Pediatric Dentistry of Naples

Dr. Jennifer B. Hughes, DMD
Pediatric Dentist
1879 Veterans Park Drive, Suite 1203
Naples, Florida 34109
(239) 260-7672

Registration Information:

Child's Name:_____
First Middle Last Preferred

DOB:_____ Age _____ Male or Female SSN ___/___/___

Mother/Guardian_____ DOB: _____
First Middle Last

SSN: ___/___/___ Relationship: _____ Lives with child: Y or N

Address_____ Home Phone:_____

City:_____ State_____ Zip Code_____ Mobile Phone:_____

Employer_____ Occupation_____

Email address_____

Father/Guardian_____ DOB: _____
First Middle Last

SSN: ___/___/___ Relationship: _____ Lives with child: Y or N

Address_____ Home Phone:_____

City:_____ State_____ Zip Code_____ Mobile Phone:_____

Employer_____ Occupation_____

Email address_____

Emergency Contact: _____ Telephone Number: _____

Dental Insurance Company:_____ Name of Primary Policy Holder:
_____

SSN___/____/___ Relationship:_____ DOB:_____ Employer: _____

****HOW DID YOU HEAR ABOUT OUR OFFICE?_____

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Medical/Dental History:

Child: _____ Date of Birth:_____
Physician/pediatrician: _____ Immunizations up to date: YES or NO

Medical History:

Please check YES or NO to each of the following items regarding your child's health:

	YES	NO		YES	NO		YES	NO
ADHD	_____	_____	Allergies	_____	_____	Asthma	_____	_____
Bleeding Problems	_____	_____	Cancer	_____	_____	Cerebral Palsy	_____	_____
Diabetes	_____	_____	Hearing Problems	_____	_____	Heart Murmur	_____	_____
Heart Problems	_____	_____	Hepatitis	_____	_____	HIV/AIDS	_____	_____
Kidney problems	_____	_____	Learning Disability	_____	_____	Latex Allergy	_____	_____
Liver Problems	_____	_____	Lung Problems	_____	_____	Pregnancy	_____	_____
Seizures	_____	_____	Sight Problems	_____	_____	Tuberculosis	_____	_____
MRSA	_____	_____	Scabies/Lice	_____	_____	Peanut/Nut Allergy	_____	_____

*Please describe these or any other medical conditions we should be aware of:

_____

*Is your child presently taking any medications or vitamins: **YES or NO**
Please list: _____
*Is your child allergic to any medications or food: **YES or NO**
Please list: _____

Dental History:

Reason for today's visit: _____
Has your child ever seen a dentist? **YES or NO** Office/name: _____
**Date of last dental visit: _____
**Date of last dental cleaning: _____
Were x-rays taken? **YES or NO
Any unpleasant dental experiences: **YES or NO** *Please explain*:

_____
Any mouth habits for example: thumbsucking, pacifier? **YES or NO** *Please explain*:

_____
Trauma to his/her teeth? **YES or NO** *Please explain*:

_____
Currently use a bottle or nurse? **YES or NO**
Does your home have well water? _____YES _____NO _____Unsure

I understand that the information I have given is true and correct to the best of my knowledge, and it will be held in the strictest of confidence. I also understand that it is my responsibility to inform this office of any changes in my child's medical status.

_____

Signature Printed Name Date

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Financial Policy/HIPPA:

Child's Name: _____Today's Date: _____

**Our goal is to provide your child/children with the best oral healthcare and the most positive experience. We also want to establish and maintain a pleasant, professional working relationship with you. Thus, please take a few moments to review the following information:

- **Payment is expected at the time services are rendered (cash, credit card, Care Credit).**
- **Our fees are what we consider usual and customary for this area. They are not set by an "insurance company's view of usual and customary."**
- **In a divorce situation, the adult signing this document is responsible for payment.**
- **There is a $35 charge for any appointment that your child misses or "no shows" unless a 24 hour notice is given.**

Dental insurance: The ultimate financial relationship is between our office and you, not our office and your insurance company. If you have dental insurance, we will bill your company directly as a courtesy to you. To do this correctly and promptly, we need the most current and accurate information, including verification of insurance and proper identity including at times parent dates of birth, social security numbers and/or dental insurance cards. Your understanding during this process is appreciated. If additional information is requested from your insurance, you should be notified by your company. We will also notify you by telephone or mail once. After 60 days from treatment date we will bill you directly for the full balance.

—At your children's first visit to our office, our staff will contact your insurance company to determine as best as possible information to estimate any costs not covered by your company. These costs are expected to be paid at the time of service. We cannot guarantee payment of benefits by your insurance company as initially reported to us. Therefore, we will send you a statement for any additional costs after the processing of a claim form with the carrier. At times, verifying these benefits may not be possible prior to treatment. It is your responsibility to make sure your insurance is active and our office will estimate accordingly.

—Once the carrier is billed for services rendered, we will allow 60 days to receive payment. If no payment is received after 60 days, the insurance balance will become your responsibility.

—You may request a "predetermination" (sometimes called a pre-treatment estimate) from your insurance carrier before any treatment is started to accurately determine what is covered. Our staff can assist you.

Your Responsibilities:

- Payment of fees at time of service, including deductibles, co-pays, and any services not covered by your insurance at time of service. If there isn't insurance involved, payment in full is expected at time of service.
- Any balances resulting from insurance company co-payments regardless of portions collected at time of service. We can only estimate balances on day of service.
- Any additional fees incurred by us when an overdue account is referred to a collection service including collection agency fees and attorney fees.

I have read and agree to follow the policies and my responsibilities as outlined above. I also give permission to receive statements via email if residual payment is due.

HIPPA **:**

Authorization for signature on file

I hereby authorize the office of Pediatric Dentistry of Naples, Dr. Jennifer B. Hughes, DMD, to affix my name to any and all claims or documents as to any and all health benefits due me and my dependents through my employment. I hereby authorize payment of dental benefits otherwise payable to me, directly to the office of Pediatric Dentistry of Naples, Dr. Jennifer Hughes, DMD. This "Signature on File" will be valid from this date forward. A photocopy of this document may act as an original.

Consent for Use and Disclosure of Health Information

I, being the parent or legal guardian of the above named child/children, understand by signing this form that I consent to our use and disclosure of my child's protected health information to carry out treatment, payment activities and healthcare operations. Your office will continue to use his/her health information in some of these ways: by calling them by first and last name from your waiting room, by posting pictures, by using information for case presentations for educational purposes, social media, mailing reminder appointment cards with reason for visit, by reminding patients needing a pre-medication on reminder cards or confirmation calls, by calling to confirm appointments, texting appointments, emailing appointments/treatment planning/billing information and internal audits of patient charts for practice evaluation purposes as described in our Notice of Privacy Practices. You have the right to request alternative means of delivery. I also give permission for consultation with other healthcare professionals regarding my child/children.

_____ _____

Signature Printed Name

Scanned document serves as original

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Consent for Dental Treatment:

Child's Name: _____Today's Date: _____

I attest that I am the legal guardian this child. I give my permission for my child to receive any and all dental treatment/emergency treatment from the doctor and staff at Pediatric Dentistry of Naples, Dr. Jennifer B. Hughes, DMD.

It is our goal to provide safe and comfortable dental treatment for our patients. In order to achieve this goal, the following methods have been chosen by Dr. Hughes and you (with this consent form) in providing dental treatment for your child/children. I am aware that use of video surveillance exists in this office. I grant my permission to Pediatric Dentistry of Naples, Dr. Jennifer B. Hughes, DMD to upload and store confidential patient information, including account information, appointment information, and clinical information. I also understand State and Federal laws impose obligations with respect to patient confidentiality and that Dr. Hughes will use commercially reasonable efforts to maintain the confidentiality of all patient information including texts and emails.

Nitrous oxide ("Laughing gas" or "Happy gas")-used to relax a child during treatment. The child remains awake at all times. the gas is blown off 100% after treatment and has no lingering side effects.

Local Anesthesia ("Sleepy juice")-Medication which is administered with the use of a "shot" to "numb" the tooth to prevent discomfort during dental treatment. We do NOT like to use there word "shot" to describe this procedure to the child and would like parents to refrain from this as well.

Mouth Prop ("Tooth pillow")-a device which is used to help your child keep his/her mouth open wide during treatment and prevent him/her from accidentally biting down onto sharp instruments.

Rubber Dam ("Raincoat")- used to protect a child's airway during dental treatment. It isolates the teeth that are being worked on and prevents debris and water from going into the child's throat.

Other techniques-It is our goal to gain the trust of each child and to provide dental treatment efficiently and safely. It is therefore an office policy that most school age children have their dental work done without their parents present in the room. By minimizing distractions, we can ensure a positive dental experience for your child. Most children respond quite positively to this technique since they can relax with the television. We do invite all parents to the dental treatment areas. A parent may stay with his/her child at all times but will be required to remain a "silent observer" during restorative treatments. We are proud of our facilities and want all parents to feel comfortable with our office.

Medical Emergencies and Medical Issues-with dental treatment, there are always risks for medial emergencies. The most common dental emergency includes minor allergic reactions (such as a rash). A more severe allergic reaction can also occur where a child has trouble breathing. This office is very equipped to handle most medical emergencies that may arise during dental treatment. I grant permission for my child/children to receive any necessary medical treatment in case of an emergency.

I understand that the proposed treatment plan may change during any given dental visit, and that additional treatment or different treatment may be necessary and may be performed. If my child/children is brought to any appointment by someone other than parent/guardian, I attest that the person is responsible for medical and dental updates as well as signing for all future treatment and dental decisions. This will serve as consent for all dental treatment.

I am aware that Pediatric Dentistry of Naples, Dr. Jennifer B. Hughes, DMD use social media outlets for positive affirmations for patients as well as advertising for the practice. I grant permission for my child/children's image and/or name to be used on the website, Facebook or other social media outlet. An example would be the "cavity free club" list of names on the website and Facebook page.

In order to treat each of of our patients in a timely manner, we reserve the right to reschedule your appointment should you show up late. I understand all of the items on this consent form and have had ample opportunity to ask any questions I may have. I therefore consent for dental treatment for my child/children to be performed by Dr. Hughes or any other member of the dental team.

_____

signature printed name relationship to above