Mt. Airy Children's Dental Associates

PATIENT INFORMATION ❒ *Male* ❒ *Female*

Name:	**Nickname:**	**Birth Date:**	**Age:**
Home Address:	Email Address for Appointment Confirmation:		❒ OK to Email
	Cell # for Text Appointment Confirmation:		❒ OK to Text
	School/Home School and Grade:		
Child's Primary Home Address has: ❒ Well Water ❒ City Water	Names & Ages of Siblings:		

MOTHER'S INFORMATION

FATHER'S INFORMATION

Who has legal custody of this child? ❒ **Mother** ❒ **Father** ❒ **Both** ❒ **Other** ***(if Other please provide legal documentation of guardianship)***

Name: ❒ *Single* ❒ *Married* ❒ *Divorced* ❒ *Widowed*		**Name:** ❒ *Single* ❒ *Married* ❒ *Divorced* ❒ *Widowed*	
Birth Date:	**SSN:**	**Birth Date:**	**SSN:**
Home Address: (*if different than Patient*)		**Home Address:** (*if different than Patient*)	
Home #:	**Cell #:**	**Home #:**	**Cell #:**
Employer Name & Address:		**Employer Name & Address:**	
Work #:		**Work #:**	

EMERGENCY CONTACT (a neighbor or relative not living with you)

Name:	**Relationship to Patient:**	**Phone #:**

PRIMARY DENTAL INSURANCE *Is your child covered under a dental insurance plan?* ❒ *Yes* ❒ *No*

Insurance Company: (*Name & Address*)	**Insurance Co. Phone #:**
	Group #/ID#:

POLICY HOLDER ❒ *Mother* ❒ *Father* ❒ *Other* ***(if OTHER is selected, complete policy holder information below)***

Policyholder's Name:	**SSN:**	**Employer Name & Address:**
Relation to Patient:	**Birth Date:**	

OFFICE FINANCIAL POLICY ◆ NOTICE OF PRIVACY PRACTICES ◆ ACKNOWLEDGEMENTS

RESPONSIBLE PARENTING ADULT: The parenting adult/guardian who accompanies the child to the appointment is responsible for charges. For separated or divorced parents, the parent who brings the child is responsible for payment. If another agrees to be responsible, that person must provide a notarized acknowledgment in writing to us.
IDENTIFICATION: Our office does require your Social Security number. Many insurance companies require this number to file a claim. We also use this number as a collection tool if necessary. We follow HIPPA rules and regulations and your information is secure in our files. If you choose not to provide this information, you must pay at each visit and we will provide you with information to file to your insurance for reimbursement.
PATIENTS WITH INSURANCE: If we have received all of your insurance information, we will file your claim for you. You must be familiar with your insurance benefits, as any amount not covered by your insurance company is payable by you including deductibles, co-payments, or certain procedures not covered in full.
PAYMENT OPTIONS: Payment for dental treatment is expected at the time of service unless the patient has dental insurance. Occasionally for large treatment plans, we can extend a payment plan. We accept cash, personal checks, Visa, MasterCard, or Discover. A fee of $25 will be charged for any check returned by your bank.
BILLING/DELINQUENT ACCOUNTS: Statements are sent to advise you of the status of your account whenever there is a balance present regardless of whether you have dental insurance. Any account balance exceeding 90 days in age may be forwarded to a collection agency. All costs incurred in collecting unpaid fees will be charged to your account. For this reason, if there is a difficulty with a balance, it is important to phone us immediately to discuss payment options. Delinquent accounts will be reported to the Credit Bureau by the collection agency.
APPOINTMENT INFORMATION: We reserve the right to charge for missed appointments not cancelled 24 hours in advance. Two consecutive missed appointments may result in discharge from this practice.

- **I acknowledge that I am aware of the Notice of Privacy Practices, and I have read or had the opportunity to read and understand the Notice. Only one acknowledgement is necessary per family.**
- **I understand that the information that I have given today is correct to the best of my knowledge, that it will be held in the strictest confidence and it is my responsibility to inform the office of any changes in my child's health. I authorize the completion of all mutually agreed upon necessary dental services.**
- **I authorize release of any information regarding my child's dental treatment to my dental/medical insurance company. I understand that I am responsible for payment of services rendered and also responsible for any co-payment and deductibles that my insurance does not cover.**
- **I hereby authorize payment of group insurance benefits to this office. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.**
- **I understand that I remain financially responsible for all treatment for my child/children including those 18 years of age or older as long as they remain patients of this practice.**

(SEAL)

Parent/Guardian Signature _____ **Print Name** _____ **Date** _____

Turn Form Over for Health History

PATIENT MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.

Patient Name:		**Child's Physician:** *(Name & Address)*
Date of last physical exam:	**Child's Height:** **Weight:**	
Immunization's up to date? ❒ Yes ❒ No *(If no, explain)*	**Is a physician treating your child for a specific illness?** ❒ Yes ❒ No	**Physician's Phone #:**

Check and Discuss with the Doctor any medical condition the child has or has had:

Allergies: ❒ Latex ❒ Metals/Plastics ❒ Seasonal ❒ Foods*/Coloring ❒ Drugs* * *Please list which drugs or foods*

❒ Accidents or severe infections	❒ Cerebral Palsy	❒ Hospital Stays/Surgeries**	❒ Psychiatric care
❒ AIDS or HIV+	❒ Convulsions, Epilepsy, or seizures	❒ Hyperactivity/ADHD/ADD *(circle)*	❒ Skeletal/Joint conditions
❒ Anemia or Blood Disorders	❒ Developmental Disabilities **	❒ Immune Deficiencies/Problems	❒ Skin Problems
❒ Asthma or Lung Problems	❒ Diabetes	❒ Kidney or Bladder Problems	❒ Special Diet **
❒ Autism/Aspergers Syndrome/PDD	❒ Genetic Conditions/Syndromes **	❒ Liver Disease/Hepatitis	❒ Speech or Hearing Impairments
❒ Bleeding problems	❒ Headaches	❒ Malignancies (Cancer)	❒ Taking/Taken Bisphosphonates
❒ Blood Transfusions	❒ Heart Conditions	❒ Prematurity	❒ Tuberculosis
			❒ Vision Problems

** *Description of medical condition if indicated above*

Is your child taking any medications, prescription or over-the-counter, please include any vitamins, supplements or herbals? ❒ Yes ❒ No *(list below)*

Drug	*Dose*	*Frequency*	*Reason*

Please describe any current medical treatment including drugs, pending or recent surgery, recent injuries, special diets or any other information the dentist should be aware of that has not been covered above.

NEW PATIENT INFORMATION

What is the reason for your visit today? _____

_____

❒ Yes ❒ No **Is your child having any discomfort?**
❒ Yes ❒ No **Have there been any injuries to the face, mouth, teeth, or chin?**
❒ Yes ❒ No **Do you have any special concerns to discuss with the doctor in private?**
❒ Yes ❒ No **Has your child experienced problems with previous dental care? If Yes, please explain:** _____

_____

❒ Yes ❒ No **Is this your child's first visit to the dentist?**

Previous Dentist: _____ Date of last visit: _____

Who can we thank for referring you to our office? _____

❒ Dentist ❒ Physician ❒ Insurance ❒ Friend ❒ Website ❒ Phonebook ❒ Advertisement

**** OFFICE USE ****

Doctor Notes: _____

Doctor Review and Signature: _____ Date: _____