# Welcome

Welcome to Children's Dentistry and Orthodontics! Our primary goal is to make every visit fun & educational. Our practice is based on preventative dental care. We strive to teach good oral care that will enable your child to maintain a beautiful smile for a lifetime! In order to provide the safest comprehensive dental care available, we ask that you complete this detailed medical form prior to your scheduled appointment. Please feel free to ask questions about any items that you are not familiar with. Thank you!

**About Your Family** Today's Date_____

Child's Name_____ Preferred Name_____

Date of Birth_____ SS# _____ ☐ Male ☐ Female

Patient Lives With: ☐Mother ☐ Father ☐ Other:_____

Email Address:_____

☐ Mother's information ☐ Step-mother ☐ Legal Guardian ☐ Grandmother ☐ Responsible for account

| | | |
|---|---|---|
| Name: | DOB: | Occupation: |
| Address: | SS# | Employer: |
| City, State, Zip: | | Work phone: |
| Home phone: | Cell phone: | Marital Status: |

☐ Father's information ☐ Step-father ☐ Legal Guardian ☐ Grandfather ☐ Responsible for account

| | | |
|---|---|---|
| Name: | DOB: | Occupation: |
| Address: | SS# | Employer: |
| City, State, Zip: | | Work phone: |
| Home phone: | Cell phone: | Marital Status: |

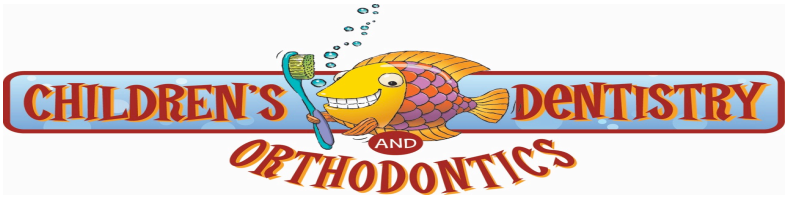
May we leave a message regarding your child's dental appointments and care with:

☐ home phone ☐ work phone ☐ cell phone ☐ answering machine ☐ anyone answering my home phone

**Dental Insurance Information**

Ins. Co. Name _____ Phone _____
Employer: _____ Group # _____ Policy # _____
Who is the primary person on this policy? _____ SS# _____

Do you have secondary insurance? Yes ☐ No ☐
Ins. Co. Name _____ Phone _____
Group # _____ Local # _____ Policy # _____
Who is the primary person on this policy? _____ SS# _____




**Emergency Information**

Patient Name _____

In the case of an emergency where neither parent nor legal guardian can be reached, please identify the following information for the next closest relative not living with the patient.

Name _____ Relation _____
Phone _____ Address _____

**How did you hear about our office?**

| | |
|---|---|
| ☐ friend _____ | ☐ Yellow Book |
| ☐ drive-by | ☐ Doctor's referral _____ |
| ☐ newspaper advertisement | ☐ insurance referral |
| ☐ Google.com or other search engine | ☐ other _____ |

**Medical/Dental Release Statement**

I give my consent for Dr. Faiz and Dr. Mallette of Children's Dentistry and Orthodontics to do a complete and thorough examination on the patient previously named, including any diagnostic radiographs needed. To the best of my knowledge, the information that I have given is correct and I understand that it will be held in the strictest of confidence. Furthermore, I understand that it is my responsibility to inform Children's Dentistry and Orthodontics of any future changes to my child's medical status. As the parent or legal guardian of the previously named patient, I do hereby grant Dr. Faiz/Mallette and his staff permission to perform any needed treatment(s). I also understand that all necessary treatment will be explained prior to commencement and that I am responsible for payment in full at the time of service, unless prior arrangements have been approved.

_____ Initial

**Requirement for Filing Insurance Claims:**

I hereby authorize payment of insurance benefits directly to Children's Dentistry and Orthodontics. I understand that I am personally responsible for any balance remaining after the insurance payment has been received. I am also fully responsible if my insurance policy fails to pay, for any reason, within 30-days of treatment. Furthermore, in the event of payment default for services previously rendered, I also agree to pay all reasonable collection &/or legal fees incurred in an attempt to collect on this amount.

_____ Initial

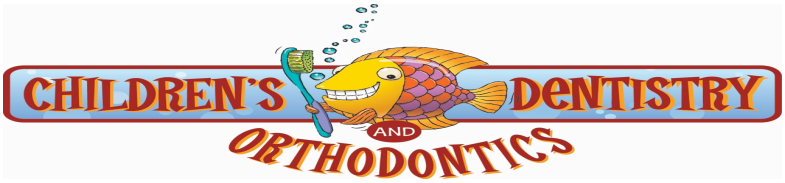
**Privacy Policy Acknowledgement Statement**

I have been told that Children's Dentistry and Orthodontics has a privacy policy in place according to the Health Insurance Portability and Accountability Act (HIPPA). As a patient of Children's Dentistry and Orthodontics, I acknowledge Children's Dentistry and Orthodontics has made this policy available to me.

_____ Initial

_____ _____

Signature of Parent or Legal Guardian Date




**Medical History**

Patient Name _____

Please check yes or no if any of the following medical conditions apply to your child.

Y ☐ N ☐ Sickle cell Anemia or trait (If yes, when _____)
Y ☐ N ☐ Bleeding Disorder or Hemophilia (If yes, when?_____)
Y ☐ N ☐ Blood Transfusion (Date_____) (Right, Left, Both)
Y ☐ N ☐ Blood Pressure Disorder
Y ☐ N ☐ Anemia
Y ☐ N ☐ Heart Condition _____
Y ☐ N ☐ Heart Murmur (innocent or pathological)
Y ☐ N ☐ Tetralogy of Fallot
Y ☐ N ☐ Rheumatic Fever or Scarlet Fever
Y ☐ N ☐ Hepatitis or Jaundice (If yes, when _____)
Y ☐ N ☐ Asthma or lung problems
Y ☐ N ☐ Pneumonia (If yes, when _____)
Y ☐ N ☐ Diabetes (NIDDM or IDDM _____ x day)
Y ☐ N ☐ Seizures, Epilepsy or convulsions
Y ☐ N ☐ Cancer, Malignancy, Leukemia, or Lymphoma
Y ☐ N ☐ Use of tobacco products
Y ☐ N ☐ Drug or Alcohol Abuse _____
Y ☐ N ☐ Emotional or Behavioral problems
Y ☐ N ☐ Diagnosed with ADD, ADHD, or Hyperactivity
Y ☐ N ☐ Handicaps or Disabilities _____
Y ☐ N ☐ Seasonal allergies, hay fever, etc…
Y ☐ N ☐ Autistic Spectrum Disorder
Y ☐ N ☐ Latex Allergy or Sensitivity
Y ☐ N ☐ Delayed Development (Approx age child functions _____)

Y ☐ N ☐ Measles, Mumps, or Chicken Pox
Y ☐ N ☐ Tonsillectomy &/or Adenoidectomy
Y ☐ N ☐ Eye problems (Right, Left, Both)
Y ☐ N ☐ Glaucoma (Right, Left, Both)
Y ☐ N ☐ Hearing Impairment (Right, Left, Both)
Y ☐ N ☐ Sexually Transmitted Disease
Y ☐ N ☐ Immunologic Disorder HIV, AIDS, or ARC
Y ☐ N ☐ Kidney Disease or transplant
Y ☐ N ☐ Liver Disease or transplant
Y ☐ N ☐ Bruises or Bleeds easily
Y ☐ N ☐ Stomach/GI Disorder
Y ☐ N ☐ Thyroid Disorder
Y ☐ N ☐ Currently pregnant
Y ☐ N ☐ Implanted shunts, pins, screws, or rods
Y ☐ N ☐ Fainting spells
Y ☐ N ☐ Physical or Emotional Abuse
Y ☐ N ☐ Ear Infection(s)/Otitis Media
Y ☐ N ☐ Cleft lip/palate
Y ☐ N ☐ Learning Disability
Y ☐ N ☐ Psychiatric problems
Y ☐ N ☐ Congenital Birth Defects/Syndrome
Y ☐ N ☐ Tuberculosis or Previous Positive Test
Y ☐ N ☐ Any stays in Hospital? _____

Signature of Parent or Legal Guardian _____

Doctor's Signature_____

Patient Name _____

Has the patient had the DPT immunization series for diphtheria, polio & tetanus? Yes ☐ No ☐

Is the patient currently taking any medication(s)? Yes ☐ No ☐
If yes, please list: _____

Is the patient currently under the care of a physician? Yes ☐ No ☐
If yes, for what? _____

Is your child allergic or has your child ever had an adverse reaction to a specific medication? Yes ☐ No ☐
If yes, please list the medication(s): _____

Please list the names & phone numbers of any treating physicians.

| Physician's Name | Type of Physician | Office Phone # |
|---|---|---|
| | | |
| | | |

What are your primary concerns about your child's oral health?

_____

**Financial Policy**

We appreciate you choosing our office for your child's dental care. At Children's Dentistry and Orthodontics, we value our relationship with your family and would like to offer the following as our payment policy.

- We understand that the patient may reside with one parent and be financially supported by a parent outside the household. However, in all cases we will ultimately seek payment from the custodial parent/guardian presenting the child for treatment.
- We will try to **estimate** your portion of the bill. After your insurance carrier remits payment you will receive a statement if you have an outstanding balance. A finance charge may be added to your account on any balance not paid in full within 30 days from date of the statement.
- Once the treatment plan and estimated insurance benefits are reviewed with you, we require that you pay your portion (unmet deductible, co-payment, etc.)in full at the time of service.
- For your convenience we accept cash, check, VISA, Discover, MasterCard, and American Express. We also have special dental financing plans available through our third party financing company.
- Please note that parents or guardians bringing the child into the office on the day of the service *will* be expected to pay for services rendered. Only if payment arrangements have been made will we see the child for treatment.
- A fee of $35.00 will be assessed for any returned checks. Any unpaid balances over 30 days will be assessed a finance charge of 1.5% per month / 18.0% annual percentage rate. Any balances left unpaid and sent to collections, will be assessed attorney /collection fees and a collection account fee of 35% of the unpaid balance.

I have read and understand the payment policies for Children's and Orthodontics.

_____ _____ _____

Parent/Guardian Printed Name Parent/Guardian Signature Date