Welcome

Patient ID # _____ Today's Date _____

to our practice! We strive to make each of your child's visits pleasant and comfortable. Please fill out this form completely in ink.

Your Child

Child's Name _____
Nickname _____ Sex _____
Birthdate _____ Age _____
SS# / SIN _____
School _____ Grade _____
Child's Home Address _____
City _____ State/ Prov. _____ Zip/ P.C. _____
Phone _____

Responsible Party

Name _____
Relationship _____
Address _____
City _____ State/ Prov. _____ Zip/ P.C. _____
Email _____
Phone _____ SS#/ SIN _____
DL# _____

Who is responsible for making appointments?

Name _____
Home Phone _____ Cell Phone _____
Work Phone _____ Ext. _____
Best time to call _____
Time _____ Day _____

Mother ☐ Stepmother ☐ Guardian

Name _____
Home Phone _____ Cell Phone _____
Work Phone _____ Ext. _____
Email _____
Employer _____
Occupation _____
SS#/SIN _____
DL # _____
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Father ☐ Stepfather ☐ Guardian

Name _____
Home Phone _____ Cell Phone _____
Work Phone _____ Ext. _____
Email _____
Employer _____
Occupation _____
SS#/SIN _____
DL # _____
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Primary Insurance

Insured's Name _____
Relationship _____
Birthdate _____ SS#/SIN _____
Employer _____ Date Employed _____
Occupation _____
Insurance Company _____
Group # _____ Employee # _____
Ins. Co. address _____
City _____ State/ Prov. _____ Zip/ P.C. _____
Deductible _____ Copay _____
Amount already used _____
Max. annual benefit _____

Additional Insurance

Insured's Name _____
Relationship _____
Birthdate _____ SS#/SIN _____
Employer _____ Date Employed _____
Occupation _____
Insurance Company _____
Group # _____ Employee # _____
Ins. Co. address _____
City _____ State/ Prov. _____ Zip/ P.C. _____
Deductible _____ Copay _____
Amount already used _____
Max. annual benefit _____

Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer.

Payment in full at each appointment. ☐ Cash ☐ Personal Check

Credit Card ☐ Visa ☐ MC ☐ Discover ☐ AMEX

☐ I wish to discuss the office's payment policy.

Dental & Health History *CONFIDENTIAL* Patient ID # _____

Your child's overall health as well as any medications which your child takes could have an important inter-relationship with the dental care your child receives. Please answer each of the following questions completely.

How often does your child brush? _____ How often does your child floss? _____

Is your child's water fluoridated?..... ☐ Yes ☐ No Does your child take fluoride supplements?..... ☐ Yes ☐ No

Does your child:

Suck thumb/finger..... ☐ Yes ☐ No Chew hard objects (pencils, etc.)..... ☐ Yes ☐ No

Suck/Bite lip..... ☐ Yes ☐ No Grind teeth..... ☐ Yes ☐ No

Bite/Chew nails..... ☐ Yes ☐ No Clench jaws..... ☐ Yes ☐ No

Previous dentist _____ Address _____

Date of last dental visit? _____ _____

Has your child had difficulty with previous dental visits? ☐ Yes ☐ No

Child's physician _____ Address _____

Phone # _____ _____

Previous Hospitalizations/Surgeries/Serious Illnesses? When?

_____ _____

_____ _____

_____ _____

Is your child currently taking medications? ☐ Yes ☐ No (if yes, please list)

_____

Has your child ever taken FenPhen/Redux? ☐ Yes ☐ No

_____

Does your child have a history of allergies/sensitivities/adverse reactions to any drugs or medications (penicillin, Novocain, etc.)? ☐ Yes ☐ No (if yes please describe) _____

Does your child have a history of allergies to any other substances (latex, environmental, etc.)? ☐ Yes ☐ No

_____

Has your child ever had any of the following:

Asthma..... ☐ Yes ☐ No Stomach, liver or kidney problems..... ☐ Yes ☐ No

Cancer..... ☐ Yes ☐ No Handicaps/Disabilities..... ☐ Yes ☐ No

Hepatitis..... ☐ Yes ☐ No Tuberculosis..... ☐ Yes ☐ No

HIV/AIDS..... ☐ Yes ☐ No Diabetes..... ☐ Yes ☐ No

Hemophilia..... ☐ Yes ☐ No Rheumatic Fever..... ☐ Yes ☐ No

A persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)..... ☐ Yes ☐ No

Congenital Heart Defect..... ☐ Yes ☐ No

Heart Murmur..... ☐ Yes ☐ No

Convulsions/Epilepsy..... ☐ Yes ☐ No

Abnormal Bleeding..... ☐ Yes ☐ No Osteoporosis..... ☐ Yes ☐ No

Acid Reflux..... ☐ Yes ☐ No

Please explain any medical problem that your child has: _____

_____

Authorization & Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need.

I also authorize the Dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the Dentist or Dentist's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____

Signature of patient (or parent/guardian if minor) Date

Dentist Review

_____ _____

Signature of Dentist Date

Patient Name: _____

Payment Policy

Thank you for choosing us as your health care provider. We are committed to providing you with excellent, affordable. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy to answer frequently asked questions. Please read it, ask us any questions you may have, and sign in the space provided.

□ Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit cards, and select insurances.

□ If you do not have insurance, payment is due in full the day of your visit.

□ If you have insurance all co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud.

□ ALL payment arrangements need to be made BEFORE the day of your appointment.

□ It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits, any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company. If you fail to provide us with the correct insurance information in a timely manner you may be responsible for the balance of a claim.

□ We will submit your claims and assist you in any way we reasonably can to help get your claims paid. We file your insurance as a courtesy. Your insurance may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or nor your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

Our practice is committed to providing the best care to our patients. Our fees are representative of the usual and customary charges for our area. Thank you for understanding our policy. Please let us know if you have any questions or concerns.

I have read and understand this policy and agree to abide by its guidelines:

_____ _____

Signature Of Patient or Responsible Party Date

DeAtley Dental Care

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices

_____
Signature

_____
Date

I give permission to those listed below to have access to my medical information and to discuss matters relating to my care. I recognize that if I do not list anyone below, I am the only person who will have access to information regarding my medical information and care.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____
Signature Date

A copy of the Notice of Privacy Practices is available upon request.