Reading
PEDIATRIC DENTISTRY
little teeth, big smiles

READING PEDIATRIC DENTISTRY
Tyler Reading, DMD

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WELCOME

We are pleased to welcome you and your child to Reading Pediatric Dentistry. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.

PATIENT INFORMATION

DATE _____ BIRTHDATE (mm/dd/yyyy) _____

NAME OF CHILD (last, first, m.i.) _____ ☐ MALE ☐ FEMALE AGE _____

NICKNAME _____ HOBBIES _____ CELL PHONE (_____) _____

EMAIL _____ PREFER TEXTS Y N

ADDRESS _____ CITY _____ STATE/ZIP _____

HOME PHONE (____) _____ WORK PHONE (____) _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

WHY DID YOU BRING YOUR CHILD TO THE DENTIST TODAY? _____

_____

PERSON FINANCIALLY RESPONSIBLE _____

SCHOOL NAME _____

MEDICAL HISTORY

MINOR/CHILD'S PHYSICIAN _____

RECEIVING ANY MEDICATIONS OR DRUGS?..... ☐ YES ☐ NO MEDICATIONS _____

EVER BEEN HOSPITALIZED? ..... ☐ YES ☐ NO _____

EVER HAD SURGERY?..... ☐ YES ☐ NO _____

ANY ALLERGIES? ..... ☐ YES ☐ NO _____

HAS MINOR/CHILD HAD ANY HISTORY OF, OR DIFFICULTY WITH, ANY OF THE FOLLOWING? IF YES, PLEASE CHECK APPROPRIATE BOX.

☐ ADD/ADHD	☐ CANCER	☐ FAINTING	☐ LIVER DISEASE	☐ THYROID DISEASE
☐ AIDS/HIV	☐ CEREBRAL PALSY	☐ HEARING PROBLEMS	☐ RHEUMATIC FEVER	☐ TUBERCULOSIS
☐ ANEMIA	☐ DOWN SYNDROME	☐ HEART PROBLEMS	☐ SEIZURES	☐ BLOOD DISORDER
☐ ASTHMA	☐ DIABETES	☐ HEPATITIS	☐ SINUS PROBLEMS	
☐ AUTISM	☐ EPILEPSY	☐ KIDNEY DISEASE	☐ TONSILS	

☐ OTHER _____

DENTAL HISTORY

DATE OF LAST VISIT TO A DENTIST _____

WHAT IS YOUR MAIN DENTAL CONCERN? _____

Has child complained about dental problems? ..... ☐ YES ☐ NO

How do you expect your child to react to today's visit? ..... ☐ WELL ☐ NERVOUS ☐ QUIET ☐ SCARED

Any mouth habits: thumb sucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc?..... ☐ YES ☐ NO

PARENT/GUARDIAN

FATHER'S/GUARDIAN'S NAME _____

ADDRESS (if different from patient's) _____

_____

HOME PH (____) _____

WORK PH (____) _____

CELL PH (____) _____

EMPLOYER _____

SSN _____ BIRTHDATE _____

MOTHER'S/GUARDIAN'S NAME _____

ADDRESS (if different from patient's) _____

_____

HOME PH (____) _____

WORK PH (____) _____

CELL PH (____) _____

EMPLOYER _____

SSN _____ BIRTHDATE _____

INSURANCE

PRIMARY DENTAL INSURANCE

PLAN NAME _____ PH (____) _____

SUBSCRIBER'S NAME _____

ADDRESS _____

GROUP# _____ ID# _____

SECONDARY DENTAL INSURANCE

PLAN NAME _____ PH (____) _____

SUBSCRIBER'S NAME _____

ADDRESS _____

GROUP# _____ ID# _____

AUTHORIZATION

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

MINOR/CHILD CONSENT

I am the parent, guardian, or personal representative of _____
PLEASE PRINT NAME OF MINOR CHILD

and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services of the child named above, including, but not limited to X-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

INSURANCE ASSIGNMENT AND RELEASE

I certify that my dependent(s) is/are covered by insurance with _____
NAME OF INSURANCE COMPANY(IES)

I understand that Reading Pediatric Dentistry bills my insurance as a courtesy to me. I am aware that I am responsible for knowing my own insurance coverage. I am fully aware that **a $25 charge will be applied to my account for all missed appointments as well as appointments canceled without a 24-hour notice.** I am also aware that I am ultimately responsible for any balance owing on the account. In the event that the insurance company does not pay as much as was estimated, I am responsible for the remaining portion. Any portion of the account that has been left unpaid for more than two months will be subject to an eighteen percent (18%) finance charge. The undersigned further agrees to pay any additional collection fees representing up to fifty percent (50%) of the principal balance if the account is referred to a collection agency. The undersigned specifically agrees to pay all attorney fees and court costs in the event legal action is taken to collect on the account. This additional amount is in recognition of the costs associated with the said collections action processing

_____
SIGNATURE OF PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE DATE

_____
PLEASE PRINT NAME OF PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE RELATIONSHIP TO PATIENT

PRIVACY

I have been given the right to review and receive a copy of Reading Pediatric Dentistry's Notice of Privacy Practices/HIPPA. I understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address above and obtain a current copy.

PATIENT NAME _____ SIGNATURE _____

RELATIONSHIP TO PATIENT _____ DATE _____