PATIENT INFORMATION

(Please Print)

Name _____ Birthdate _____-_____-_____

Preferred Name_____ Marital Status_____

Home Address_____ Apt #_____

City_____ State_____ Zip_____

Please circle: Male Female

Who can we thank for referring you to our office?_____

GENERAL INFORMATION (Parents)

- (Mr.) Name_____ Phone:_____
  Home Address_____ Apt#_____
  City _____ State_____ Zip_____ Marital Status_____
  Social Security Number_____ DOB_____
  Occupation_____ Employer _____
  Email Address_____

- (Mrs., Miss., Ms.) Name_____ Phone:_____
  Home Address_____ Apt #_____
  City_____ State_____ Zip_____ Marital Status_____
  Social Security Number_____ DOB_____
  Occupation_____ Employer_____
  Email Address _____

- Insurance Co._____ Policy Holder:_____
  Insurance Address_____ Phone:_____
  Employee ID #_____ Group #_____

- Secondary Insurance Co._____ Policy Holder:_____
  Insurance Address_____ Phone:_____
  Employee ID #_____ Group #_____

I understand that the information that I have given today is correct to the best of my knowledge. I understand that this information will be hold in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform, with my informed consent, any necessary dental services that I may need during diagnosis and treatment. Payment is due in full at time of service.

Signature:_____ Date:_____

TODDLER HISTORY

Patient Name:_____ DOB:_____ Today's Date_____

Medical Issues:_____ Medications Taking:_____

Allergies:_____ Previous Clip or release of Tongue, Lips or Cheeks?_____

Has the patient experienced any of the following issues? Please check and elaborate as needed:

Speech:
___ Frustration with communication
___ Difficult to understand by parents
___ Difficult to understand by outsiders
___(%) Percent of time you understand your child
___ Difficulty speaking fast
___ Trouble with sounds (Which?) _____
___ Speech delay (When?) _____
___ Stuttering
___ Speech harder to understand in long sentences
___ Mumbling or speaking softly
___ "Baby Talk"

Feeding:
___ Frustration when eating
___ Difficulty transitioning to solid foods
___ Slow eater (doesn't finish meals)
___ Grazes on food throughout the day
___ Packing food in cheeks like a chipmunk
___ Picky with textures (Which?_ _____
___ Choking or gagging on food
___ Spits out food

Nursing or Bottle Feeding Issues as a Baby:
___ Painful nursing or swallow latch
___ Poor weight gain
___ Reflux or spitting up
___ Unable to hold pacifier
___ Milk dribbling out of mouth
___ Poor supply
___ Nipple shield required for nursing
___ Clicking or smacking noise when eating
___ Poor seal on a bottle nipple
___ Other:

Other related issues:
___ Neck or shoulder pain or tension
___ TMJ pain, clicking, or popping
___ Headaches or migraines
___ Strong gag reflex
___ Mouth open/Mouth breathing during day
___ Tonsils or adenoids removed previously
___ Ear tubes previously
___ Reflux (medicated or not)
___ ADHD/ADD
___ Constipation
___ Thrush

Sleep Issues:
___ Sleeps in strange positions
___ Kicks and flails around at night
___Wakes easily or often
___ Wets the bed
___ Wakes up tired and not refreshed
___ Grinds teeth while sleeping
___ Sleeps with mouth open
___ Snores while sleeping (how often) _____
___ Gasps for air or stops breathing (sleep apnea)
___ Has had a sleep study
___ use a CPAP

Anything else we need to know?_____
_____
_____

Pediatrician/Family Practitioner:_____
_____Phone #_____
Other Therapist:_____
_____Phone #_____
Who referred you to us:_____
_____Phone #_____

_____DOCTOR USE ONLY_____
Exam: Palate_____ Gum Ridges_____ Lips: Type_____ Face _____ Occlusion_____
Tongue: Type_____ Coated _____ Cupping____ Lateralization_____ Anesthetic_____ Topical _____ Local_____
Treatment: Scissors_____ Laser_____ Settings:_____ Safety glasses worn_____
Post Op Instructions:_____

Ped Z Dental
Dr. Stacey Zaikoski, DDS

Financial Policy

Thank you for choosing us as your dental provider. We are committed to your successful treatment. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy which we require you to read and sign prior to your treatment.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECK, VISA, MASTERCARD AND CARE CREDIT.

Insurance

We require all deductibles and co-pays be paid at the time of service. **The balance is your responsibility regardless of whether or not your insurance company pays for your claim**. We must have the correct insurance information in order for us to bill your insurance company. We are a 3rd party to the contract. **We file claims to your insurance as a courtesy to you. It's ultimately your responsibility to know and understand your dental insurance. IE: Coverages, Maximums and Frequencies; including deductibles**. If your insurance company has not paid your account within 60 days, the balance becomes your responsibility. Please be aware that some and perhaps all of the services provided may be non-covered services and not considered reasonable and necessary by your insurance company.

Usual and Customary Rates

Our practice is committed to providing the best possible care to our patients. Our fees are based on what is usual and customary for our area. You are responsible for payment regardless on insurance company's arbitrary determination of usual and customary rates.

Unique Family Situations

We will be happy to submit to either parent's insurance, however, **it is our office policy that the parent who brings the child in for their appointment is responsible for any co-pays and the balance on the account**.

Missed Appointments

We may apply a missed appointment fee for any missed appointments. We have set that time aside to serve our patients dental needs. We ask you respect that time by keeping scheduled appointments.

Waver of Confidentiality

You understand that if this account is submitted to an attorney or collection agency, if taken to court, or if your past due status is reported to a credit reporting agency, your treatment at our office may become a matter of public record.

THANK YOU FOR UNDERSTANDING OUR FINANCIAL POLICY. PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS.

I HAVE READ AND UNDERSTAND THIS FINANCIAL POLICY:

X_____ **Date** _____

Ped Z Dental
Dr. Stacey Zaikoski, DDS

HIPAA PATIENT ACKNOWLEDGEMENT NOTICE OF PRIVACY PRACTICES, CONSENT, AUTHORIZATION AND RECORDS RELEASE FORM

You may refuse to sign this acknowledgment & authorization. In refusing we may not be allowed to process your insurance claims.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices WHICH CAN BE FOUND IN a HARD BOUND BOOK IN OUR RECEPTION/WAITING ROOM for this healthcare facility. A copy of this signed dated document shall be effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI (protected health information) DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OF RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR OR FACILITIES IN THE FUTURE.**

_____
Please **PRINT** name of PATIENT (s)

_____
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_____
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_____
Please **PRINT** name of PATIENT (s)

_____ _____
PRINT name Parent/Guardian Relationship to patient(s)

Please list any other parties who can have access to your health information: (this includes step-parents, grandparents and caretakers who can have access to patient's records)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CORRESPONDENCE FROM THIS OFFICE TO CONFIRM MY CHILD/CHILDREN(S) APPOINTMENTS, TREATMENT/HEALTH INFORMATION, AND BILLING INFORMATION, VIA:

Cell Phone Confirmation
Home Phone Confirmation
Work Phone Confirmation

Text Message - Cell Phone
Mail
Email Confirmation

_____ _____
Signature of patient or parent/guardian **Date**

Ped Z Dental
Dr. Stacey Zaikoski, DDS

CONSENT FOR NITROUS OXIDE
"HAPPY AIR"

Nitrous Oxide (N2O) is an odorless, tasteless gas often used in medical and dental procedures to decrease anxiety. Most commonly nitrous oxide is breathed in through the nose. When used alone, (with no other drug or medicine), it is considered an anxiolytic (decreases anxiety), not a sedative. Most children/adults do not fall asleep while breathing in nitrous oxide. Rather, most report feeling "floaty" and relaxed. Nitrous oxide takes 3-5 minutes to take effect, and at the end of the case, the nitrous oxide is turned off and replaced by 100% oxygen for 3-5 minutes. The effect of nitrous oxide lasts for about 5 minutes after treatment has ended. For routine fillings, children can return to school/daycare with no restrictions unless directed differently by your dentist.

Children who are sick and/or congested may be rescheduled to a later date. Children/adults who have received Bleomycin Sulfate (chemotherapy drug), had recent head trauma, have COPD, or who are pregnant should NOT receive nitrous oxide/oxygen.

Please be advised we will collect $74 for nitrous oxide (happy air) at the time of service for appointments of 75 minutes or less. We will collect $150 for nitrous oxide (happy air) at time of service for appointments longer than 75 minutes. We will still bill to your insurance for this service. However, this is usually not a covered service. If you happen to have an insurance that covers the nitrous we will reimburse you.

I have disclosed my child's current medical conditions, medications, and allergies to Dr. Stacey Zaikoski. We have reviewed treatment risks, benefits and alternatives. All questions have been answered. I give consent for Dr. Stacey Zaikoski and the staff at PedZ Dental to administer nitrous oxide for my child.

Patient Name: _____

Parent/Legal Guardian Printed Name: _____

Parent/Legal Guardian Signature: X _____

Date: _____

Ped Z Dental
Dr. Stacey Zaikoski, DDS

DIGITAL MEDIA CONSENT

I/we, _____, the parent(s)/guardian(s) of (child's full name) _____, hereby give Dr. Greg Notestine, DDS permission to use any still and/or moving images, including video footage, photographs, and audio footage depicting my/our child named above for the following uses:

-Advertisements, marketing, leaflets, or any other use such as training, educational, or publicity purposes

Signed:_____ Date:_____

Signed:_____ Date:_____

INFORMED CONSENT

The **lingual frenectomy/frenotomy** is a minor surgical procedure that involves clipping and/or lasering the band of tissue located on the underside of the tongue (frenum or frenulum). When this band is too tight, too short, or both, normal tongue movement is prevented.

The treatment may accomplish the following, but not be limited to:

- Allow the tongue to move in a greater range of motion
- Possibly improve breastfeeding comfort
- Possibly improve breastfeeding efficiency
- Possibly reduce the severity of speech difficulties

Complications of this treatment may include, but not be limited to:

- Excessive bleeding
- Damage to the vital structures under the tongue
- No perceivable benefit may be achieved

The **labial frenectomy/frenotomy** is a minor surgical procedure to free the lip attachment from the gums when it is too tight and/or too short. It can restrict proper lip movement and flexibility.

The treatment may accomplish the following, but not be limited to:

- Allow adequate lip flange to improve nursing effectiveness
- Reduce the pockets on either side of the frenum to prevent food trapping
- Give the upper lip more freedom of movement for speech sounds
- Possible reduction in reflux/aerophagia

Complications of this treatment may include, but not be limited to:

- Excessive bleeding
- Lip muscle damage
- No perceivable benefit may be achieved

Please note that this treatment is NOT intended to prevent a gap between the upper front teeth. If that is the goal, it may need treatment at about 11-12 years of age.

_____ I accept treatment _____ I decline treatment Signed:_____ Date: _____

Witness:_____ Date:_____

I give Dr. Notestine, DDS permission to contact and share any information regarding treatment and/or medical history with my medical provider:

Provider Name: _____ Contact Phone:_____

Provider Name: _____ Contact Phone:_____

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