DAVID E. SHAPTER, D.D.S.

Pediatric Dentistry

(814) 868-8673

Standard Square, Suite 300
128 W. 12th Street
Erie, PA 16501

PATIENT INFORMATION FORM

Please complete and return this form on the first visit. If the space is inadequate, use remark section. Thank you for your cooperation.

PERSONAL

(Questions are on BOTH SIDES of each page)

Child's Name _____ Date of Birth _____
Nickname _____ SS# _____

Mother's Name _____ Occupation _____
Date of Birth _____ SS# _____

Father's Name _____ Occupation _____
Date of Birth _____ SS# _____

Home Address Street _____ City _____
State _____ Zip _____ Phone# _____

Mother's Employer _____

Business Address Street _____ City _____
State _____ Zip _____ Phone # _____

Father's Employer _____

Business Address Street _____ City _____
State _____ Zip _____ Phone # _____

Child's Physician _____
Address Street _____ City _____
State _____ Zip _____ Phone # _____

Child's Previous
Dentist (if applicable) _____
Address Street _____ City _____
State _____ Zip _____ Phone # _____

Child's school _____ Grade _____

Age & Name of Siblings _____

Who can we thank for referring you? _____

HEALTH INSURANCE INFORMATION

Dental Coverage

Company _____

Policy # _____

Name of Policy Holder _____

Major Medical Coverage

Company _____

Policy# _____

Name of Policy Holder _____

DENTAL HEALTH HISTORY

"x" The main reason for the first visit. Also place a "v" next to problems about which you are concerned.

__First Exam
__Routine check-up
__Accident
__Bleeding gums
__Cavities
__Broken Tooth
__Toothache/swelling
__Staining/discoloration
__Crowding of Teeth
__Thumb Habit
__Other Habits
__Other Problems

Please circle either YES or NO. Please complete all questions.

Past dental history of your child.

1. Is this the first visit to a dentist? Yes No

2. If your child has been to a dentist previously,
   a. When was last visit? Date_____
   b. Have x-rays been taken and when? Date_____
   c. How did your child react and describe his/her temperament_____
_____

3. How do you think your child will react to dental treatment now?_____
_____

4. Has your child had Fluoride in any of the following forms?
   Fluoride tablets or in multiple vitamins Don't know Yes No
   Drinking water (community Fluoridation) Don't know Yes No
   Topical application on teeth: Last Date_____ Don't know
   Toothpaste: Brand_____

5. Does your child brush his/her own teeth? Yes No
How frequently & when? A.M. P.M. After Snacks Before Bed After Breakfast

6. Do you brush your child's teeth? Yes No
How frequently & when? A.M. P.M. After Snacks Before Bed After Breakfast

7. Do you floss child's teeth? Yes No
How frequently & when? A.M. P.M. After Snacks Before Bed After Breakfast

8. Does your child have between meal snacks? Yes No

9. Have your child's teeth ever been injured in an accident? Yes No
   When?_____
   Which Teeth?_____
   Cause?_____
   Were the teeth treated? Yes No
   If so, describe treatment_____

10. Has your child received any unusual dental or surgical treatment to the mouth? Yes No
    If so, what?_____

11. Does your child have any of the following habits? (indicate ages when)
    Bottle to bed at night or nap_____
    What was in bottle?_____
    Use a pacifier?_____
    Thumb or finger sucking_____
    Tongue Thrusting_____
    Lip sucking or biting_____
    Mouth breathing_____
    Grinds teeth_____

12. Does your child tend to get frequent headaches? Yes No
    How Often?_____ Duration_____

    Does your child tend to get frequent earaches? Yes No
    How Often?_____

    Does your child tend to complain of clicking, popping or crunching noises in his/her ears while chewing? Yes No

MEDICAL HISTORY

(Questions asked so hereditary factors may be evaluated)

1. Birth History:

Was this child born premature?	Yes	No
Were there any problems during pregnancy?	Yes	No
Did you take any medicine during pregnancy?	Yes	No
Were there any problems with the delivery?	Yes	No
Did child go home with mother?	Yes	No
Did your child have pneumonia or staph infection during the first year?	Yes	No
Is this child adopted?	Yes	No

Any other information that might be pertinent?_____

_____

2. General Health:

Is a physician treating your child now for an illness Yes No

If so, for what reason_____

Is your child taking any medication at this time? Yes No

Drug	Dose	Frequency	Reason

Has your child taken any unusual medications in the past? Yes No

If so, what?_____

Has your child shown any allergies or unusual reactions? Yes No

a. Medications or drugs_____

b. Foods_____

c. Other_____

Has your child had any of the following immunizations?

__DPT: Date of last booster_____

__Polio (all 3 oral doses)
__Measles
__Rubella (German Measles)
__Mumps
__Sickle Cell Test
__Tuberculin Skin Test

Does your child have any history of the following diseases or conditions?

__Rheumatic Fever
__Heart Murmur. Type?_____
__Bleeding Problems
__Kidney Disease
__Seizures
__Ear Infections
__Cerebral Palsy
__Liver Disease
__Diabetes
__Chicken Pox
__Anemia
__Asthma
__Pneumonia
__Digestive Disorders
__Learning Disabilities. Type?_____
__Emotional Disabilities. Type?_____
__Hearing difficulty. Type?_____
__Speech difficulty. Type?_____

Has your child ever been hospitalized? Yes No

If so, When?_____

For what reason?_____

Has your child had any operations? Yes No

If so, When?_____

For what reason?_____

Was general anesthesia used? Yes No

Any Complications?_____

Does your child bruise easily? Yes No

Has there ever been any history of spontaneous bleeding, (e.g. nose bleeds) or prolonged bleeding following tooth removal surgery, cuts, etc.? Yes No

3. Growth and Development:
   - Age child's first tooth noticed _____
   - Age child lost first tooth _____
   - Age first spoke a word _____
   - Age first started to walk _____

   General Development would be Early Average Late

4. Family History (with whom child resides)
   - Is mother living? Yes No
   - Is father living? Yes No
   - Are parents living together? Yes No
   - Are mother's teeth & gums in good health? Yes No
   - Are father's teeth & gums in good health? Yes No

5. Remarks: _____

The signature of a parent or guardian affixed below authorizes the completion of all mutually agreed upon necessary dental services.

Signature _____ Relationship _____ Date _____

RE-EVALUATION OF ORIGINAL PATIENT INFORMATION FORM

DATE	NO CHANGE	CHANGES	PARENT INITIAL

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PATIENT POLICIES

A. Appointments

1. A responsible adult over 21 years of age must accompany all patients under 18.
2. Appointments can be made over the phone or immediately after seeing the dentist.
3. Parent or guardian **must remain** in waiting room while child is being seen, **unless requested by dentist to accompany child to treatment area**.
4. Cancelled appointments require at least **24 hour prior notification.** This will allow us time to fill the vacant appointment with another patient.

B. Broken Appointments

1. A broken appointment may be recorded when **at least 24 hours** notice has **not** been given prior to cancellation.
2. If a patient is **more than 10 minutes late** for an appointment, it is considered a broken appointment, and the next scheduled patient will be seen.
3. All patients who fail to keep scheduled dental appointments will not be rescheduled, but will be placed on "call list".
4. Cancellations made within 24 hours will be considered a failed appointment, and will not be rescheduled, but will be placed on a call list.
5. Excessive cancellations and failed appointments will result in termination of patient care privileges at this office.

C. Late Arrival

1. Patients arriving 10 minutes late may have to wait to be seen and may need additional appointments to complete planned care.
2. Patients arriving 15 minutes or more late, may need to be rescheduled or placed on "call list".

I have reviewed and understand the above policies.

_____ _____

Parent's Signature Date

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PERMISSION FOR TREATMENT OF A MINOR

TO WHOM IT MAY CONCERN:

I, _____, hereby give the following persons my consent/permission to obtain treatment for my minor child,_____, Date of Birth _____/_____/_____, from David E. Shapter, D.D.S.. This permission enables Dr. David E. Shapter to obtain a history, examine the child, administer anesthesia, and perform dental procedures when the child is brought in for treatment by the following people (in addition to myself).

Must be 18 years or older.

Name:_____Relationship to Patient:_____Phone:_____

Name:_____Relationship to Patient:_____Phone:_____

Name:_____Relationship to Patient:_____Phone:_____

_____ **Date:**_____
(PARENT/LEGAL GUARDIAN)

_____ **Phone:**_____
(PARENT/LEGAL GUARDIAN ADDRESS

OUR FINANCIAL POLICY

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

- **All patients must complete our "*Patient Information Form*" before seeing the doctor.**
- **FULL PAYMENT IS DUE AT TIME OF SERVICE.**
- **WE ACCEPT CASH, CHECKS, AND VISA/MASTERCARD.**

MINORS ACCOMPANIED BY AN ADULT

The adult accompanying a minor, and his/her parents (or guardians), are responsible for **full payment** at time of service.

UNACCOMPANIED MINORS

The parents (or guardians) are responsible for **full payment.** Non-emergency treatment will be denied unless charges have been pre-authorized to an **approved** credit plan or to Visa/Mastercard, or paid by cash or check at time of service.

REGARDING INSURANCE

If you have insurance, we will help you receive maximum benefits.

We will NOT accept insurance on your first visit. However, we will help you complete claim forms so that you can be reimbursed by your insurance company to the extent of your coverage.

On subsequent visits, we MAY accept your insurance if you obtain approval from our office staff prior to the date of service. If we accept your insurance, you must pay at least 30% of total charges at time of service (some procedures require 50% payment). If your insurance company has not paid the FULL BALANCE within 45 days, you have 15 days to pay the balance. Late Payment Charges are added to unpaid accounts after 60 days from date of service. If your insurance company pays more than the balance due, we will send a refund check to you immediately.

Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases, (We will inform you if we are a party to your insurance contract, and will handle your claims according to our agreement with the insurance company, if one exists.) We will file insurance claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual & customary" charges, etc., other than to supply factual information as necessary. **You are responsible for the timely payment of your account.**

MEDICARE/MEDICAID/CHAMPUS/WORKER'S COMPENSATION

If you are covered by Medicare, Medicaid, Champus, Worker's Compensation, or any other government- sponsored program, please discuss your payment situation with our office staff prior to date of service.

MISSED APPOINTMENTS

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

Responsible Party Signature _____ Date _____

Dr. David E. Shapter, Pediatric Dentistry

HIPAA OMNIBUS RULE
PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

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

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITYS IN THE FUTURE.**

_____ _____

Please ***print*** your name Please ***sign*** your name

_____ _____

Legal Representative Description of Authority

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Sir Name ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message
☐ Text Message
☐ Email
☐ **Any of the Above**
☐ **None of the above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ____

_____
Signature of Privacy Officer