PEDIATRIC DENTISTRY

JOSEPH A YALE, DDS
KATIE McCLENDON, DDS
KATHLEEN CORBIN, DDS

(225) 664-2646 • (225) 664-2640 (fax)
245 VETERANS BLVD. • DENHAM SPRINGS, LA 70726

1 Tell Us About Your Child

Today's Date: _____ Child's Name: _____
First Middle Last

Nickname: _____ ☐ M ☐ F Birthdate: _____/_____/_____

Billing Address: _____ City:_____ St:_____ Zip:_____

Age: _____ SSN: _____

School: _____ Grade: _____

E-Mail Address: _____

2 Who is Accompanying Your Child Today?

Name: _____ Relation: _____

Do you have legal custody of this child? Yes No

Whom may we thank for referring you? _____

List other siblings seen by our office _____

_____

3 Parent Information

☐ Mother ☐ Stepmother ☐ Guardian

Name: _____ Birthdate: _____/_____/_____

Cell #: (_____) _____-_____ Home #: (_____) _____-_____ Work #: (_____) _____-_____

Employer: _____ SSN: _____

☐ Father ☐ Stepfather ☐ Guardian

Name: _____ Birthdate: _____/_____/ _____

Cell #: (_____) _____-_____ Home #: (_____) _____-_____ Work #: (_____) _____-_____

Employer: _____ SSN: _____

Parent's Marital Status: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

If foster parent, provide case worker: Name: _____ Ph #: (_____) _____-_____

4 Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Ph. #: (_____) _____-_____ Group #: _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: _____/_____/ _____ I.D. # _____

Policy Owner's Employer: _____

*If child does not have dental insurance, how do you intend to pay? Cash Check MC / VISA / Discover

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Child's Name _____ Birthday _____ / _____ / _____

Medical History

Child's Physician _____ Address _____ Phone # (____)_____

Date of Last Visit _____ Reason_____

Is your child in good physical health?	❑ Yes	❑ No	
Is your child up to date with immunizations?	❑ Yes	❑ No	
Has your child been hospitalized since birth?	❑ Yes	❑ No	
Was child born premature?	❑ Yes	❑ No	How many weeks early? _____

Please check any of the following that may pertain to your child

___ADD/ADHD	___Brain Injury	___Eczema	___Kidney Problem	___Sickle Cell Anemia
___Aids'/HIV+	___Cancer	___Epilepsy	___Latex Allergy	___Sight Problems
___Allergies	___Cerebral Palsy	___Handicaps	___Learning Disability	___Snoring/Sleep Apnea
___Anxiety	___Chemo/Radiation	___Hearing Problems	___Liver Problem	___Syndrome:_____
___Asthma	___Congenital Birth Defect	___Heart Condition	___Lung Problem	___Other
___Autism	___Cystic Fibrosis	___Heart Murmur	___Psychiatric Disorder	
___Bleeding Problem	___Diabetes	___Hepatitis	___Seizures	

Please describe any medical condition that was checked above **or any condition that was not listed:**

_____

Please list all medications your child is taking _____

Is your child allergic to any medications, food, etc.? ❑ Yes ❑No If yes, list_____

Dental History

Reason Your Child Is Here Today _____

Is this your child's first dental visit? _____ Date of Last Visit _____ Were X-Rays taken? _____

Has your child had an unfavorable experience in a dental office? _____

If yes, please explain _____

Child's Previous Dentist _____ Address _____ Phone # (____)_____

What is your water source?	❑ Private Well	❑ Public System	
Does your child suck their thumb or finger?	❑ Yes	❑ No	
Does your child use a pacifier?	❑ Yes	❑ No	
Was your child bottle fed?	❑ Yes	❑ No	Age it was discontinued _____
Has your child ever had trauma to their teeth?	❑ Yes	❑ No	
Do you assist your child with tooth brushing?	❑ Yes	❑ No	❑ Sometimes

Permission

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

Parent/Guardian's Signature _____

Date _____

PEDIATRIC DENTISTRY

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KATIE McCLENDON, DDS
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245 Veterans Blvd
Denham Springs, La 70726
225-664-2646

Parent/ Guardian Consent

I, _____, Custodial Parent of

_____,
(Minor/ Minors)

Authorize Dr. Yale, Dr. McClendon, or Dr. Corbin and their employees to render dental treatment to the above listed child/ children.

If I am unable to attend any appointments with my child(ren), the names listed below are authorized to bring them to their appointments and to discuss my child(ren)'s dental care. I also give them permission to make treatment and financial decisions.

Person's Name	Relationship to Patient	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Parent/ Guardian Signature:_____

Date:_____

Consent for Dental Treatment

State Law requires us to obtain your consent for dental treatment. Please feel free to ask any questions you may have. In general terms, contemplated treatment is: dental restorations, sealants, extractions, exam, cleaning, local anesthetic, and nitrous oxide.

Alternatives to the Recommended Dental Treatment

Any alternatives to the recommended treatment, including no treatment, have been explained to me, as have the advantages and disadvantages of each.

Risks associated with the Recommended Dental Treatment

I understand dentistry is not an exact science and complications may occur despite our best efforts. A partial listing of the risks known to be associated with dental treatment and anesthetic care are:

Infections, Bleeding, Failure of wound to heal, Injuries to adjacent teeth or soft tissues, Paresthesia or numbness of tongue, mouth or face, Fracture of Lower jaw or Upper Jaw, opening between mouth and sinus or mouth and nose, Incomplete removal of tooth, Dry socket, Loss of teeth, Loss of bone, Loss of hard or soft tissues, Instrument breakage, Breakage of roots and retained root fragments, Swallowing or aspiration of objects, Allergic reactions to drugs, Jaw Pain or difficulty opening mouth, Bacterial Endocarditis, Additional Oral Surgery, Hospitalization, or further treatment upon complications.

State law also requires the we specifically advise you that, although rarely occurring, dental treatment or anesthetic may result in: Death, Brain Damage, Paraplegia, Quadriplegia, Loss of Organs, Loss of Function of an Organ, Loss of function of Face, Arms, Legs, and Disfiguring Scars.

Acknowledgment

I have read and understand the information stated above. I have been given ample opportunity to ask any questions I may have about treatment. All questions have been answered in a satisfactory manner. I understand the success of this treatment and the avoidance of treatment complications depends upon my complying with the instructions, restrictions, and any recommendations, that have been explained to me. I also understand that I am to notify the dentist immediately of any suspected complications, where further treatment may be discussed or administered, which is not currently anticipated.

I, as the patients legal guardian, authorize and request **Dr. Joseph A. Yale, Dr. Mary K. McClendon, Dr. Kathleen Corbin** and/or assistants of his choice, to perform any dental procedures, including anesthetic, that deem necessary during treatment. I understand the treatment plan to be presented, along with the fees outlining, could change depending upon the time elapsed since the initial examination and the extent of dental pathology. **By signing this I agree to be responsible for full payment of all charges on the above named patient.**

This consent will remain valid until revoked in writing. All blanks have been filled in prior to my signature.

Patient Name_____

Guardian
Signature_____date_____

YALE PEDIATRIC DENTISTRY

Joseph A. Yale DDS
Mary K. McClendon DDS
Kathleen Corbin DDS
245 Veterans Blvd. DS, LA 70726
(225)664-2646 (225)664-2640 (fax)

Hipaa

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post this new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E-mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown above.

ACKNOWLEDGEMENT OF RECEIPT

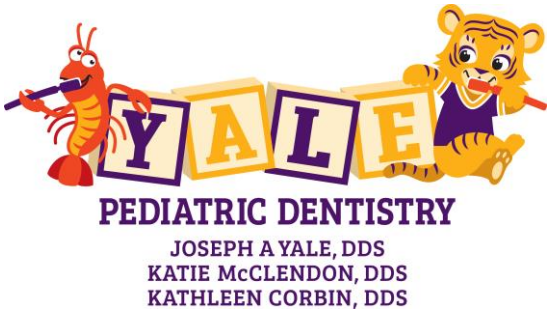
Patient name _____

_____

_____

Signature _____

Date_____



- **Louisiana Medicaid**

We want to help you get the full benefits afforded you by the Medicaid Program. To assist you in receiving these benefits, we will file your Medicaid claims for payment of services we have rendered to you. For your benefit, please let us know of any changes or if your coverage has been terminated. If coverage has terminated and no benefits are paid by Medicaid for services rendered, **then the responsibility falls to you to pay in full**.

- **Dental Insurance**

As a courtesy to you, we will assist in filing your dental claims to help you get the full benefit your insurance offers. Please be advised treatment plans are only an **estimated** cost based on an estimated coverage breakdown given to us by your insurance company. **Any cost not covered by insurance is your responsibility**. If you have any changes with your insurance company or policy, please inform our office before your next appointment.

- **Attendance Policy**

The best care for your child is received when you make the appointments we have scheduled together. If for some reason you have to cancel your child's appointment, please call our office **24 hours in advance** of your scheduled time. **If your child does not show for two scheduled appointments, unfortunately we will no longer be able to reserve future appointments for your family with our office,** This rule is important for your child and other children, because we make every effort to plan all appointments to provide the best preventative care. So if you miss yours, most if not all, appointment times are filled and your child misses out on their care.

- **Confirmation Policy**

Our office REQUIRES that all appointments are CONFIRMED. Several attempts will be made to contact you in regards to appointments. It is your responsibility to ensure that we have spoken to you and received a confirmation that your child will be at his/her appointment. If no confirmation has been received by the working day prior to the appointment, unfortunately **this appointment can no longer be held and the appointment WILL BE CANCELLED.**

I understand and agree to the above terms.

Patient's Name: _____

Signed: _____ Date:_____

Parent/Guardian

Photo Release Form

We have created a Website, Social Media pages and LED sign for our office. These items provide a fun way to share new things going on in our office and with our patients, as well as update you on important information. Please fill out the bottom of this form granting **Yale Pediatric Dentistry** permission to post photos of your child on one or all of the places listed above. You may see this picture on www.drjoeyale.com or www.facebook.com/DrJoeYale.

With your signature, you consent as follow:

I am legal guardian of _____ and I give **Yale Pediatric Dentistry** permission for the above patient to be photographed and the pictures to be placed on Social Media,our website, and/or our LED sign.

_____ _____

Parent or Guardian Signature Date