (prescription & over the counter), including the reason for taking the medication:

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Please list any known allergies: ____

Has your child ever been diagnosed with or treated for the following?

Y N Acid Reflux	Y N Cancer/Malignancy	Y N Hearing Impairment	Y N Seizures/Epilepsy
Y N ADHD/Hyperactivity	Y N Cerebral Palsy	Y N Heart Condition/Disease	Y N Sensory Issues
Y N Allergies	Y N Chemotherapy/Radiation	Y N Heart Murmur	Y N Sickle Cell Disease
Y N Anemia	Y N Cleft Lip/Palate	Y N Hepatitis	Y N Speech Delay
Y N Arthritis	Y N Congenital Heart Defect	Y N Kidney Problems	Y N Tonsillectomy/adenoidectomy
Y N Asthma	Y N Developmental Delay	Y N Latex sensitivity/allergy	Y N Vision Problem
Y N Autism/ASD	Y N Diabetes	Y N Liver Disease	Y N Other
Y N Birth Defects	Y N Down Syndrome	Y N Mental Retardation	
Y N Bleeding Disorder	Y N GI/Stomach Disease	Y N Premature Birth	
Y N Breathing Problems	Y N HIV/AIDS	Y N Psychiatric Problems	

If other, please specify: ____

Please provide more information on any of the above marked yes:_________________________

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Patient Dental Questionnaire

Please check below if your child has had problems or concerns with any of the following :

☐ Cavities	☐ Gum infection	☐ Grinding/Bruxism	☐ Sensitivity	☐ Crooked teeth
☐ Toothache	☐ Canker sores	☐ Jaw pain	☐ Tooth color	☐ Missing teeth

When was your child's last dental visit? ____

Previous dentist's name and address: ____

Why did your child leave his/her previous dentist? ___________________________________

The information provided in this form is complete to the best of my knowledge. I will notify **Suncoast Pediatric Dentistry** at future visits if any of the information changes. Guardian name: ________________________ Relationship: ________________

Signature: ____ Date: ________________________

Patient Name: ____ Date of Birth: _______________________________

Consent for Treatment

I, the undersigned parent/legal guardian, authorize Dr. Amanda Velazquez and her staff to examine this child, clean his/her teeth, perform necessary dental treatment, administer local anesthetics, administer medications, apply topical fluoride, obtain study models and other records necessary for an accurate diagnosis for my child. I further request and authorize the taking of dental radiographs (x-rays) as may be considered necessary by Dr. Amanda to diagnose and/or treat my child's dental condition. I will allow photographs to be taken of my child and/or my child's teeth for diagnostic or educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr. Amanda will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, using variable voice tone, mouth props, nitrous oxide (laughing gas), or protective stabilization when necessary to promote cooperative behavior and a positive experience and to protect my child from potential injury.

Initial to Acknowledge: ________

Appointment Policy

We reserve your appointment time specifically for you. If you need to reschedule, please give us at least 24 hours notice so that we may give someone else the opportunity to use that time. A fee, up to $50, may be charged for late cancellations(less than 24 hour notice) and/or missed appointments. This fee must be paid before a new appointment is scheduled. If your child is under the age of 6, we ask that you schedule a morning appointment. Younger children often respond better to new environments when they are well rested.

Initial to Acknowledge: ________

Financial Policy

Thank you for choosing our office as your child's dental provider. We are committed to providing you with the highest quality lifetime dental care, so that your child may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Payment is due at the time service is provided. Our office accepts cash, MasterCard, and Visa.

Please Note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal charges up to 35%.

Do You Have Insurance?

- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.
- Our practice is committed to providing the best treatment for our patients and our fees are usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office (assignment of benefits to the provider).
- We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, by cash, MasterCard, or Visa at the time we provide the service to the patient.
- Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your child's dental health care needs and welcome any questions you may have concerning your child's care or our financial policy.

Consent:

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. **I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO SUNCOAST PEDIATRIC DENTISTRY, P.L./AMANDA P. VELAZQUEZ, D.M.D.** I understand that responsibility for payment for dental services provided in this office for my dependents is mine, due and payable at the time services are rendered. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance.

Name: ____________________________________ Relationship to Patient: _____________________________________

Date: ___________________ Signature: ____