



Mt. Airy Children's Dental Associates

PATIENT INFORMATION

Male Female

Patient Name:			Nickname:	Birth Date:	Age:
Street Address:			Email Address for Appointment Confirmation:		<input type="checkbox"/> OK to Email
City:	State:	Zip:	Cell # for Text Confirmation:		<input type="checkbox"/> OK to Text
School/Home School and Grade:			Names & Ages of Siblings:		

LEGAL GUARDIAN #1 (Primary Contact)

LEGAL GUARDIAN #2 (Secondary Contact)

Name:			<input type="checkbox"/> Male <input type="checkbox"/> Female			Name:			<input type="checkbox"/> Male <input type="checkbox"/> Female		
SSN:		Relationship to patient:				SSN:		Relationship to patient:			
Birth Date:		<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Partnered <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated				Birth Date:		<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Partnered <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated			
Street Address:			Street Address:			Street Address:			Street Address:		
City:	State:	Zip:	City:	State:	Zip:	City:	State:	Zip:	City:	State:	Zip:
Home #:		Cell #:				Home #:		Cell #:			
Employer Name:						Employer Name:					
Work #:						Work #:					

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

Name:	Relationship to Patient:	Phone #:
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PRIMARY DENTAL INSURANCE

Name of Policyholder:				Relationship to Patient:			
Birth Date:		SSN:		Name of Employer:			
Name of Insurance Company:				Group #:		ID#:	

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. 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, Discover and American Express. 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. 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 insurance company. 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 am responsible for payment of services rendered and also responsible for any co-payment and deductibles that my insurance does not cover.
- If email address and cellular number is provided above, I consent to receive electronic transmission
- 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: _____		Name of Child's Physician: _____	
Date of last physical exam: _____	Child's Height: _____	Weight: _____	Physician's Phone #: _____
Immunizations up to date? <input type="checkbox"/> Yes <input type="checkbox"/> No <small>(If no, explain below**)</small>	Is a physician treating your child for a specific illness? <input type="checkbox"/> Yes <input type="checkbox"/> No	Child's Primary Address has: <input type="checkbox"/> Well Water <input type="checkbox"/> City Water	

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

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

<u>Drug</u>	<u>Dose</u>	<u>Frequency</u>	<u>Reason</u>

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: _____