

**WELCOME TO
COLUMBUS PEDIATRIC DENTISTRY, P.C.**
3158 N. National Rd. Columbus, IN 47201
(812) 376-0166 www.ColumbusPediatricDentistry.com
Dr. Hayley H. Pavlov
Diplomate of American Board of Pediatric Dentistry

Dear Parent/Guardian,

We are very excited to welcome you to Columbus Pediatric Dentistry, P.C.! At Columbus Pediatric Dentistry we strive to provide you and your child with the best pediatric dental treatment available by a Board Certified Pediatric Dentist and fully trained and certified staff.

We firmly believe that every child can have a healthy mouth with proper guidance, care, and understanding. I am looking forward to helping you feel confident knowing that you will be receiving the best dental care for your little one. We are looking forward to becoming a part of your child's life and helping them grow into smiles they can be proud of!

At our office, we do all that we can to create a comfortable, safe, and caring environment for your child. For your child's first visit, we welcome you to accompany your child in the treatment area for the initial meeting and future meetings. This gives you an opportunity to see our staff at work and how we engage with your child. You will also have the opportunity to meet Dr. Hayley Pavlov and speak with her regarding any concerns or questions you may have.

We promise to do all that we can to work with your child and gain a positive relationship through understanding, guidance, and patience.

We're looking forward to meeting you and your child and, if any questions may arise, please feel free to call us!

Sincerely,

Dr. Hayley Pavlov and Staff



PATIENT INFORMATION

Date _____

Patient Name _____ Nickname _____

Date of Birth _____ Gender _____ School _____

Person Responsible for account Mother Father Legal Guardian Other _____

Address _____ City _____ ST _____ Zip _____

Home Phone _____ Email _____

Parents Marital Status Married Single Widowed Separated Divorced

Who Is Primarily Responsible for Child Mother Father Legal Guardian Other _____

Mother or Legal Guardian's Name _____ Employer _____

Work Phone _____ Date of Birth _____ Cell Phone _____ SS# _____

Father's Name _____ Father's Employer _____

Work Phone _____ Date of Birth _____ Cell Phone _____ SS# _____

Phone Number You Prefer We Call For Confirmation/Appointment Reminders? _____

How did you hear about our office? Internet Insurance Driving By Event Mailer
 Dr./Person _____ Other _____

Does The Patient Have Any Siblings That Come To Our Office? (If So, Name/Age) _____

EMERGENCY CONTACT

In The Event Of An Emergency, Who Should We Contact?

1) Name _____ Relationship To Patient _____ Phone _____

2) Name _____ Relationship To Patient _____ Phone _____

HEALTH HISTORY

Child's Physician (Office and Doctor's Name) _____

Phone Number of Physician's Office _____ Date of Last Physical _____

Are Immunizations Up to Date? Yes No Is Your Child in Good Health? Yes No

Has Your Child Ever Been Hospitalized or Had Any Kind of Surgery? Yes No

If so, Please explain and give date _____

Is Your Child **Allergic** to any Antibiotics/Drugs? Yes No If Yes, Please Explain What and What Type of Reaction _____

Is Your Child **Allergic** to Anything Else? Yes No If Yes, Please Explain What and What Type of Reaction _____

PATIENT NAME _____

Please check if your **child** has been diagnosed or treated for any of the following:

	YES	NO		YES	NO		YES	NO
ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	HEART DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	BLEEDING DISORDERS	<input type="checkbox"/>	<input type="checkbox"/>
ENIRONMENTAL			TYPE _____			ANEMIA	<input type="checkbox"/>	<input type="checkbox"/>
/SEASONAL ALLERGIES	<input type="checkbox"/>	<input type="checkbox"/>	LIVER DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	TYPE _____		
ADHD/ADD	<input type="checkbox"/>	<input type="checkbox"/>	TYPE _____			SEIZURES/EPILEPSY	<input type="checkbox"/>	<input type="checkbox"/>
AUTISM SPECTRUM			KIDNEY DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	DIABETES	<input type="checkbox"/>	<input type="checkbox"/>
DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	TYPE _____			TYPE _____		
DOWN'S SYNDROME	<input type="checkbox"/>	<input type="checkbox"/>	CANCERS/TUMORS	<input type="checkbox"/>	<input type="checkbox"/>	HEPATITIS	<input type="checkbox"/>	<input type="checkbox"/>
CEREBRAL PALSY	<input type="checkbox"/>	<input type="checkbox"/>	TYPE _____			TYPE _____		
CLEFT LIP/PALATE	<input type="checkbox"/>	<input type="checkbox"/>	PERSONALITY/SOCIAL	<input type="checkbox"/>	<input type="checkbox"/>	AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/>
MENTAL DELAYS	<input type="checkbox"/>	<input type="checkbox"/>	DISORDERs			SPEECH/HEARING	<input type="checkbox"/>	<input type="checkbox"/>
PHYSICAL DELAYS	<input type="checkbox"/>	<input type="checkbox"/>	VISION PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	DIFFICULTIES		
NEUROLOGICAL PROBLEM	<input type="checkbox"/>	<input type="checkbox"/>	ACID REFLUX/GERD	<input type="checkbox"/>	<input type="checkbox"/>	EATING DISORDERS	<input type="checkbox"/>	<input type="checkbox"/>

OTHER (NOT LISTED) _____

PLEASE ELABORATE ON ANY MEDICAL INFORMATION MARKED _____

Is Your Child Currently Taking Any Medications? Yes No If Yes, Please Explain Below...

Drug Name _____ Dosage/Frequency _____ Reason _____

Drug Name _____ Dosage/Frequency _____ Reason _____

Is There Any Significant Family History Of Diseases /Oral Cancers? Yes No Explain: _____

DENTAL HISTORY

Are There Any Specific Concerns/Questions Regarding Your Child's Mouth/ Teeth? _____

Has Your Child Ever Seen a Dentist? Yes No If So, Name of Dentist and Date of Last Exam _____

Does Your Child Have Any Potential Fears About the Dentist? Yes No If So, Please Explain _____

Is There Anything You Can Tell Us To Help "Connect" With Your Child?
(i.e: Princesses, Trains, Spiderman, Family dog, etc.) _____

Does Your Child Have a Special Blanket or Toy? Yes No Does Your Child Participate in Any Recreational Activities? Yes No

Is Your Child Currently Breast or Bottle Feeding? Yes No

Does Your Child Thumb Suck or Take a Pacifier? Yes No If Not, at What Age Did it Stop? _____

Has Your Child Ever Suffered Any Injuries to The Mouth or Teeth? Yes No If Yes, Please Explain _____

What Type of Water Does Your Child Primarily Drink?

City Water (from the tap) Filtered Water (from the tap or fridge) Reverse Osmosis Well Water Bottled Water

Does Your Child Use Fluoride Toothpaste? Yes No Any Other Form Of Fluoride? (Rinse, Vitamins, etc.) _____

CONSENT FOR DENTAL TREATMENT

I request and authorize Dr. Hayley Pavlov and her staff to perform cleanings, exams and place topical fluoride treatments on my child. I request and authorize dental x-rays to be taken on my child as considered necessary by Dr. Hayley Pavlov to diagnose and/or treat my child's dental needs. I acknowledge that I have been explained all the behavior management techniques that may be used with my child while experiencing dental treatment. I have been given the opportunity to discuss any questions that I may have.

Parent/Guardian Signature _____ Date _____

Parent/Guardian Printed Name _____

FINANCIAL POLICY

At our office, we plan to work together to achieve one common goal and that is for your kids to grow up feeling confident about their smiles. We promise to properly communicate all that is needed to obtain that goal, including our financial policy.

Payment in full for office visits and treatment is expected at the time service is rendered, unless prior arrangements are made or you have insurance. Patients with dental insurance must provide our office with accurate dental insurance information in advance.

INSURANCE

We can file most major PPO dental insurances. In the event we are not a provider for your dental insurance, we will file the claims as an out-of-network provider for you. This means that at the time of service, you are required to pay the difference of what the insurance company is estimating not to pay. This includes deductibles, co-payments and any service performed that is not covered by your policy. If any balance is remaining after insurance has paid, a statement will be sent to you requesting that you pay the remaining balance. In some instances, some insurance companies will not reimburse our office. This will require you to be responsible for the full cost of each visit at the time service is provided.

By signing this form, I am authorizing assignment of benefits and payment from my child's dental insurance directly to Hayley Pavlov D.M.D., M.S.D. I am also authorizing Dr. Hayley Pavlov to furnish my insurance company with any and all information that may be contained in my child's medical and dental records that relates to procedures performed in the office of Dr. Hayley Pavlov.

Again, most insurance companies do not tell us EXACTLY what they will pay, so we are giving you our best estimate.

TREATMENT PLANS

Prior to beginning and completing any restorative treatment, we will provide you with the best cost estimate of our total fee, your estimated insurance coverage, and your estimated out-of-pocket fees. Please remember, these are only estimates and may change during the course of treatment. In order to provide your child with the best treatment option, changes in treatment plans may occur. You will be notified prior to any treatment plan modification along with any fee change incurred.

For your convenience, we accept cash, personal checks, debit cards, and most major credit cards. If a check is returned for insufficient funds, a \$35 charge will be applied to your account. We cannot accept responsibility for negotiating a disputed claim and allow a maximum of 30 days from time service is rendered for your insurance company to clear account balances. If your insurance company does not pay within 30 days from the date service is rendered, you will be responsible for full payment. A late fee of 2% of the balance will be charged per month to unpaid balances over 60 days past due. If after 90 days from the date of service and attempts have been made to collect any outstanding balances, parents/legal guardians not fulfilling their financial obligation will be sent to collections, which you will be responsible for any collection and legal fees.

Any questions you have may be directed to our office and we will be happy to assist you! We are looking forward to beginning a wonderful relationship with you and your child.

I have read and understand the above financial policy set forth by Columbus Pediatric Dentistry and agree to be held responsible for the terms and conditions mentioned above.

Signature of parent/ legal guardian _____ Date _____

Print Name _____ Relationship to patient _____

Patient's Name _____

E-Mail/Text Notification Opt-in Consent Form

Columbus Pediatric Dentistry, P.C. is in the process of offering E-Mail and Text Message notification for Appointment Reminders and other patient care related information. This system will allow you to verify appointment at a time convenient to you, to request future appointments, and to keep you informed of office and patient care information. If you choose to opt-in to this system please provide us with your email address and text messaging number below. This information is only used for Columbus Pediatric Dentistry, P.C. purposes and is governed by the same HIPAA protection as all other information. We will start utilizing this system once we have enough text/email addresses from our patients' parents/guardians.

Your Name: _____ Patient's Name: _____

E-Mail: _____ Text Number: _____

I authorize Columbus Pediatric Dentistry, P.C. to notify me of patient care related information on my E-Mail or Text Messaging (Please circle one or both).

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(You may refuse to sign this acknowledgement)

I, _____, have received a copy of Columbus Pediatric Dentistry, P.C. Notice of Privacy Practices.

Parent/Guardian Printed Name

Date

Parent/Guardian Signature

Patient's Name

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, however, acknowledgment could not be obtained for the following reason:

- Individual refused to sign
- Communications Barriers prohibited obtaining acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Other _____

Staff Signature

Date