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

Patient Information

Patient: _____ Today's Date: _____
Preferred Name: _____ Date of Birth : _____ Age: _____ Sex: M F
School: _____ Grade: _____
Home Address: _____ City/State: _____ Zip: _____
Phone Number: _____ May we provide text reminders for appointments? Yes No
Who has legal custody of this patient? _____
How did you hear about Suncoast Pediatric Dentistry? _____
Patient's hobbies, interests, or pets: _____
How do you think your child will respond to dental treatment : _____
Reason for today's visit: _____
E-mail address: _____

MOTHER'S INFORMATION

Name: _____ Date of Birth:_____
Occupation: _____ Employer: _____
Driver's License #: _____ Social Security Number: _____
Work Phone #: _____ Home Phone #: _____ Cell Phone #: _____

FATHER'S INFORMATION

Name: _____ Date of Birth:_____
Occupation: _____ Employer: _____
Driver's License #: _____ Social Security Number: _____
Work Phone #: _____ Home Phone #: _____ Cell Phone #: _____

Financial & Insurance Information

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT ☐ Same as Mother ☐ Same as Father

Name: _____ Relationship to Patient:_____
Billing Address: _____ City: _____ Zip: _____
Work Phone #: _____ Home Phone #: _____ Cell Phone #: _____

INSURANCE INFORMATION

Dental Insurance Company: _____ Phone #: _____
Insurance Company Address: _____
Name of Insured: _____ SS#: _____ DOB: _____
Group/Policy #: _____ Employer: _____

Patient Name: _____ Date of Birth: _____

Patient Medical History

Pediatrician: _____ Phone #: _____

Date of last physical: _____ Reason:_____ Are your child's immunizations up to date? Y N

Y N Has your child ever been hospitalized? If yes, please describe when & why: _____

Y N Has your child ever been treated in the emergency room? If yes, please describe when & why: _____

_____

Y N Has your child ever had surgery? If yes, please describe when & why: _____

Y N Has your child ever had pre-medication with antibiotics before dental appointments?

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

_____

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:_____

_____

Patient Dental Questionnaire

What is your main concern about your child's teeth? _____

Y N Do you supervise or assist your child in brushing his/her teeth?

Y N Does your child use dental floss?

Y N Does your child have a click, pop, or other noise in the jaw joint?

Y N Do you or your child have any concerns about the appearance of his/her teeth? Describe: _____

Y N Does your child have a current or previous pacifier or thumb/finger sucking habit? Please circle which habit. Until what age? _____

Y N Has your child ever had an accident or injury involving the teeth/jaws? When & where? _____

Y N Was your child bottle fed? Until what age? _____

Y N Was your child breast fed? Until what age? _____

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? _____

Fluoride Exposure

Your child drinks water primarily from: ☐ Public Supply. County? _____ ☐ Well ☐ Bottled: fluoride or non-fluoride

Y N Does your child use toothpaste with fluoride?

Y N Does your child use fluoride rinses?

Y N Do you have a reverse osmosis water filter?

Y N Does your child take prescription fluoride tablets/drops? Type/Dosage? _____ Prescribed by? _____

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: _____

Amanda P. Velazquez, D.M.D

Consent for Use and Disclosure of Protected Health Information and Release of Medical Records

Patient Name: _____ Date of Birth: _____

I, _____, the undersigned, and _____,
(Print Name of Parent/Legal Guardian) (Relationship to the patient)
of the above named patient, hereby authorize Amanda P. Velazquez, D.M.D and Suncoast Pediatric Dentistry, P.L. (hereafter collectively referred to as the "Practice") to use and disclose the entire medical record concerning the above named patient (hereafter referred to as the "Patient") in accordance with the attached Notice of Privacy Practices (NOPP). I have reviewed the NOPP, been given an opportunity to ask questions about it, understand it and do hereby agree to its terms. A copy of this signed, dated Consent shall be effective as the original. I release, hold harmless and agree to indemnify the Practice, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this Consent. I specifically authorize the Practice to use and disclose verbally, by mail, fax or unencrypted e-mail, the Patient's medical record.

By Parent: _____ Date: _____
(Signature)

Or

By Patient Representative: _____ Date: _____
(Signature & Describe relationship to Patient)

ONLY COMPLETE THIS SECTION IF REQUESTING RELEASE OF RECORDS

1. Please send a copy of my records (including information from other health-care providers that it may contain) to:
   _____ at _____.
   I understand that my records may be subject to re-disclosure by recipient(s) and unprotected by federal or state law.

2. Please allow _____ to pick up a copy of my records (including information from other health-care providers that it may contain).

3. Please send a copy of my records (including information from other health-care providers that it may contain) by unencrypted email to: _____. I understand it may be unprotected by federal or state law.

Authorizing Signature: _____ Date: _____
Print Name: _____ Relationship to Patient: _____