NORTH STAR
PEDIATRIC DENTISTRY

Patient Intake & Consent Form

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Please complete all sections. Information is protected under HIPAA regulations.

1 Patient Information

Child's Full Name: _____ **Preferred Name:** _____

Date of Birth: _____ **Grade:** _____ **Age:** _____ **Ht:** _____ **Wt:** _____

Address: _____ **Zip:** _____

School / Daycare: _____ **Pediatrician Name & Phone:** _____

2 Parent / Guardian Information

Parent/Guardian Name: _____ **Relationship to Child:** _____

Cell Phone: _____ **Alt. Phone:** _____ **Email:** _____

Address (if different): _____ **Zip:** _____

Occupation & Employer: _____ **Emergency Contact:** _____

Emergency Cell: _____ **Alt. Phone:** _____ **Email:** _____

Preferred method of non-emergency contact:

☐ Email ☐ Text ☐ Cell Phone ☐ Other: _____

Patient lives with (check all that apply):

☐ Mother ☐ Father ☐ Grandparents ☐ Other: _____

Legal guardian(s) if different from above: _____ _____

3 Dental Insurance

Dental Insurance Company: _____ **Group Number:** _____

Insured Name: _____ **Policy Number:** _____

Group Name & Contact Phone Number: _____ _____

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4 Pediatric Medical History

Asthma	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Seizures / Epilepsy	☐ Yes	☐ No	Congenital Heart Condition	☐ Yes	☐ No
Bleeding Disorder	☐ Yes	☐ No	ADHD / ADD	☐ Yes	☐ No
Autism Spectrum Disorder	☐ Yes	☐ No	Premature Birth	☐ Yes	☐ No
Malignant Hyperthermia	☐ Yes	☐ No	HIV / AIDS	☐ Yes	☐ No
Hepatitis (A/B/C)	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Immune Disorders	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Thyroid Disorders	☐ Yes	☐ No	Developmental Delay	☐ Yes	☐ No
Behavioral / Emotional Conditions	☐ Yes	☐ No	Other Condition	☐ Yes	☐ No

Allergies: _____ _____

Medications: _____ _____

Surgeries / Hospitalizations: _____ _____

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

5 Dental History

General / Previous Dentist: _____ **Phone:** _____

Date of Last Dental Exam: _____ **Reason for Today's Visit:** _____

History of cavities, extractions, or toothache?

☐ Yes ☐ No ☐ ☐

If yes, please describe: _____ _____

6 Consent for Dental Treatment

6. Consent for Dental Treatment

I authorize the dentist and staff of Northstar Pediatric Dentistry to perform examinations, take radiographs, and provide preventive and restorative care as deemed necessary for my child's oral health.

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

7 Behavior Guidance Consent (AAPD-Based)

7. Behavior Guidance Consent (AAPD-Based)

I understand that behavior guidance techniques may be used to make my child's dental visit safe and comfortable. These may include: Tell-Show-Do, positive reinforcement, distraction, voice control, nitrous oxide sedation, and parental presence or absence. All techniques follow AAPD and Minnesota standards.

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

8 Financial Policy & Minnesota MHCP Compliance

8. Financial Policy & Minnesota MHCP Compliance

Copayments, deductibles, and non-covered services are due at the time of service. If your child is enrolled in Minnesota Health Care Programs (MHCP/Medicaid), we will bill your plan directly. Any remaining balance after insurance payment is the responsibility of the parent/guardian.

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

9 HIPAA Acknowledgment & Communication Authorization

9. HIPAA Acknowledgment & Communication Authorization

I acknowledge receipt of the Notice of Privacy Practices for Northstar Pediatric Dentistry, PLLC. I authorize the office to communicate with me via phone, text, or email regarding my child's care.

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

10 Assignment of Benefits

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10. Assignment of Benefits

I authorize payment of dental benefits directly to Northstar Pediatric Dentistry, PLLC for services rendered to my child.

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

11 Nitrous Oxide (Laughing Gas) Consent

11. Nitrous Oxide (Laughing Gas) Consent

I consent to the use of nitrous oxide/oxygen as a relaxation aid during my child's dental treatment. I understand that benefits and risks have been explained to me and that I may withdraw consent at any time.

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

12 Photo & Media Release

12. Photo & Media Release

I authorize Northstar Pediatric Dentistry to use photographs or videos of my child for educational or marketing purposes. I understand my child's identity will be protected and no personally identifying information will be shared without further consent.

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

13 Authorized Adults for Pick-Up / Release

Please list all adults authorized to bring or pick up your child:

Authorized Adult #1: _____ **Phone:** _____ **Relationship:** _____

Authorized Adult #2: _____ **Phone:** _____ **Relationship:** _____

Authorized Adult #3: _____ **Phone:** _____ **Relationship:** _____

By signing below, I confirm that all information provided is accurate and complete to the best of my knowledge.

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