Patient Information

Patient's Name: _____ _____ Gender: _____
Last First MI (Preferred Name)

Date of Birth: _____ Age: ____ Name of child's favorite pet/hobby/playmate: _____

Phone (Home): _____ Mom / Dad's Cell: _____ Is it ok to text this number? ☐ Yes ☐ No
(please circle which)

How would you like to be contacted to confirm all future appointments? ☐ Cell ☐ E-mail ☐ Text ☐ Home

Address: _____
Street Apartment #

_____
City State Zip Code

Parent/Guardian's E-mail Address:_____

Parent/Guardian(s) Information

Mother/Guardian's Name:_____ _____ _____
Last First MI Date of Birth Social Security #

Occupation: _____ Work Number: _____ Ext: _____ Cell Number: _____

Father/Guardian's Name:_____ _____ _____
Last First MI Date of Birth Social Security #

Occupation: _____ Work Number: _____ Ext: _____ Cell Number: _____

With whom does the patient live? _____

MARITAL STATUS: ☐ MARRIED ☐ PARTNERS ☐ SINGLE ☐ DIVORCED ☐ WIDOWED ☐ SEPERATED

Insurance Information

Primary

Name of Policy Holder: _____ Relationship to Patient: _____
Last First MI

Policy Holder's Date of Birth: _____ ID/SSN #: _____ Group #: _____

Policy Holder's Employer Name: _____

Employer Address: _____
Street City State Zip Code

Insurance Company Name: _____ Insurance Phone #: _____

Insurance Claims Mailing Address: _____
Street City State Zip Code

Is your child covered under more than one plan? ☐ Yes ☐ No

*** The coordination of primary and secondary insurance is determined by a strict set of guidelines. While we are happy to file your secondary insurance claims for you, we ask that you provide accurate information on your coverage. Any errors or omissions may lead to the incorrect filing of your claims, which may delay payment - and can be considered insurance fraud.

If we are billing a secondary insurance on your behalf, please provide their information on the next page.

Secondary **(Primary and Secondary Insurances are determined by the parent's month of birth)**

Name of Policy Holder: _____ Relationship to Patient: _____
Last First MI

Policy Holder's Date of Birth: _____ ID/SSN #: _____ Group #: _____

Policy Holder's Employer Name: _____

Employer Address: _____
Street City State Zip Code

Insurance Company Name: _____ Insurance Phone #: _____

Insurance Claims Mailing Address: _____
Street **City** **State** **Zip Code**

I hereby authorize payment to the above named dentist of the group dental benefits, otherwise payable to me, but not to exceed the charges shown on the claim. I understand that I am financially responsible for any charges not covered by my insurance or by this authorization.

_____ _____ _____
Signature Relationship to Patient Date

Office and Financial Policies

Our primary goal and responsibility is to help our patients obtain good dental health and make you and your child's visit to our office a very positive experience. So that we can focus our time and energy on your child, we have prepared this letter to inform you of our office and financial policies.

APPOINTMENTS:
When you make an appointment with us, we consider your time as "confirmed" or reserved. As a courtesy, we will be happy to call you prior to your child's visit to see if you have any questions regarding your appointment. Should a scheduling conflict arise, please notify our office **at least 2 business days prior to your scheduled appointment** so that we may reschedule you properly as well as serve our other patients. Because late cancellations may prevent us from being able to appoint another patient during your time, you may be charged an administrative **fee of $35**. This fee will not be billed to your insurance company.

FINANCIAL POLICY:
Payment is DUE IN FULL at the time of service. If you have insurance, you will be expected to make an estimated payment for that portion not covered by your insurance plan. We are sensitive to the fact that families have different needs in fulfilling their financial obligation, therefore, in addition to cash and check, we accept Visa/Mastercard and CareCredit. If special arrangements are needed, please talk to our office *prior* to receiving service.

DENTAL INSURANCE:
As a courtesy to our patients who have dental insurance, we are happy to submit the necessary forms. Because insurance policies can vary greatly, **we can only estimate your coverage in good faith**, but cannot guarantee coverage; due to the complexities of insurance contracts. We recommend you contact your insurance company directly to verify your coverage for services. **Your estimated patient portion must be paid at the time of service.**

It is important to remember that the policy is a contract between you and your insurance company. We will fully attempt to help you receive full insurance benefits; however, you are responsible for your account. If your insurance policy does not pay within 60 days, **you are responsible for the entire balance, paid-in-full.** Please keep us informed of any insurance changes, such as policy name, insurance company address, or a change of employment.

We sincerely thank you for your support and belief in our office. If you have any questions, our courteous staff is always available to answer them.

I have read the above, and I understand and agree to this financial policy.

_____
Name of Patient

_____ _____ _____
Signature of Responsible Party Relationship to Patient Date

Patient's Health History

Child's Pediatrician/Physician: _____ Phone: _____

Date of Last Medical Exam: _____

Has your child ever had any of the following? Please check those that apply:

- ☐ AIDS/HIV
- ☐ Allergies _____
- ☐ Allergy to Codeine
- ☐ Allergy to Penicillin
- ☐ Allergy to LATEX
- ☐ Allergy to Dairy Products
- ☐ Allergy to Nuts _____
- ☐ Anemia
- ☐ Asthma
- ☐ Attention Deficit Disorder (ADD)
- ☐ Autism
- ☐ Brain Injury
- ☐ Cancer _____
- ☐ Cerebral Palsy
- ☐ Cleft Lip / Palate
- ☐ Convulsions / Seizures
- ☐ Diabetes
- ☐ Dizziness
- ☐ Emotional Disturbance
- ☐ Epilepsy
- ☐ Eye Problems
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Hearing Loss
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hemophilia
- ☐ Hepatitis (Type_____)
- ☐ Hyperactivity (ADHD)
- ☐ Jaundice
- ☐ Leukemia
- ☐ Developmentally Delayed
- ☐ Nervous Disorders
- ☐ Nutritional Deficiency
- ☐ Orthopedic Problems
- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ Sensory Disorder
- ☐ Sickle Cell Anemia
- ☐ Spina Bifida
- ☐ Syndrome _____
- ☐ Tuberculosis

OTHER:

- ☐ _____
- ☐ _____
- ☐ _____

☐ **MY CHILD IS IN GOOD HEALTH AND NONE OF THE ABOVE APPLY.**

- Has your child ever been hospitalized? ☐ Yes ☐ No If yes, please explain:_____
- Is your child up to date with immunizations? ☐ Yes ☐ No
- Is your child **allergic to any medications?** ☐ Yes ☐ No
- Is your child **allergic to latex?** ☐ Yes ☐ No
- Is your child currently taking any medications? ☐ Yes ☐ No If yes, please list:_____
- Have you ever been told that your **child needs premedication for a heart condition before dental treatment?** ☐ Yes ☐ No If yes, please explain:_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If my child's health information ever changes, I will inform the doctor at the next appointment without fail.

_____ _____ _____

Signature Relationship to Patient Date:

Dental History

REASON FOR TODAY'S VISIT: _____

Is this your child's first visit to the dentist? ☐ YES ☐ NO If no, then what was your child's:

Date of Last Dental Visit: _____ Name of Previous Dentist: _____

Date of Last Dental X-rays: _____

In order for us to better serve your child, please answer the following questions:

1. Does/did your child take a bottle to bed at night? ☐ Yes ☐ No Age Discontinued: _____
2. Does your child use fluoride (other than toothpaste) at home? ☐ Yes ☐ No

   If so, what is the name of the supplement? _____
3. Does your child suck his thumb/finger/pacifier? ☐ Yes ☐ No

   *(please circle all above that apply)
4. Does your child have a toothache? ☐ Yes ☐ No
5. Has your child experienced any unfavorable reaction from any medical or dental care? ☐ Yes ☐ No

   Is yes, please explain: _____

Dental History
(continued)

ORAL HYGIENE:

Tooth brushing is completed _____ times a day. Do you help your child brush? ☐ Yes ☐ No

If so, then how often to you help them brush? (Please circle). Sometimes Always

Flossing is completed _____ times a day. Do you help your child floss? ☐ Yes ☐ No

Do you every notice that your child eats or swallows toothpaste? ☐ Yes ☐ No
Name of child's toothpaste: _____

FAMILY DENTAL HISTORY:

Mom / Dad have a history of frequent dental treatment?	☐ Yes	☐ No
Mom / Dad have weak teeth?	☐ Yes	☐ No
Mom / Dad have had cavities as an adult?	☐ Yes	☐ No
Mom / Dad have congenitally missing teeth?	☐ Yes	☐ No

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice:_____