NICKEL
PEDIATRIC
DENTISTRY

Dr. Andrew B. Nickel, DDS

Welcome to our practice! We're so glad you're here!

Office Policies

Thank you for choosing Nickel Pediatric Densitry. We believe that all relationships are built on trust. We take great care in serving our community. We promise to provide quality service and recommend treatment based on the well being of your child. Please feel free to ask our business team any questions regarding these forms and they will be happy to assist you.

If your child is under the age of 6 we ask that you schedule their appointments during our morning schedule. We have found that younger children have a much better experience in the morning. Your child's scheduled appointment time has been reserved specifically for them. Our office asks that you give 48 hours notice when canceling or rescheduling an appointment. We understand that sometime unforseen events take place that may require missing an appointment. Please be aware if you change your appointment with less than 48 hours notice or simply do not show up we may assess a missed appointment fee. Frequent missed appointments or short notice cancellations may result in your child no longer being eligible for services in our office. In that case, we will be happy to assist you in the transfer of your child's records to another dental office.

Financial Policy

For your convenience, we accept all major credit cards, cash and Care Credit.

Our office is committed to helping you maximize your insurance benefits. However, it is important to remember that you are responsible for all fees associated with your child's treatment at Nickel Pediatric Dentistry. Dental insurance does not cover all dental services. Our business team will make every effort to give you the most accurate estimate based on your insurance benefits for each appointment. The person accompanying the child will be responsible for that amount at the time of service. After we receive payment from your insurance company, if there is a balance we will send you a statement of your final responsibility for each visit. In the event that the insurance pays more than expected we will issue you a refund.
Please note that insurance companies do not dictate recommended treatment. We will recommend treatment based on the need of your child and not based on insurance benefits.

Photo Release

I hereby give release to Nickel Pediatric Dentistry staff members to take photographs and/or videos of me and my child that may be used for educational and/or advertising purposes. I understand that these photographs and/or videos may be displayed in the office, on the dental office's webpage, and social media sites. I also understand that personal data will be protected. I understand that I, or my child, will not receive compensation for use of photographs/videos.

Communications Release

Nickel Pediatric Dentistry may contact me via phone, email, or text to provide health care information such as appointment reminders and information about my child's treatment, payment, account and insurance. The office may also use artificial voice or telephone equipment that may be capable of automatic dialing.

Consent for Treatment

I hereby authorize Dr. Nickel and his team to perform on my child all recommended treatment that has been mutually agreed upon by me. I authorize the doctor and team to use the appropriate medication and/or therapy indicated for such treatment. I am advised that though good results are expected,there still exists the risk of complications associated with dental procedures and local anesthetic. Furthermore, I authorize and consent that the doctor choose and employ such assistance as deemed fit to provide recommended treatment. Lastly, I understand that all responsibillity for payment of dental services provided in this office is due at the time of service. I authorize my insurance company to pay Nickel Pediatric Dentistry directly. I understand that I am responsible for all deductibles, co payments and any rejected procedures.

Patient Last Name: ____________________ Patient First Name: ______________________ Patient Birthdate: ______________

I acknowledge that I have read and understand the Office Policies, Financial Policy and Photo Release and Consent For Treatment.

Signature: ____ Date: ______________________

Relationship to Patient: ____

Notice of HIPAA Privacy Policy

Patient Last Name: ______________ Patient First Name: ______________ Date of Birth: ______________

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
We may use and disclose health information about your child for treatment, payment, or healthcare operations and other purposes that are permitted or required by law. We may disclose your child's information to a healthcare provider treating him/her. You may give us written authorization to disclose health information to anyone for any purpose. This may be revoked in writing. We may use your child's health information to obtain payment for services. If we suspect a possible victim of abuse, neglect, or domestic violence we may disclose your child's health information, as the law requires. We may disclose your child's health information to provide you with appointment or treatment recommendations (such as voicemails, postcards, emails, text messages or letters).

If you are concerned that we may have violated your privacy rights, or disagree with a decision we made about access to your health information or in response to a request to amend or restrict the disclosure of health information you may submit a written complaint to the US Department of Health and Human Services. If you have any further questions about our privacy practices please contact a member of our business team. Your signature below confirms that you have received a copy and read the Notice of Privacy Practices notice from our office.

Signature ______________________________ Date: ______________

PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can.
If you have any questions we'll be glad to help you.

Patient's Information

Name: ______________________________
Last First MI (Preferred Name)

Birthdate: __________ SS #: __________ Gender: ☐ M ☐ F

School: ______________________________

How did you hear about us?

____

(If someone referred you here, please enter their name so we can thank them.)

PARENT #1

Last Name: __________ First Name: __________ Birthdate: __________

SS#: __________ Cell Phone: __________

Employer: __________ Work Phone: __________

PARENT #2

Last Name: __________ First Name: __________ Birthdate: __________

SS#: __________ Cell Phone: __________

Employer: __________ Work Phone: __________

ADDRESS AND CONTACT INFORMATION

Best Phone Number for Communications: __________

Email: ______________________________

Address: ______________________________

Address 2: ______________________________

City: __________ State: ______ Zip: __________

Check box if same for entire family: ☐

INSURANCE POLICY 1

Subscriber Name: __________ Subscriber ID #: __________

SS#: __________

Insurance Company: __________ Phone: __________

Employer: __________ Group Name: __________ Group #: __________

Please present insurance card to receptionist.

INSURANCE POLICY 2

Subscriber Name: __________ Subscriber ID #: __________

SS#: __________

Insurance Company: __________ Phone: __________

Employer: __________ Group Name: __________ Group #: __________

We will not accept payment for secondary insurances. We will happily submit the claim for you and any payment will be sent directly to you.

Medical History

Last Name: ____________ First Name: ____________ Birthdate: ____________

Name of Pediatrician: ____________ City/State: ____________

Is your child under the care of a physician for any diagnosed medical problems? Y ☐ N ☐

If yes to above, please explain: ____________

Does your child see any other medical specialist?
If yes, please explain. ____________

Describe your child's overall health: (Excellent, Good, Fair, Poor) ____________

Has your child had any serious illness or injury?
If yes, please explain. ____________

Has your child ever had any Hospitalizations/Surgeries?
If yes, please explain ____________

Please list ALL MEDICATIONS your child is taking: ____________

Please list ALL ALLERGIES your child has: ____________

Are immunizations considered current? Y ☐ N ☐

Was your child considered full term birth? ____________

Has your child has any of the following?

☐ Y ☐ N Asthma/Breathing Problems
☐ Y ☐ N Bleeding Problems
☐ Y ☐ N Cancer/Tumors
☐ Y ☐ N Diabetes
☐ Y ☐ N Heart Murmur
☐ Y ☐ N Acid Reflux/GERD
☐ Y ☐ N Bleeding Disorders
☐ Y ☐ N Seasonal Allergies
☐ Y ☐ N Chronic Ear Infections
☐ Y ☐ N Congenital Heart Defects
☐ Y ☐ N GI System Problems
☐ Y ☐ N Immune System Disorders
☐ Y ☐ N Seizures
☐ Y ☐ N Sight/Hearing Impairment
☐ Y ☐ N Autism
☐ Y ☐ N Developmental Disabilites
☐ Y ☐ N Thyroid Problems
☐ Y ☐ N Cerebral Palsy
☐ Y ☐ N "Syndrome"Diagnosis

☐ Y ☐ N Kidney Problems
☐ Y ☐ N Hepatitis/Liver Disease
☐ Y ☐ N Cleft Lip/Palate
☐ Y ☐ N Psychiatric Treatment
☐ Y ☐ N Sinus Trouble
☐ Y ☐ N Abnormal Bleeding
☐ Y ☐ N Anemia
☐ Y ☐ N Allergic Reactions
☐ Y ☐ N Congenital Birth Defects
☐ Y ☐ N Mitral Valve Prolapse
☐ Y ☐ N Endocrine Disorders
☐ Y ☐ N Epilepsy
☐ Y ☐ N Frequent Infections
☐ Y ☐ N ADD/ADHD
☐ Y ☐ N Learning, Behavioral Disabillites
☐ Y ☐ N Growth Problems
☐ Y ☐ N Sickle Cell
☐ Y ☐ N Down Syndrome

If yes to any of the above please explain: ____________

Any disease or condition not listed above: ____________

Is there anything else regarding physical, mental or emotional health that you feel we should know?

____

Anything you would like to discuss with the doctor in private? ____________

Adolescent Women:

Are you pregnant or thinking of becoming pregnant? Y ☐ N ☐

Are you taking birth control? Y ☐ N ☐

Date: Signature ____________

DENTAL HISTORY

Name: ____
Last First

Birthdate: __________

Is this your child's first dental appointment? ______________________________

Date of last dental exam: ____________________

Have you been satisfied with your child's previous dental care? ______________________________

Has your child had any previous dental treatment other than hygiene? ______________________________

How has your child reacted to the dentist before? ______________________________

Has your child had dental trauma in the past? ______________________________

Do you think your child has a tongue or lip tie? ______________________________

Check All That Apply

- ☐ Tooth Pain
- ☐ Nursing
- ☐ Pacifier
- ☐ Finger Habit
- ☐ Tongue Thrust
- ☐ TMJ/TMD Pain

Airway/Sleep History: check all that apply

- ☐ Snoring
- ☐ Does your child ever stop breathing during the night?
- ☐ Grinding/Clenching
- ☐ Bed Wetting
- ☐ Daytime Sleepyness
- ☐ Mouth Breathing
- ☐ Speech Issues

Please list any concerns you have: ______________________________

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