the littletooth company
PEDIATRIC DENTISTRY

Patient Demographic Information

Patient Name: _____ **Preferred Name/Nickname:** _____

Date of Birth: _____ **Male** ☐ **Female** ☐

Husky ID (If applicable): _____

Primary Address: _____
Street City State Zip Code

Best Contact Number: _____ **Alternative Contact Number:** _____

1. Parent/Guardian Information

Name: _____ **Date of Birth:** _____

Home Address: _____
Street City State Zip Code

Home Phone: _____ ☐ **Cell Phone:** _____ ☐ **Work Phone:** _____ ☐
*Please check off best contact number

E-Mail Address: _____

2. Parent/Guardian Information

Name: _____ **Date of Birth:** _____

Home Address: _____
Street City State Zip Code

Home Phone: _____ ☐ **Cell Phone:** _____ ☐ **Work Phone:** _____ ☐
*Please check off best contact number

E-Mail Address: _____

Primary Dental Insurance (Subscriber Information)

Subscriber Name: _____ **Employer:** _____

Subscriber Date of Birth: _____ **Subscriber SSN:** _____

Insurance Company: _____ **ID Number:** _____ **Group Number:** _____

Secondary Dental Insurance (Subscriber Information) *If Applicable

Subscriber Name: _____ **Employer:** _____

Subscriber Date of Birth: _____ **Subscriber SSN:** _____

Insurance Company: _____ **ID Number:** _____ **Group Number:** _____

I attest that the information I have provided is correct to the best of my knowledge & that it is my responsibility to notify TLTC of any changes.

Parent/Guardian Name: _____ **Signature:** _____ **Date:** _____

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Notice of Privacy Practices and Office Policies

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Please read the following guidelines and initial each line.

Informed Consent

_____ I do hereby authorize and consent to any dental radiograph, examination, anesthetic, sedative or dental treatment rendered under the general, direct, or indirect supervision of Dr. Jay Leung and his associates/providers as he may deem necessary. I understand that all proposed dental treatment will first be reviewed with me. This authorization will remain in effect until cancelled in writing by me.

HIPAA

_____ I give consent for the use and disclosure of health information of myself and/or my dependent for the purpose of treatment, payment and/or communication between authorized healthcare professionals. I understand that I may ask for a copy of HIPAA prior to signing this condensed notice.

Appointment/Financial Policies

_____ I understand that cancelling and/or rescheduling of any appointment without 48-hours' notice may be subject to a $50 charge per broken appointment.

_____ I acknowledge that The Little Tooth Company reserves the right to NOT schedule any subsequent appointments after two missed or cancelled appointments without 48-hours' notice.

_____ I understand that The Little Tooth Company will file claims to my insurance company as a courtesy, and that the estimated amount that my insurance company is not expected to pay will be due from me at the time of services rendered.

_____ I acknowledge that all estimated patient portions for services rendered are due in full at the time of service.

_____ I understand that The Little Tooth Company's acceptance of insurance assignments does not absolve me of full responsibility for the treatment rendered. I acknowledge that in the unlikelihood my insurance does not pay for a procedure in full, I will then be responsible for the remaining balance.

I understand that the information I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence, and that it is my responsibility to inform The Little Tooth Company of any changes in my child's status or information. In signing, I authorize the dental team at The Little Tooth Company to perform the necessary dental services my child may require.

Parent/Guardian Name: _____ **Signature:** _____ **Date:** _____

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Jason Leung, DMD
264A Queen Street
Southington, CT 06489
Ph (860) 426-2643
Fax (860)426-1029

140 Grandview Ave,
Suite 102
Waterbury CT 06708
Ph (203) 518-8250

Supplemental Informed Consent

Thank you for your continued trust in our practice. As with the transmission of any communicable disease like a cold or the flu, you may be exposed to COVID-19, also known as coronavirus, at any time or in any place. Be assured that we have always followed the strictest state and federal regulations and recommended personal protection and disinfection protocols. This has been in a combined effort to limit the transmission of all diseases in our office and we continue to follow those protocols. Despite our careful attention to sterilization, disinfection, and use of personal protective equipment and barriers, there is still a chance that you could be exposed to an illness in our office, just as you might be at your grocery store, favorite restaurant, or fitness facility. The nationwide implementation of social distancing has greatly reduced the transmission of COVID19, and we have made every effort to allow space for distancing, when possible, within our offices. However, due to the nature of the services and procedures we perform, it is impossible to maintain distance between patients and providers at all times. By selecting "yes" below, you acknowledge, understand, and accept any potential for exposure and associated risks, and consent to treatment for your child at The Little Tooth Company.

Although exposure is unlikely, do you accept the risk and consent to treatment?

□**Yes** □ **No**

Patient Name: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ **Date:** _____

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Patient Medical History

Patient Name: _____ Date of Birth: _____

Health History Update (ALL fields must be complete)

Does your child have any of the following conditions? Please check all that apply.

__ ADD/ADHD
__ AIDS/HIV+
__ Allergies
__ Artificial Joints
__ Asthma (Current__ History__)
__ Autism
__ Blood/Bleeding Disorder
__ Bone/Muscular Disorder
__ Cancer (Current__ History __)
__ Congenital Birth Defects
__ Congenital Heart Defects
__ Convulsions/Epilepsy (Current__ History__)
__ Depression/Anxiety
__ Disabilities/Special Needs
__ Diabetes (Type I__ Type II__)
__ Hearing/Visual Impairment
__ Heart Disease
__ Hepatitis
__ Immune Disorder
__ Kidney Disease/Disorder
__ Liver Disease/Disorder
__ Premedication for Dental Txmt (Antibiotics)
__ Rheumatic/Scarlett Fever
__ Sensory Disorders
__ Tuberculosis
__ Other: _____

Please explain any serious medical conditions noted _____
_____
_____

Does your child take any DAILY MEDICATIONS including over the counter medications? Yes ☐ No☐
Please list all current medications: _____
_____
_____

Does your child have any ALLERGIES? (Medication/Food/Environmental) Yes ☐ No ☐
Please list all allergies: _____

Have there been any other major medical changes since your child's last visit such as surgeries, hospitalizations, etc.? Yes☐ No ☐ Please Explain: _____

Primary Care Physician Name: _____ **Phone #:** _____

I understand that the information I have provided is correct to the best of my knowledge, and that it is my responsibility to inform The Little Tooth Company of any changes pertaining to my child.

Parent/Guardian Name: _____ **Signature:** _____ **Date:** _____

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Permission for Accompaniment

Patient Name: _____ **Date of Birth:** _____

A parent/legal guardian or named representative must be present during all visits for any patient under the age of 18. In the event that a parent or legal guardian cannot be present with their child at a scheduled appointment, they may appoint a named representative(s) who may accompany their child to the appointment. This/These named representative(s) should have permission from the parent/legal guardian to consent to the following; cleanings, exams, radiographs, fluoride application, and any existing planned treatment. In the event that previously planned restorative treatment is changed, or new restorative treatment is recommended, the parent/legal guardian will be informed and must give consent prior to the treatment being performed.

Named Representative(s) and Relationship: _____

_____

Named Representative Contact #: _____

☐ **I do not give anyone other than myself or another parent/legal guardian to accompany my child to their dental appointments.**

Parent/Legal Guardian Name: _____

Parent/Legal Guardian Signature: _____

Date Signed: _____ **Permission Expiration Date:** _____