BRANDYWINE PEDIATRIC DENTISTRY, P.A.

2000 Foulk Road, Suite C Wilmington, Delaware 19810 - Phone: 302-475-3110

Patient Information (PLEASE PRINT)

First Name: _____ MI: _____ Last Name: _____

Gender: _____ Date of Birth: _____ Social Security #: _____

Address: _____ City: _____State: _____Zip Code: _____

Home Phone: _____ Cell Phone: _____ School Name: _____

Whom should we contact in case of an emergency? _____ Phone #: _____

Parent / Guardian Information (PLEASE PRINT)

Parent or Guardian's Name: _____ Relationship to the Child: _____

Gender: _____ Date of Birth: _____ Social Security #: _____

Address: _____ City: _____State: _____Zip Code: _____

Home Phone: _____Cell Phone: _____ Email Address: _____

Employer Name: _____ Employer Phone #: _____

Whom may we thank for referring your child? _____

Responsible Party

First Name: _____ MI: _____Last Name: _____

Complete the below information in this section, if Responsible Party is other than the patient, parent or guardian referenced in the above sections.

Gender: _____ Date of Birth: _____ Social Security #: _____

Address: _____ City: _____State: _____Zip Code: _____

Home Phone: _____Cell Phone: _____ Work Phone: _____ Email Address: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: Self ○ Spouse ○ Child ○ Other ○

Insured's Social Security #: _____ Insurance ID #: _____

Insured's DOB: _____ Group #: _____

Employer: _____ Insurance Company: _____

Employer's Address: _____ Ins Co.'s Address: _____

City, State, Zip: _____ City, State, Zip: _____

Phone Number: _____ Phone Number: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: Self ○ Spouse ○ Child ○ Other ○

Insured's Social Security #: _____ Insurance ID #: _____

Insured's DOB: _____ Group #: _____

Employer: _____ Insurance Company: _____

Employer's Address: _____ Ins Co.'s Address: _____

City, State, Zip: _____ City, State, Zip: _____

Phone Number: _____ Phone Number: _____

PLEASE COMPLETE THE REVERSE SIDE OF THIS PAGE

Patient Name (PLEASE PRINT): _____

How should we addressed your child when summoned from the reception area: ○ First Name Only ○ Proper Surname
○ Other: _____

Acknowledgement: I certify that I have read and understand the questions asked on this form and I have answered them accurately, to the best of my knowledge. I also, understand that this information will be held in the strictest confidence, and it is my responsibility to inform the office of any changes in my child's personal and insurance information as changes happen.

✖ _____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Brandywine Pediatric Dentistry Representative Date

HIPAA CONSENT

With my consent, Brandywine Pediatric Dentistry, P.A. may use and disclose protected health information (PHI) about my child to carry out treatment, payment and healthcare operation (TPO). I also authorize them to call my home, cell, or designated location, send email and/or text messages, and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results, among others. With this consent, Brandywine Pediatric Dentistry, P.A., may mail to my home, cell, or other designated location any items that assist the practice in carrying out TPO, such as patient statements.

Brandywine Pediatric Dentistry, P.A. reserves the right to remove unconfirmed appointments from the schedule, and requires 24 business hours' notice to cancel or change appointments. Failed appointments may result in a charge, the loss of the privilege to pre-schedule appointments, and/or dismissal from the practice.

Please list the persons with whom we may discuss your child's information, if needed.

Name: _____Relationship to the patient: _____

Name: _____Relationship to the patient: _____

I give Brandywine Pediatric Dentistry, P.A. permission to send appointment reminders and notifications through:

○ Text Messages: _____ ○ Email: _____

By signing this form, I am consenting Brandywine Pediatric Dentistry, P.A. use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Brandywine Pediatric Dentistry, P.A. may decline to provide treatment to me. This consent will remain in effect until I request in writing to cancel my authorization. I understand the above guidelines, have had the opportunity to ask questions, and will be given a copy of the privacy notice upon my request.

✖ _____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Brandywine Pediatric Dentistry, P.A. Representative Date

MINOR CONSENT - I understand that a parent, guardian, or authorized agent is required to accompany all minor patients and must stay for the duration of the appointment. I understand that Brandywine Pediatric Dentistry, P.A. has an open door treatment policy for a minor child and I know that I may accompany my minor child into the treatment room or observe from a safe distance. I understand that the minor may be exposed to radiographs as necessary, use of local anesthetic and use of appropriate medicaments and materials for such treatment. I understand and accept the risk(s) associated with these procedures and agree to release and hold harmless the Doctor and staff of Brandywine Pediatric Dentistry, P.A. from any damage or injury resulting from any of these procedures. If a minor is coming to his/ her appointment with an authorized agent, who is not a parent or legal guardian, PRIOR signed consent and payment arrangements for the services being performed at the scheduled appointment must be made with the office. Payments by credit card are accepted by phone.

✖ _____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Brandywine Pediatric Dentistry, P.A. Representative Date