Dr. Jairo Montoya, DDS, MScD

Board Certified Pediatric Dentist

6245 Rufe Snow Dr • Suite 240 • Watauga, TX 76148 • Telephone: (817) 985-7550 • frontdesk@aviatorpediatricdentristry.com

Demographic Information

Patient_____ Today's Date_____

Name child would like to be called_____Home Phone_____

Birthday_____ Age_____ Sex_____ Cell Phone_____

Guardian's Email _____

Home Address_____

street *town* *state* *zip code*

Names *and ages* of other children in family_____

School_____ Grade _____

Parent/Legal Guardian: _____Relation to patient_____

Parent/Legal Guardian: _____Relation to patient_____

Who has legal custody of patient?_____Dental Insurance: Yes No

Person responsible for payment of account_____ SS#_____DOB_____

Name of child's physician/group_____City/St_____Ph #_____

Whom may we thank for referring you to us?_____

What is the reason for your child's dental visit?_____

Health History

Yes No Is your child in good health? Date of last physical exam_____

Yes No Has your child ever had a health problem?_____

Yes No Has your child ever been hospitalized? Please give reason and dates_____

_____

Yes No Is your child allergic to anything?_____

Yes No Is your child currently taking any medications? Please give medication, dose and reason_____

Yes No Were there any problems at birth?_____

Please circle if your child has been treated for any of the following:

Heart disease	Bleeding/transfusions	Asthma/breathing	Blood dyscrasias
Liver/GI disease	Anemia	Diabetes	AIDS
Kidney disease	Rheumatic fever	Hepatitis	Mental delays
Speech/hearing	Seizures	Cleft lip/palate	Physical delays
Eyesight	Congenital birth defects	Personality/social	Other problems
Cancer/tumors	Recurrent headaches	Frequent infections	Adverse Drug reactions
Cerebral palsy	Significant injuries	Endocrine/growth	Autism

Please elaborate on any items circled:_____

_____

_____

_____

Office use only

-over-

Do you consider your child to be advanced in the learning process
progressing normally
slow in the learning process

Was your child breast fed bottle fed - at what age was it stopped?_____

Dental History

Yes No Has your child ever been to the dentist? Date of last xrays (if taken)_____
Name of dentist and date_____

Yes No Has your child experienced any unfavorable reaction from previous dental care? Explain_____

Yes No Does your child suck a finger, thumb or pacifier?

Please check if your child is having problems with any of the following:

Snoring or audible breathing	Gasping for air/cessation of breathing	Mouth Breathing
Lips apart/Mouth open	Restless Sleep/Moves a lot	Sweating at Night
Bruxism (Teeth grinding)	Nightmares	Sleeping in Strange positions

Comments: _____

_____

Consent for Dental Treatment

I request and authorize Dr. Jairo Montoya DDS to examine, clean, and provide dental treatment on my child's teeth. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Jairo Montoya DDS to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or child's teeth for diagnostic or educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr. Jairo Montoya DDS will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone. I will be responsible for any charges incurred on this child for dental treatment.

Signature _____ **Date** _____

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Patient Insurance Information

Our office is considered in network with your insurance company. In order to complete claims and calculate your deductible and out pocket fess we will need to import your insurance information or any insurance changes into our computer system. Please fill out your insurance information below.

Primary Insurance

Insurance Company/plan name:_____

Insurance Company Address:_____
(P.O Box/Street #) (City) (State) (Zip Code)

Policyholder/Subscriber Information

Policyholder's Name:_____
(Last) (First) (Middle Initial)

Policyholder Date of Birth:_____ **Gender:** ☐ **F** ☐
(MM/DD/CCYY)

Policyholder/Subscriber ID: (SSN or ID#):_____

Plan/Group Number:_____ **Employer Name:**_____

Scheduled Patient(s) Information

Patient Name:_____
(Last) (First) (Middle Initial)

Patient Name:_____
(Last) (First) (Middle Initial)

Patient Name:_____
(Last) (First) (Middle Initial)

Medical Insurance (If not applicable leave blank)

Insurance Company/plan name:_____

Insurance Company Address:_____
(P.O Box/Street #) (City) (State) (Zip Code)

Policyholder/Subscriber Information

Policyholder's Name:_____
(Last) (First) (Middle Initial)

Policyholder Date of Birth:_____ **Gender:** ☐ **F** ☐
(MM/DD/CCYY)

Policyholder/Subscriber ID: (SSN or ID#):_____

Plan/Group Number:_____ **Employer Name:**_____

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CONSENT FOR USE / DISCLOSURE OF HEALTH INFORMATION

Notice to Patient:

By signing this form, you grant us consent to use and disclose your/ your child's protected health care information for the purpose of treatment, various activities associated with payment, and health care operations. Our Notice of Privacy Practices provides more details on our treatment, payment activities, and health care operations. If there is not a copy of the Notice accompanying this consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your/your child's health care information.

As stated in our Notice of Privacy Practices we reserve the right to change our privacy practices. If we should do so, we will issue a revised privacy notice. Since revisions may apply to your health care information, you he a right to receive a copy by contacting our Privacy Officer.

You have the right to revoke your/your child's Consent by giving written notice to our Privacy Officer. The revocation will not affect any actions that were already taken upon this Consent. You should also understand that if you revoke this Consent, we may decline to treat you.

You are entitled to a copy of this Consent Form after you have signed it.

(To Be Completed by Parent or Patient Representative)

I, _____ have read the contents of the Consent Form and the Notice of Privacy Practices. I understand that I am giving you my consent to use and disclose my child's health care information to carry out treatment, payment activities, and health care operations.

_____ _____

Signature of Parent / Guardian Date

_____ _____

Printed Name of Parent / Guardian Child's Name

Our Privacy Officer can be contacted as follows:

Name of Privacy Officer: John Montoya

Practice Address: 6245 Rufe Snow Dr. Ste #240
Watauga, Texas 76148

Phone: 817-985-7550

Fax: 817-985-7551

Email: info@aviatorpediatricdentistry.com

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GENERAL CONSENT FORM

Patient Name: _____ Date of Birth: _____/_____/_____

I, hereby authorize, Aviator Pediatric Dentistry and staff, to take radiographs, study models, intraoral photographs, do examinations or use any other diagnostic tools, all deemed appropriate by the dentist to make a thorough diagnosis of the patient's dental needs. I also authorize the dentist to perform all forms of treatments including cleaning, fluoride, and sealants (back teeth have grooves and pits in which decay usually starts. An assistant will "seal" the grooves with a plastic coating to help prevent the decay from starting. No anesthesia is needed. Good oral hygiene and avoidance of sticky and hard food/ candles are important to maintain sealants).

And further **authorize and consent** that the dentist chooses and employs such assistance as she deemed fit. I **understand** that antibiotics, local anesthesia ("shots") and all other medication given to the patient before, during and after treatment, can cause allergic causing redness and swelling of tissue, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). Administration of local anesthesia ("shots") may cause nerve damage (paresthesia) that can last for days, months or indefinitely. Women of children bearing age need to know antibiotics may make birth control medications ineffective and need to rely on other methods of birth control to prevent pregnancy.

I **understand** that I am responsible for payments of services rendered by Aviator Pediatric Dentistry, and responsible for paying any copayment and deductible that my insurance does not cover. I hereby authorize the Aviator Pediatric Dentistry to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

I **affirm** that the information I have given is correct to the best of my knowledge. All information herein will be held in the strictest confidence, and it is my responsibility to inform Aviator Pediatric Dentistry of any changes in my medical status. I truthfully revealed my/my child's health history, and I realized failure to have done so many have done so may have negative consequences for my/my child's health and success of my/my child's treatment.

I **agree** to cooperate fully with the recommendations of the Dentist and Dental Hygienist, and I realized that failure to do so many results in less than optimum result and compromise the life span of my/my child's treatment. I **also agree** to follow the recommendations for home care and schedule for future tooth cleaning and check-ups. I realize that failure to do my part in the maintenance of my/my child's oral health will compromise the success of any dental treatment received.

I **understand** and acknowledge that I may choose not to be treated by the dentist. The dentist has explained to me the reasonably foreseeable risks associated with not treating my condition. Alternative treatment plans with their foreseeable associated risks and benefits have been adequately presented to me.

Parent / Legal Guardian Name: _____

Relationship to the above patient: _____

Parent / Legal Guardian Signature: _____ Date: _____/_____/_____

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Consent for Dental Treatment

I, as the legally responsible parent/guardian of _____, hereby authorize Dr. Jairo Montoya as may be selected to treat the condition(s) described:

Filling(s)	**Pulpotomy / Stainless Steel Crown(s)**	**Extraction(s)**	**Any necessary spacer(s)**
Exam(s)	**X-rays**	**Cleaning(s)**	**Fluoride**

1. The procedure(s) necessary to treat the condition(s) have been explained to me and I understand the nature of the procedure(s).
2. I have been informed of possible risks, benefits, and alternative methods of treatment (if any), including no treatment at all, and the risks of non-treatment. I further understand that this is an elective procedure and other forms of treatment or no treatment at all are choices that I have, and that this treatment is intended to provide improved dental health and prevent future potential problems in my child.
3. Dr. Montoya and associates of Aviator Pediatric Dentistry and/or their employees have explained to me that there are certain inherent and potential risk in any treatment plan or procedure, and that such treatment risks include, but are not limited to, the following:
    a. **Possible postoperative discomfort and swelling,**
    b. **Possible biting of lip and tongue while anesthetized causing discomfort and swelling,**
    c. **Possible stretching of corners of mouth with possible cracking lips,**
    d. **Possible decision to leave a small piece of root in the jaw if tooth is extracted and if removing root tip would require extensive surgery,**
    e. **Possible prolonged bleeding following tooth extraction,**
    f. **Possible damage to adjacent teeth or restorations during procedure,**
    g. **Possible petechiae, tiny purple or red, non-raised spots on the face and neck.**
4. It has been explained to me that, while the procedure(s) unforeseen conditions may be revealed that necessitate an extension of the original procedure(s) or different procedure(s) that those set forth above. I therefore authorize and request that the doctors perform such procedures as are necessary and desirable in the exercise of their professional judgement. This authorization shall extend to the treatment of all conditions that require treatment and that are not known at the time the original procedure started.
5. I consent to administration of nitrous oxide, analgesia, and topical and local anesthesia in connection with that procedure(s).
6. It has been explained to me, and I understand that a perfect result is not guaranteed or warranted and cannot be guaranteed or warranted.

I certify that I read and write English and fully understand this consent for treatment.
PLEASE ASK THE DOCTOR IF YOU HAVE ANY QUESTIONS CONCERNING THIS CONSENT BEFORE YOU SIGN.

_____ _____
PARENT OR LEGAL GUARDIAN DATE

_____ _____
WITNESS (DOCTOR OR STAFF MEMBER) DATE

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Cell Phone and Video-Taping Policy

1. Use of cellular telephones is prohibited in the treatment area and waiting room to prevent any distractions, and to respect the privacy of other families.

2. Cameras and videotaping of any form are not allowed in the treatment area, waiting room, or any other part of the office to ensure the privacy of our patients and their families.

3. If you need to make or receive an urgent call, please step out of the treatment area and waiting room and find a suitable location outside the office.

4. Any violation of this policy may result in termination of treatment and/or dismissal from the practice.

5. If you need to use your cellphone or other device while in the waiting room, please use it quietly and respect the other patients' right to a peaceful environment.

We appreciate your cooperation in maintaining a professional and private atmosphere for all our patients and their families.

Parent / Legal Guardian Name: _____

Parent / Legal Guardian Signature: _____

Date: _____/_____/_____

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PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your/your child's health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of Aviator Pediatric Dentistry's Notice of Privacy Practices.

_____	_____
Print Name	Child's Name
_____	_____
Signature of Parent / Guardian	Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from the patient/patient parent/guardian, but it could not be obtained because:

- o The Patient/ Parent/Guardian refuse to sign.
- o Due to an emergency situation, it was not possible to obtain an acknowledgement.
- o We weren't able to communicate with the parent.
- o Other (Please provide specific details)

_____

_____

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Patient Acknowledgement Appointment Cancellation and General Anesthesia Policy

Dear Parent and Patient,

Aviator Pediatric Dentistry has instituted an **Appointment Cancellation and General Anesthesia Policy**. A cancellation with **less than a 48-hour** notice significantly limits our ability to make the appointment available for another patient in need. To remain consistent with our mission, we have instituted the following policy:

1. **Please provide our office with 48-hour notice if you need to reschedule your appointment.** This will allow us the opportunity to provide care to another patient. A message can always be left with the answering service to avoid a cancellation fee being charged.

2. A **"No-Show," "No-Call," or missed appointment without proper 48-hour notification may be assessed with a $25 fee and could be reported to your insurance provider.** This fee is not billable to your insurance and **MUST** be paid before rescheduling another appointment.

3. If you are **15 or more minutes late** for your appointment, the appointment will be canceled and rescheduled to the next available slot. **FOR GENERAL ANESTHSIA APPOINTMENTS**: this could be **over 60 – 90 days out.**

4. As a courtesy, we send reminder texts, e-mails, and phone calls for appointments **two weeks, one week, five days, two days, and one day before your appointment.** Please note if a reminder call or message is not received, the cancellation policy remains in effect.

5. **Repeated missed appointments (more than two) may result in the termination of the Physician/Patient relationship and could be reported to your insurance provider.**

If you have any questions regarding this policy, please let our staff know, and we will gladly clarify any questions. A copy of this policy will be provided to you. Please sign and date below your acknowledgment.

I have read and understand the Appointment Cancellation and General Anesthesia Policy and acknowledge its terms. I also understand and agree that the clinic may amend such terms occasionally.

Parent Name (Printed)	**Child / Patient's Name (Printed)**
Parent Signature as Acknowledgement	**Date**