David T. Pascia, D.M.D
Kelly Kidwell, D.M.D.

Minor Paperwork

Welcome to our practice!
In maintaining our philosophy of excellence in dentistry it is important that you provide us with an accurate dental and medical history. Thank you for your cooperation.

MINOR NAME: _____ BIRTHDATE: _____/_____/_____
ADDRESS: _____ APT: _____
CITY: _____ ZIPCODE: _____

CONTACT INFORMATION (PARENT/GUARDIAN):

PARENT/GUARDIAN NAME: _____ BIRTHDATE: _____/_____/_____
CONTACT PHONE: _____ CONTACT EMAIL: _____
ADDRESS (IF DIFFERENT FROM ABOVE) _____
RELATIONSHIP TO PATIENT: _____

PARENT/GUARDIAN NAME: _____ BIRTHDATE: _____/_____/_____
CONTACT PHONE: _____ CONTACT EMAIL: _____
ADDRESS (IF DIFFERENT FROM ABOVE) _____
RELATIONSHIP TO PATIENT: _____

WHOM MAY WE THANK FOR REFERRING YOU: _____
DO YOU HAVE DENTAL INSURANCE? YES ☐ NO ☐
NAME OF DENTAL INSURANCE: _____

HEALTH HISTORY

NAME OF CHILD'S PEDIATRICIAN? _____ NUMBER: _____
IS YOUR CHILD TAKING ANY MEDICATIONS? LIST INDIVIDUALLY NAME AND USE:
NAME _____ USE _____
NAME _____ USE _____
HAS YOUR CHILD HAD ANY SERIOUS ILLNESS OR INJURY? ---------- YES NO
IF SO, PLEASE DESCRIBE _____
DOES YOUR CHILD HAVE ANY MEDICAL CONDITIONS THAT WE SHOULD BE AWARE OF? ---------- YES NO
IF SO, PLEASE DESCRIBE _____
IS YOUR CHILD ALLERGIC TO ANY MEDICATIONS? .....YES NO
☐ PENICILLIN ☐ ASPIRIN ☐ CODEINE ☐ ERYTHROMYCIN ☐ LATEX
ARE YOU AWARE OF THEM BEING ALLERGIC TO ANY OTHER MEDICATION OR SUBSTANCE (IE LATEX)? ..... YES NO

_____

PLEASE CHECK ANY OF THE FOLLOWING WHICH YOUR CHILD HAS NOW OR HAS HAD IN THE PAST:

- ☐ ANEMIA/BLOOD DISORDER
- ☐ ASTHMA
- ☐ BRAIN INJURY
- ☐ BLOOD TRANFUSIONS
- ☐ CEREBRAL PALSY
- ☐ CONGENITAL HEART DEFECT/PROBLEM
- ☐ DIABETES
- ☐ EPILEPSY/SEIZURES
- ☐ HAS A MEDICAL DOCTOR EVER SAID YOUR CHILD HAS CANCER OR A TUMOR?
  TYPE: _____ DIAGNOSED _____
- ☐ HEPATITIS
- ☐ LUNG PROBLEMS
- ☐ RHEUMATIC FEVER
- ☐ SPEECH DELAY
- ☐ TUBERCULOSIS
- ☐ VISION DISORDER
- ☐ OTHER: _____
- ☐ HEART MURMUR

IS THERE ANY INFORMATION CONCERNING YOUR CHILD'S HEALTH IN WHICH WE NEED TO BE AWARE OF?.... YES ☐ NO ☐

IF YES, PLEASE EXPLAIN: _____

_____

_____

_____

_____

DENTAL HISTORY

IS THIS YOUR CHILD'S FIRST TIME TO THE DENTIST: ---------- YES ☐ NO ☐

IF NO, WHEN WAS THE DATE OF THEIR LAST VISIT: _____

IS YOUR CHILD CURRENTLY IN BRACES: _____ YES ☐ NO ☐

*IF YES, WHO IS THEIR ORTHODONTIST? NAME: _____ STARTED ORTHO (YEAR) _____

*IF NO, HAVE THEY HAD BRACES IN THE PAST? YES ☐ NO ☐ (PLEASE WRITE YEAR THEY COMPLETED BRACES _____)

TO THE BEST OF MY KNOWLEDGE THE ABOVE INFORMATION IS TRUE AND CORRECT. I AGREE TO NOTIFY THE DENTIST ABOUT ANY CHANGES IN MY CHILD'S HEALTH STATUS OR THE ABOVE INFORMATION. I UNDERSTAND I AM RESPONSIBLE FOR DENTAL SERVICES PROVIDED AND PAYMENT IS DUE WHEN SERVICES ARE RENDERED.

PATIENT'S (MINOR) NAME PRINTED: _____

PARENT/GUARDIAN'S NAME PRINTED : _____

PARENT/GUARDIAN'S SIGNATURE: _____ DATE: _____

David T. Pascia, D.M.D.
Kelly Kidwell, D.M.D.

Minor Consent Form

Patient's name (under the age of 18): _____

Patient's birthday: _____

I, _____, am the parent/guardian of , _____, who is a minor child. I do hereby authorize and consent to any x-rays, examination, anesthetic, sedative, and dental treatment rendered under the general, direct, or indirect supervision of Dr. David T. Pascia, Dr. Kelly Kidwell, their hygienist, and staff members that deem necessary. I am aware that diagnostic x-rays and an exam with the doctor will be performed yearly at their dental hygiene appointments.

This authorization will remain in effect until cancelled in writing to our office.

Parent/Guardian Name Printed: _____

Parent/Guardian Signature: _____ Date: _____

2143 49th St. N – St. Petersburg, FL 33710
(727)321-1900 - www.PasciaDentistry.com
"We Cater to Dental Cowards"

David T. Pascia, D.M.D
Kelly Kidwell, D.M.D.

Office Policy

**We reserve time for each patient in our practice.
Therefore, our office policy is very firm.**

We value the time of our patients, and thank you in advance for valuing our time as well.

- **Please arrive promptly for all scheduled appointments.**
- **Lateness of more than 20 minutes will necessitate a rescheduling of the appointment.**
- **All cancellations and rescheduling of appointments require a 48 hour notice.**

Should you cancel an appointment with less than 48 hours notice it will constitute a broken appointment and a fee of $50 will be assessed.

I, _____, understand that if I fail to keep _____
Parent/Guardian Name Printed — Minor Patient's Name Printed
scheduled appointments, a fee of $50 will be assessed to my account or he/she may be denied further appointments.

Please review each statement below:

- A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you change your appointment, we require at least 48 hour notice to avoid a **$50 cancellation fee** (emergencies are an exception).
- If you do not show for your confirmed appointment a **$50 fee** will be assessed to you your account.
- If you are **15 minutes or later** to a confirmed, scheduled appointment we will need to reschedule this appointment. Please note that each appointment is scheduled just for you.
- **We require a firm confirmation for all appointments.** You will receive an email and/or text message one week prior to your scheduled appointment. You can confirm your appointment by calling the office or through text/email. It is the parent/guardian's responsibility to confirm their child's scheduled appointment by phone call, email, and/or text message in order to keep their appointment.
  If we do not receive a **firm confirmation** for your appointment we will take you off the schedule.

I fully understand Pascia Dentistry's Office Policy & agree with the above conditions.

Print Minor Patient's Name: _____

Print Parent/Guardian's Name: _____

Parent/Guardian Signature: _____ Date: _____

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HIPAA COMPLIANCE & GENERAL CONSENT FORM

HIPAA PRIVACY RIGHTS

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the ***Health Insurance Portability and Accountability Act of 1996 (HIPAA)***. I understand that by signing this consent, I authorize Drs. Pascia & Pascia ("you") to use and disclose my protected health information to carry out:

* Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
* Obtaining payment from third party payers (e.g., my insurance company); and
* The day-to-day healthcare operations of your practice

I have also been informed of, and given the right to review and secure a copy of, your *Notice of Privacy Practices,* which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However; if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

CONSENT FOR TREATMENT

I hereby authorize Drs. Pascia & Pascia and its employees, staff, and agents to take x-rays, study models, photographs and/or any other diagnostic aids deemed necessary by the treating dentist to make thorough diagnosis of me or my dependent's dental needs.
Upon such diagnosis, I authorize Drs. Pascia & Pascia to perform all recommended treatment agreed upon by me, and to give such assistance as required to provide proper care. **I understand that I may ask for a full explanation of any possible complications.**
Additionally, I authorize Drs. Pascia & Pascia to contact me at all telephone numbers and addresses provided by me and updated by me, or available through public records.

_____
Minor Patient's Name Printed

_____
Parent or Guardian Name Printed

_____ _____
Parent or Guardian Signature Date

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FINANCIAL POLICY

At **Pascia Dentistry,** we believe that you deserve the best care. That's why we always present you with the best dental solution possible to treat your personal dental situation. It is always our goal to provide our wonderful patients with outstanding dental care.

Please read below to fully understand Pascia Dentistry's financial policy. Payment is due at time services are rendered. Thank you for allowing us to provide you with a great dental experience in a warm and friendly dental environment.

*ALL PATIENTS - PAYMENT INFORMATION

■ **Pascia Dentistry does require payment in full at every dental appointment when services are rendered.**
We accept MasterCard, Visa, Discover, cash and checks.
We accept American Express for payments over $500.
We are happy to offer a 5% accounting courtesy for all treatment over $1000 that is paid in full prior to treatment commencing that is paid by cash or check only. (Debit cards not included in this discount)
If you are in need of an extended finance option, we also work with Care Credit (Healthcare Provider Credit Card). They offer 6 or 12 month interest free payments based on approved credit.

**FOR PATIENTS WITH INSURANCE

■ **Pascia Dentistry is not contracted with any Dental Insurance, and therefore is considered Out of Network with all Dental Insurance plans.** What does this mean for you? Pascia Dentistry strives to provide the highest quality of care to all of our wonderful dental patients. Becoming Out of Network with insurance helps us give patients better access to exemplary care and increased quality time during all dental visits.
If you have a PPO Dental Insurance Plan, that has Out of Network benefits, you will pay for each appointment in full at time services are rendered. Our wonderful front desk team will help you by filing your dental claims to your dental insurance for you. Depending on your individual Out of Network benefits, insurance will send you, the patient, a reimbursement check.
If you would like to have a better idea of what your dental insurance reimburses for out of network benefits, we will be glad to file a complimentary benefits analysis "Pre-Estimate of Treatment" with your insurance company prior to any appointments and treatment. Keep in mind this is not a guarantee of coverage. This does delay treatment but will give you better idea of what amount of reimbursement to expect from your insurance. Please note pre-estimates can sometimes take 4-8+ weeks to receive.
I authorize release of information to my insurance company.

■ Your Out Of Network Dental Benefits are based upon a contract made between your employer and an insurance company. **If you have any questions regarding your Out of Network Dental Benefits please contact your employer or insurance company directly. Dental Insurance plans will never pay for completion of your dental care in full. It is only meant to assist you.**

■ **Pascia Dentistry requires payment on the day services are rendered.** As a courtesy, and to expedite reimbursement, we will file your Dental Insurance claims for you. Please understand that your insurance policy is a legal contract between you and your insurance company. Our office is not, and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

■ If at any time your Dental Insurance changes and/or you get new dental insurance, please contact the office to update your insurance information **prior** to any scheduled appointments you may have. This will help our office when filing your dental claim to better assist you in receiving any Out of Network Dental Insurance reimbursement.

I have read the Financial Policy. I understand and agree with the above conditions.

Print Minor Patient's Name: _____

Print Parent/Guardian's Name: _____

Parent/Guardian Signature: _____ Date _____

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