Sprout
Kids Dentistry

1250 HANCOCK ST, SUITE 110N, QUINCY, MA 02169 Tel: (617) 328-1700 Fax: (617)481-5673

Child's Name: _____ Preferred Name: _____

Sex: Male / Female DOB: ____/_____/_____ Age: _____ School:_____

Mother's Name (First, Last): _____

SSN:_____-_____-_____ DOB (MM/DD/YY):_____/_____/_____ Driver's License #:_____

Father's Name (First, Last):_____

SSN:_____-_____-_____ DOB (MM/DD/YY):_____/_____/_____Driver's License #:_____

Child's Address: _____ , Unit/Apt#_____

City: _____ State: _____ Zip: _____ Phone#: _____-_____-_____

Text Appt. reminders: _____-_____-_____ Email: _____

Let's be Friends! Facebook: _____ Instagram:_____

Consent of a parent/guardian is necessary for dental treatment of a minor. I give permission for dentists of Sprout Kids Dentistry of Quincy, LLC to use diagnostic measures deemed necessary in his/her professional judgment to render the best dental treatment to my child. This may include but is not limited to an oral evaluation, cleaning, dental x-rays, and/or fluoride application at the time of an initial visit, routine visit, or consultation. The information I have given is accurate to the best of my knowledge and it will be held in the strictest of confidence according to HIPAA laws and regulations. It is my responsibility to inform the dentist of any changes to my child's health status.

Initials: _____ Signature:_____ Date:_____

Financially Responsible Person (First, Last name):_____

Billing Address: _____ , Unit/Apt#_____

City: _____ State: _____ Zip: _____ Phone#: _____-_____-_____

E-mail Address:_____

Emergency Contact (**do not list spouse/partner**):_____

Tel #: _____-_____-_____

PRIMARY DENTAL INSURANCE

Dental Insurance Company: _____ Member ID#: _____

Group# (if applicable): _____

Card Holder's name: _____ Relationship to child: _____

Social Security # _____-_____-_____ DOB (DD/MM/YY): _____/_____/ _____

Employer:_____ work#: _____-_____-_____

SECONDARY DENTAL INSURANCE

Dental Insurance Company: _____ Member ID#_____

Group# (if applicable): _____

Card Holder's name: _____ DOB (DD/MM/YY): _____/_____/ _____

HEALTH HISTORY

Pediatrician's name: _____ Med Center (if applicable): _____

Address: _____

City:_____State:_____Zip:_____Tel #: _____-_____-_____

Allergies to medicine/antibiotic(s) Y N:_____ Reaction:_____
_____ Reaction:_____

Allergy to foods (ex. Peanuts, shellfish) Y N:_____ Reaction:_____
_____ Reaction:_____

Allergy to food-dye Y N:_____ Reaction:_____

Circle "Y" only if medical condition applies, otherwise leave blank if condition is not applicable

Heart murmur	Y	N	Hemophilia/ bleeding disorder	Y	N
Latex Allergy	Y	N	Hepatitis	Y	N
Cancer/ Radiation therapy	Y	N	Eczema	Y	N
Seizures/epilepsy	Y	N	Vision Impaired	Y	N
Developmental delays	Y	N	HIV+ /AIDS	Y	N
Diabetes	Y	N	Migraines	Y	N
Ear infections	Y	N	Liver Problem	Y	N
Physical disabilities	Y	N	Lactose Intolerance	Y	N
Heart defect (congenital)	Y	N	Tuberculosis (TB)	Y	N
Asthma or lung problems	Y	N	Cerebral Palsy	Y	N
Blood transfusion	Y	N	ADHD/ ADD	Y	N
Autism	Y	N	Hearing Impaired	Y	N
Down's Syndrome	Y	N	Kidney Insufficiency	Y	N
Speech Delays	Y	N	Thyroid Problems	Y	N
Obesity	Y	N	Iron Anemia	Y	N
Sickle Cell Anemia	Y	N	Acid Reflux	Y	N
Constipation	Y	N	Canker Sores	Y	N
High Blood Pressure	Y	N	Gluten Allergy	Y	N
Emotional/Aggression Problems	Y	N	Sinusitis/Seasonal Allergy	Y	N

Other medical problems: _____

List medications taken, if any:

_____

_____

Is your child taking any supplemental fluoride? Yes No If yes, how? *(Circle one)* Tablets drops

☐ **I wish to decline a fluoride application for my child during today's visit. Initials: _____**

DENTAL HISTORY

Has your child seen a dentist before? Yes No If yes, date of last visit (MM/YY): _____/_____

Dentist/Dental Office Name: _____

Date of last dental x-rays (MM/YY): _____/ _____

I have reviewed my child's medical history and all information I have provided is known to be true.

Initials: _____ Signature:_____ Date:_____

FINANCIAL ARRANGEMENTS/INSURANCE AGREEMENT

For patients with dental insurance: I hereby authorize the dentist to release any information including diagnosis and records to the third party payer and/or other health care practitioners. I authorize and request my insurance to pay directly to the above named dentist, otherwise payable to me but not to exceed the charges shown on the claim. I understand I am financially responsible for any charges not covered by my insurance or by this authorization. I realize that the failure to keep this account current may result in the dentist unable to provide additional dental services except for dental emergencies or where there is a prepayment for additional services**. I understand a late charge of 1.5% per month (for a past due amount greater than $200), or a monthly late charge of $10 will be added to unpaid balances over 30 days past due** and where appropriate, a credit bureau report may be obtained. Patients with dental insurance must provide accurate and complete insurance information so we may assist you in filing your claim promptly. You will be required to pay your co-pay on the day of dental treatment.

For patients without insurances: payment in full is expected at the time of any dental service rendered. I realize that failure to keep this account current may result in the dentist refusing to provide additional dental services to my child except for dental emergencies or where there is a prepayment for additional services**. I understand a late charge of 1.5% per month (for a past due amount greater than $200), or a monthly late charge of $10 will be added to unpaid balances over 30 days past due** and where appropriate, a credit bureau report may be obtained.

☐ By checking this box, I understand the above Financial Arrangements/ Insurance Agreement, and agree to its contents.

HIPAA ACKNOWLEDGEMENT

I understand that I may inspect or copy the protected health information described by this authorization. I understand that at any time, this authorization may be revoked, when the office that receives this authorization, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my child's healthcare and the payment for their healthcare will not be affected if I refuse to sign this form. I understand that the information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

☐ By checking this box, I understand the above Financial Arrangements/ Insurance Agreement, and agree to its contents.

CONSENT TO INTERNET COMMUNICATIONS

I grant my permission to the dental practice to upload and store confidential patient information (including accounting information and clinical information) to the secured website for the dental practice. I understand that for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand that the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice website with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services, or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my dependent's patient information. I understand the dental practice will use commercially reasonable efforts to maintain confidentiality of all patient information that is uploaded to the website on my behalf. I understand that the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SIRE OR THE SERVICES.

☐ By checking this box, I have read the information regarding secured uploading of patient information to the website for the dental practice, and grant the dental practice permission to securely upload my dependent's information to the website.

Parent/Legal Guardian Signature: _____ Date: _____

For Office Use Only: We attempted to obtain written acknowledgment of receipt of our NOTICE OF PRIVACY PRACTICES, but acknowledgment could not be obtained because of: ___Individual refused to sign ___Communication barriers prohibited obtaining the acknowledgement ___An emergency situation prevented us ___Acknowledgment not returned by parent. HIPAA information given. Medical and Dental History Reviewed Verbally with Parent/Guardian for Patient Named Above. Initial_____ Date:_____