Tell us about your child:

Child's Name: _____ Child's Birth date: _____/_____/_____

Preferred Name: _____ □ Male □ Female Child's Social Security #: _____

Child's Home Address: Child's Home #: (_____)_____

_____

Street City State Zip Code

School: _____ Grade: _____

Who is accompanying the child today?

Name:_____ Relation:_____

Do you have legal custody of this child? □ Yes □ No **If not, please provide legal paperwork.**

Other siblings seen by us: _____

Mother's Information: □ Biological Mother □ Step Mother □ Guardian

Parent's Marital Status: □ Single □ Married □ Widowed □ Divorced □ Separated

Name: _____ Birth date: _____/_____/_____

SS#: _____ DL#: _____

Address:

_____

Street City State Zip Code

Email: _____

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

Employer: _____

Father's Information: □ Biological Father □ Step Father □ Guardian

Parent's Marital Status: □ Single □ Married □ Widowed □ Divorced □ Separated

Name: _____ Birth date: _____/_____/_____

SS#: _____ DL#: _____

Address:

_____

Street City State Zip Code

Email: _____

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

Employer: _____

Primary Dental Insurance:

Insurance Co. Name: _____ Phone #: (_____)_____

Policy Holder's Name: _____Group #: _____ Employer: _____

Policy Holder's Birth date: _____/_____/_____ Social Security/ID #: _____

Relationship to Patient: _____

Secondary Dental Insurance:

Insurance Co. Name: _____Phone #: (_____)_____

Policy Holder's Name: _____Group #: _____ Employer: _____

Policy Holder's Birth date: _____/_____/_____ Social Security/ID #: _____

Relationship to Patient: _____

Referral Information:

Who can we thank for referring you to our practice?

□ Internet/Website □ Local Event □ Newspaper □ Radio □ School □ Work

□ Orthodontic/Dental Office □ Location □ Other _____

Dental History:

Why did you bring your child to the dentist today? _____

Is this your child's first dental visit? □ Yes □ No

Previous Dentist: _____Phone # (____)_____ Last Visit Date: _____

Has the child ever had a serious/difficult problem associated with previous dental work? □ Yes □ No

Is the child's water fluoridated? □ Yes □ No

Has the child ever had any pain or tenderness in his/her jaw joint (TMJ/TMD)? □ Yes □ No

Does the child brush his/her teeth daily? □ Yes □ No

Floss his/her teeth daily? □ Yes □ No

Anything you would like to discuss with the Doctor in private? □ Yes □ No

Medical History:

Child's Physician: _____Phone #: (_____)_____Last Visit Date: _____

Are the child's immunizations current? □ Yes □ No If no, please explain: _____

Has your child ever had or currently have any of the following medical conditions?

□ Yes □ No ADD/ADHD
□ Yes □ No Anemia
□ Yes □ No Arthritis
□ Yes □ No Artificial Joints/Valves
□ Yes □ No Aspergers Syndrome
□ Yes □ No Asthma
□ Yes □ No Autism
□ Yes □ No Behavioral Problems
□ Yes □ No Cancer/Leukemia
□ Yes □ No Cardiac Pacemaker
□ Yes □ No Celiac Disease/Gluten Sensitivity
□ Yes □ No Chicken Pox
□ Yes □ No Cleft Palate/Lip
□ Yes □ No Congenital Heart Defect
□ Yes □ No Craniofacial Anomalies
□ Yes □ No Diabetes
□ Yes □ No Down's Syndrome
□ Yes □ No Epilepsy
□ Yes □ No Glaucoma
□ Yes □ No Handicaps/Disabilities
□ Yes □ No Hearing Impairment
□ Yes □ No Heart Murmur
□ Yes □ No Hemophilia
□ Yes □ No Hepatitis Type:_____
□ Yes □ No HIV/AIDS
□ Yes □ No Hospital Stays _____
□ Yes □ No Kidney/Liver Problems
□ Yes □ No Low Blood Pressure
□ Yes □ No Measles
□ Yes □ No Mental Disorder
□ Yes □ No Mitral Valve Prolapse
□ Yes □ No Nervous Disorder
□ Yes □ No Oppositional Defiance Disorder
□ Yes □ No Pregnancy
□ Yes □ No Pervasive Development Disorder
□ Yes □ No Premed Antibiotic Needed (Heart Condition)
□ Yes □ No Seasonal Allergies
□ Yes □ No Seizures
□ Yes □ No Sickle Cell Disease
□ Yes □ No Skin Rash _____
□ Yes □ No Speech Impairment
□ Yes □ No Stroke
□ Yes □ No Surgeries:_____
□ Yes □ No Therapies (i.e: speech, occupational, behavioral, developmental _____
□ Yes □ No Thyroid Problems
□ Yes □ No Tuberculosis
□ Yes □ No Ulcers
□ Yes □ No Any other medical conditions we should be aware of: _____
_____
_____

Please list all prescription and over the counter drugs the child is currently taking:

_____

_____

Is your child allergic to or have they had any reactions to the following?

□ Yes □ No Barbiturates
□ Yes □ No Sedatives/General Anesthesia
□ Yes □ No Iodine
□ Yes □ No Aspirin
□ Yes □ No Any metals (nickel, mercury, etc)
□ Yes □ No Sulfa Drugs
□ Yes □ No Latex Rubber
□ Yes □ No Local Anesthetics (Lidocaine, Septocaine)
□ Yes □ No Penicillin or other antibiotics (amoxicillin, clindamycin, erythromycin, cephalexin)
□ Yes □ No Dyes
□ Yes □ No Other: _____
□ Yes □ No Demerol
□ Yes □ No Lortab (Hydrocodone)
□ Yes □ No Dairy/Milk/Lactose
□ Yes □ No Codeine
□ Yes □ No Vistaril
□ Yes □ No Gluten
□ Yes □ No Nuts

Does/did your child have any of the following habits?

□ Yes □ No Lip Sucking
□ Yes □ No Nail Biting
□ Yes □ No Mouth Breathing
□ Yes □ No Pacifier Habit
□ Yes □ No Nursing Bottle Habits
□ Yes □ No Thumb/Finger Sucking
□ Yes □ No Clenching/Grinding Teeth
□ Yes □ No Snoring

I certify to the best of my knowledge, the questions on this from have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any change in my child's medical status.

Patient Name: _____

Signature of parent/legal guardian: _____ Date:_____

Appointment Policy:

At My Village, we make every attempt to schedule appointments at your convenience and limit absences from school. After school hours are available upon request, but are subject to availability. Appointment times are designed to fit your child's specific needs. Younger children and special needs patients are typically scheduled in the early morning when they are alert and more cooperative. Children receiving extensive treatment and sedation appointments are also preferably scheduled in the morning. This allows parents more time during the day to address any concerns and make sure their child is comfortable after the appointment. We will be happy to provide their school with a letter explaining the absence and necessary dental treatment.

In order to provide each child with the individual care and attention they deserve, we ask that you arrive on time for scheduled dental appointments. We work very hard to see each patient at their scheduled appointment time; however accidents and emergencies happen due to the nature of our practice. We ask for your patience if we are delayed in seeing your child due to treating another child on an emergency basis.
Because appointed times are reserved exclusively for each patient we ask that you please notify our office **24 hours in advance** of your scheduled appointment time if you are unable to keep your appointment. Broken and short notice cancellations may result in a **$25 charge**. This fee must be paid before any additional services are rendered. After two missed appointments, we reserve the right to dismiss your child from our practice. We realize that unexpected things can and do happen, but would appreciate the earliest notification possible. This allows us to inform other patients in need of our care of the opening.
******If you are more than 15 minutes late for the reserved appointment time, you may be asked to reschedule**.

Financial Policy:

We are a provider for Delta Dental PPO and Premiere, Delta Dental Smiles, MCNA, AR Medicaid, Blue Cross Blue Shield of Arkansas, MetLife, Cigna DPPO, Guardian, Municipal, Principal, United Healthcare, United Concordia, GEHA, Humana, and Aetna. As a courtesy, our office will file dental claims with these and most other insurance companies. We do our best to estimate your portion of payment based on the information your insurance has provided us; however, it is only an estimate and you will be ultimately responsible for any balance remaining after insurance pays their portion. The estimated portion/copay is due at the time services are rendered, regardless of who accompanies the patient on the day of his/her appointment.
We accept cash, checks, Visa, Mastercard, Discover, American Express, and Care Credit. There is a $25 charge for returned checks or other "insufficient funds" notifications to our office.
After 90 days, unpaid balances may be assigned to a collection service for processing.

I have read and understand My Village Pediatric Dentistry's appointment and financial policy.

Patient Name: _____

Signature of parent/legal guardian: _____ Date: _____

Authorization and Release:

I certify that I have read and understand the above information to the best of my knowledge and that I have given accurate information. I authorize the dental staff to perform the necessary dental services my child may need.
I authorize and request my insurance company to pay directly to Rock Dental Brands, PLLC dba My Village Pediatric Dentistry insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less that the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient Name: _____

Signature of parent/legal guardian: _____ Date:_____

Acknowledgement of Receipt of Notice of Privacy Practices and Consent:

I have received and/or reviewed a copy of Rock Dental Brands, PLLC (aka My Village Pediatric Dentistry) Notice of Privacy Practices.
****You may refuse to sign this acknowledgement.

Child's Name: _____

Signature of parent/legal guardian: _____ Date: _____

Accompanying Child Consent:

Please list below the names of individuals that may ever accompany your child at an appointment and that your authorize to act as appointed healthcare representatives with whom the patient's dental care may be discussed, in the event the parent/legal guardian cannot be present.

Name: _____Relationship: _____

Name: _____Relationship: _____

Name: _____Relationship: _____

Name: _____Relationship: _____

Name: _____Relationship: _____

Photo and Image Release Consent:

I hereby authorize Rock Dental Brands, PLLC (aka My Village Pediatric Dentistry) to reproduce, use and/or publish still or video photography for promoting or advertising for Rock Dental Brands, PLLC

In giving this consent, I release Rock Dental Brands from liability for any violation or any person proprietary right I may have in connection with such sale, reproduction, use or compensation.

- Revocation: I understand that I may revoke this authorization at any time by sending a notice to the Corporate Office of Rock Dental Brands, PLLC.
- Re-disclosure: I understand that information used or disclosed in accordance with this authorization may no longer be protected by federal law, and could be re-disclosed by receiving party.
- Refusal to sign: I understand that I may refuse to sign this authorization and that Rock Dental Brands, PLLC will not condition employment or treatment on whether I sign this authorization.
- Certification: I certify that I am than 18 years of age and am authorized to sign on behalf of the named patient of Rock Dental Brands, PLLC.

Patient Name: _____

Signature of parent/legal guardian: _____ Date: _____

Text and Email Policy:

My Village Pediatric Dentistry can email and/or text you appointment reminders and general information about our services. If you would like to receive communications via email/text in the future, please read and sign the consent attached below.

Consent to Email and/or Text Message for Appointment Reminders and Other Communications:

You may be contacted via email/and or text messaging to remind you of an appointment, to obtain feedback on your experience with our team, and to provide general treatment reminders and information about our products and services. By signing below, you consent to receiving appointment reminders and other communication and information via email or text from our practice sent to any email address or phone number you provide to us. Any email or text messages we send may not be encrypted or otherwise protected and could be intercepted by a third party. By executing this consent, you assume the risk that the information contained in any such communication will be intercepted. We will not charge you for sending texts or emails, but charges from your carrier may apply. I understand that this request to receive emails and/or text messages will apply to all future appointment reminders and communications sent by our practice until I request a change in writing.

Patient Name: _____

Communication Preference: □ Text □ Email □ Both

Signature of parent/legal guardian: _____ Date:_____

Non-Discrimination Policy:

DISCRIMINATION IS AGAINST THE LAW

My Village Pediatric Dentistry complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. My Village Pediatric Dentistry does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

My Village Pediatric Dentistry:
Provides free aids and services to people with disabilities to communicate effectively with us, such as:

-Qualified interpreters
-Information written in other languages

If you need these services, contact Paul D. McNiel, Director of Dental Operations.

If you believe that My Village Pediatric Dentistry has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Paul McNiel, Chief Compliance Officer
610 Clinton Ave. Little Rock, AR 72201. 501-259-8331 paul.mcniel@rockdentalbrands.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Paul D. McNiel, Director of Dental Operations is available to help you.

You can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office of Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/ortal/lobby.jsf, or by mail or phone at:

U.S Department of Health and Human Services
200 Independence Ave, SW Room 509F, HHH Building
Washington, DC 20201
800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov.ocr/office/file/index.html.

By signing below, I agree that I have read and understand My Village Pediatric Dentistry's Non-Discrimination Policy.

Signature of parent/legal guardian: _____ Date:_____