DR. MELISSA M. BEAUDET-UY

GENERAL DENTISTRY LIMITED TO CHILDREN AND TEENS

MELISSA M. BEAUDET-UY D.D.S.

Hillside Plaza

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Kailua-Kona, HI 96740

(808)329-7351

New Patient Pre-Appointment Check-List

Welcome to our practice. We want to make sure your first visit to our office is an exceptional one. To help us meet your expectations please use this checklist to make sure we have all of the information we will need for your visit.

- Contact your previous dentist and ask them to send your records to the office email: beaudetdds@gmail.com
- Complete the new patient health history form **before you arrive** and **bring it with you to the appointment.**
- **Arrive 15 minutes before** your scheduled time to complete additional paperwork.
- Bring your insurance card if one was issued
- Please be sure you have the following information for the person who carries the insurance for the child.
    - Insured's Name, Address & Phone Number
    - Insured's Date of Birth
    - Insured's Plan, Member ID# or SSN
    - Insured's Group Number
    - Insured's Employer
- Payment is expected at the time of service. For your convenience, we accept cash, personal checks, VISA, MasterCard, American Express, Discover or Care Credit. As a courtesy we will submit your insurance claim.
- A parent and/or legal guardian **must** accompany the child to their initial visit

We look forward to meeting you!

Dr. Beaudet-Uy and Staff

Dr. Beaudet-Uy's

Health History Form

1. Tell us about your child

Child's Name: _____
Goes by: _____ Sex: M F
Names & Ages of Siblings: _____
_____
Child's Birthday ___/___/___ Child's Age: _____
School _____ Grade_____
Reason for Visit: _____
_____
_____

2. Mother's Information

Name_____
Circle one: Mother Stepmother Guardian
Birthdate ___/___/___ Marital Status:_____
Employer:_____
Home #_____ Cell #_____
Work #_____ Ext._____
Home Address_____
_____

3. Father's Information

Name_____
Circle one: Father Stepfather Guardian
Birthdate ___/___/___ Marital Status: _____
Employer:_____
Home #_____ Cell #_____
Work #_____Ext. _____
Home Address _____
_____

4. With whom does your child reside?

_____

5. We confirm appointments by text and email

Cell number(s) to text to _____
_____
Email address_____
_____

6. Who may we thank for referring you to our office?

_____

7. Primary Dental Insurance

Insurance Company Name _____
_____
Insurance Co. Address _____
_____
Insurance Co. Phone # _____
Group # _____ ID #_____
Policy Owner's Name _____
Relationship to Patient _____
Policy Owner's Birthday ___/___/___
Policy Owner's Employer_____

8. Secondary Dental Insurance

Insurance Company Name _____
_____
Insurance Co. Address _____
_____
Insurance Co. Phone # _____
Group # _____ ID #_____
Policy Owner's Name _____
Relationship to Patient _____
Policy Owner's Birthday ___/___/___
Policy Owner's Employer_____

9. Dental History

Is this your child's first visit to the dentist? _____
If not, how long since the last visit to the dentist?
_____
Previous Dentist's name & number _____
_____
Were any x-rays taken at previous Dentist? _____
Have there been any injuries to the teeth, face or mouth?
_____ If yes, please explain _____
_____
How do you expect your child to act at this visit?
_____
_____

Does your child have any of the following habits? Circle:
Lip Sucking/Biting Nail Biting

Thumb/Finger Sucking Grind Teeth

Clench Jaws Nursing/Bottle Habits

Has your child ever had a serious or difficult problem associated with previous dental work?
_____

Is your child's water fluoridated?	Yes	No
Is your child taking fluoride supplements?	Yes	No
Does your child brush his/her teeth daily?	Yes	No
Does your child floss daily?	Yes	No

PARENTS: This section is about you. Certain dental conditions are inherited so we need to know a little about you! Please circle all that apply

Missing Permanent teeth Extra teeth
Missing baby teeth Gestational diabetes

How would you rate your dental health now?
Excellent Good Fair Poor

How would you rate your dental health as a child?
Excellent Good Fair Poor

Do you have a fear of dental treatment **YES NO**
Are you considering braces for your child? **YES NO**
What are your dental concerns for your child?_____
_____

10. Health History

Has your child ever had any of the following conditions? (Please circle)

Abnormal bleeding	Convulsions	Hepatitis
Allergy to Dyes	Developmental Delay	HIV/AIDS
Allergy to Latex	Diabetes	Kidney/Liver Disease
Asthma	Handicaps/Disabilities	Pacemaker
Autism	Hearing/Speech Impaired	Respiratory Disease
Bleeding Disorder	Heart Disease	Rheumatic Fever
Cancer	Heart Murmur	Thyroid Disease
Cerebral Palsy	Hemophilia/Blood Disorders	Tuberculosis

Has your child had a TETANUS Vaccination: Yes / No
If no conditions above are circled initial here _____
If heart murmur was circled, does your child require premedication?
_____
Please discuss any other medical conditions/surgeries/ hospital stays your child has had _____
Was your child delivered at **FULL TERM** or **PREMATURE** If your child was early, how early?_____
Please list all medications your child is currently taking
_____
_____
Please list the child's allergies including medications, latex, dyes, ect.
_____
_____
Child's Physician___ _____ Number_____
Child's Cardiologist _____ _____ Number_____
Is the child currently under the care of a physician?
Yes No
If yes, please explain_____
_____

☐ I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need. This consent shall remain in effect until cancelled by the parent or guardian. I agree to be responsible for the payment of all rendered treatment on behalf of my dependents.

☐ I have been offered a copy of the office's Notice of Privacy Practice.

☐ I choose not to receive the copy of the office's Notice of Privacy Practice.

_____ _____ _____
Signature of Parent or Guardian Date Relationship to Patient

Medical History Update

Date _____ Comments _____

No Changes ( ) Parent Signature _____
Emergency Contact:_____Phone Number:_____

Date _____ Comments _____

No Changes ( ) Parent Signature _____
Emergency Contact:_____Phone Number:_____

Date _____ Comments _____

No changes ( ) Parent Signature_____
Emergency Contact:_____Phone Number:_____

Date _____ Comments _____

No changes ( ) Parent Signature_____
Emergency Contact:_____Phone Number:_____

Date _____ Comments _____

No changes ( ) Parent Signature_____
Emergency Contact:_____Phone Number:_____

Date _____ Comments _____

No changes ( ) Parent Signature_____
Emergency Contact:_____Phone Number:_____

Date _____ Comments _____

No changes ( ) Parent Signature_____
Emergency Contact:_____Phone Number:_____

Date _____ Comments _____

No changes ( ) Parent Signature_____
Emergency Contact:_____Phone Number:_____

Financial/Insurance/Appointment Agreement

I authorize the office of Dr. Beaudet-Uy to release any information, including the diagnosis and the records of any treatment or examination rendered to my dependents or me during the period of such dental care, to third party payers.

Payment is due at the time of service. If you do have dental coverage, it will be submitted to your insurance company, unless the procedure is not covered under your plan. This is done as a courtesy from our office. If the patient has two or more dental insurances, we will file to those plans.

It is your responsibility to monitor your benefits and annual maximum. We will be happy to assist you with any resubmissions, but we cannot make telephone calls to the insurance company on your behalf. Regardless of participation, we will not become involved in disputes between you and your insurance company regarding deductibles, coinsurances, covered/non-covered charges, etc., other than provide factual information as necessary. If such a dispute occurs, the balance will become your responsibility and must be paid promptly.

I understand that I am responsible for all charges. The parent/guardian/authorized adult accompanying the minor child is responsible for payment. Payment plan needs to be addressed prior to appointment if someone other than the guardian is bringing the child. We do not get involved in financial disputes between parents.

I understand that I will be responsible for any unpaid balance (as listed on billing statement) not paid within 60 days of the monthly billing date. This includes an assessed late charge of $5.00 each month. I realize that failure to keep this account current, with the exception of dental emergencies, will not permit additional appointments to be scheduled. If a collection agency becomes involved in the settlement of your account, all collection costs and legal fees for both parties will be the responsibility of the account holder. Scheduled appointments under this account will then be cancelled.

A parent or legal guardian (as determined by an Order of the Court) must accompany the patient to all appointments. Upon arrival, please check in with the receptionist.

A broken appointment is an appointment that is cancelled with less than 24 hours notice to the scheduled appointment. An arrival of 10 or more minutes past the beginning of the scheduled appointment time by the patient, parent or legal guardian may be considered a broken appointment. **I acknowledge there is a fee of $50 per half hour for a broken appointment.**

_____

Name of child/children

_____ _____ _____

Signature Relationship to patient Date

MELISSA M. BEAUDET-UY, D.D.S.

76-6225 Kuakini Hwy. Suite A-106
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(808) 329-7351

HIPAA CONSENT FORM

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time.

On behalf of _____

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my child/ childrens protected health information to carry out treatment, payment activities and heath care operations.

Signature: _____ **Date:** _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____ Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
This consent form will be kept in your childs file until the age of 18.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____