Pediatric Dentistry

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Everyone Smiles in the Same Language

Today's Date _____

Welcome to our practice!

Our goal is to make each of your child's visits pleasant and comfortable.
Our mission is to teach your child good oral habits which will help your child keep their teeth healthy and smiles beautiful!

Your Child

First _____ M.I. ___ Last _____ Birthdate _____ Age ____ Sex ____

Address _____ City/State _____ Zip _____

Home Phone _____ Siblings _____

Nickname _____ Pets/Hobbies _____

Father ☐ Responsible Billing Party

First Name _____ MI ___ Last _____

Address _____ City/State _____ Zip _____

☐ Same as Above

Home Phone _____ Cell _____

Work Phone _____

Soc. Sec. No. _____ / Birthdate _____

Email _____

Employer _____

Occupation _____

Mother ☐ Responsible Billing Party

First Name _____ MI ___ Last _____

Address _____ City/State _____ Zip _____

☐ Same as Above

Home Phone _____ Cell _____

Work Phone _____

Soc. Sec. No. _____ / Birthdate _____

Email _____

Employer _____

Occupation _____

Parent's Marital Status:

☐ Single ☐ Married ☐ Divorced
☐ Widowed ☐ Separated

Who is responsible for making appointments?

Name _____

Home Phone _____ Work Phone _____

Best time to call _____ Days _____

Email _____

Referred by _____

Phone Number _____

Primary Dental Insurance

Insured's Name _____

Relationship _____

Birthdate _____ Soc. Sec. No. _____

Employer _____

Insurance Co. _____

Group/Policy # _____ ID # _____

Insurance Co. address _____

Insurance Co. phone _____

Additional Insurance

Insured's Name _____

Relationship _____

Birthdate _____ Soc. Sec. No. _____

Employer _____

Insurance Co. _____

Group/Policy # _____ ID # _____

Insurance Co. address _____

Insurance Co. phone _____

PEDIATRIC DENTISTRY

Woodbury **Inver Grove Heights** **Stillwater**

FINANCIAL POLICY

Our doctors are dedicated to providing you with high quality dental care. In order to maintain that commitment we realize the need to collect billing in a timely manner. This credit policy is designed for that purpose.

1. New patients are required to pay for services in full at the time of their visit unless dental insurance information is provided and verified. Dental claims for service provided will be filed by our office to insurance carriers.

2. We do participate with many insurance companies but we do recommend that you verify with your insurance company in advance your eligibility and benefits with our clinic. Please understand that the amount of benefits to be derived under your policy is a predetermined arrangement between your employer and the insurance company; we are unable to increase benefits beyond that which your insurance agreement allows.

3. For your convenience, we are able to do a predetermination of benefits with your insurance company for diagnosed treatment. This is just an estimate as treatment sometimes changes.

4. To help in keeping our costs down, **we do require that all payment and insurance copayments will be due in full at the time of service.**

5. We offer a 5% discount for patients who pay at the time of service on current charges by cash or check payment only. We also accept most major credit cards.

6. If extensive work is required or financial difficulties exist, the account holder must make acceptable payment arrangements with the business office. We offer Wells Fargo Health Advantage or Care Credit payment plans for those who qualify. If the business office is unable to secure acceptable payment arrangements or the account holder refuses to cooperate in the resolution of the balance due, the account will be referred to an outside collection agency.

OFFICE POLICY

1. The office will attempt to schedule appointments at your convenience and when time is available. Children under the age of 5 should be seen in the morning because they tend to be more cooperative at that time. We know that you don't like missing school or work for appointments. Because of the nature of our practice, it is impossible to accommodate everyone for these sought after appointment times. Dental appointments are an excused absence. We do appreciate your understanding in this matter.

2. We realize that unexpected things happen and you may be unable to make your scheduled appointment. We do ask to **please notify our office 24 hours in advance** of your scheduled appointment if you are unable to keep the appointment. **Not showing for 2 appointments may result in the family being dismissed from the practice.**

3. Please plan to arrive 5 minutes before your scheduled appointment. This will allow for any additional paperwork and for us to see your child on time. **A parent or legal guardian must be present in the office during the initial examination and/or any restoration appointments.**

I hereby authorize the administration of such diagnostic and therapeutic procedures as may be necessary for the proper dental care of my child. I authorize the dentist to release any information including the diagnosis and the records of treatment rendered to my child to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist benefits otherwise payable to me. I understand that my dental carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services on behalf of my dependents.

I have received and understand the above information.

_____ Date_____

Signature (Parent or Legal Guardian)

Today's Date_____

New Patient Dental History

Child's Name _____ **Birthdate**_____

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

If no, who was your child's previous dentist? _____

Office phone number _____

Date of last exam _____ Date of last x-rays? _____

At what age did your child's first baby tooth come in? _____

Was your child breastfed? If yes, for how long? _____

Was your child bottle fed? If yes, for how long? _____

Does your child use a sippy cup? **Yes** **No**

Throughout the day or just with meals? _____

Does your child snack throughout the day? **Yes** **No**

If yes, what and how much? _____

Does your child drink juice or pop on a daily basis? **Yes** **No** if yes, how much? _____

Does (or did) your child have habits which might affect oral health?

- Finger or thumb habits **Yes** **No**
- Pacifier user **Yes** **No**
- Clenching or grinding teeth **Yes** **No**
- Mouth breathing **Yes** **No**

Has your child had any injury to any teeth?

If yes, when and what kind of injury? _____

How often are the child's teeth brushed/flossed? _____

Who brushes the child's teeth? _____

Is your tap water fluoridated? **Yes** **No** Does your child take fluoride supplement? **Yes** **No**

Has your child ever had a negative dental experience? If yes, please explain_____

_____

_____ _____ _____

Signature **Print name please** **Relationship to child**

Time 12:21 PM | Pediatric Dentistry | Date 6/15/2015

Child Medical History - Recall Consent

Patient Name: | Birth Date: | Date Created:

Health issues and medications have a critical interaction(s) with dental treatment. Please answer the following questions about your child.

Recall Consent

I consent to digitial X-Rays(taken every 12+ months) ○ Yes ○ No

I consent to fluoride treatment every 6 months ○ Yes ○ No

I prefer for my child to have fluoride once every 12 months ○ Yes ○ No

***Please note, we recommend fluoride for your child every six months. Dependent on your dental insurance provider, this may or may not be a covered procedure due to benefit limitations. If you have any questions, please speak to the front desk.

Health History

Does your child have, or has your child had, any of the following?

Diabetes	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No	Congenital Heart Defects	○ Yes ○ No
Jaundice	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No	Anemia	○ Yes ○ No
Hepatitis A,B or C	○ Yes ○ No	Excessive/prolonged bleedin	○ Yes ○ No	Fainting spells/dizziness	○ Yes ○ No
Asthma or hay fever	○ Yes ○ No	Psychiatric Care	○ Yes ○ No	ADHD/ADD	○ Yes ○ No
Autism spectrum	○ Yes ○ No	Seasonal allergies	○ Yes ○ No	Genetic disorder	○ Yes ○ No
Developmental delays	○ Yes ○ No	Chemotherapy	○ Yes ○ No	Radiation Treatment	○ Yes ○ No
Reflux/GERD	○ Yes ○ No	High or low blood pressure	○ Yes ○ No	AIDS/HIV positive	○ Yes ○ No
Tuberculosis	○ Yes ○ No	Heart Murmur**	○ Yes ○ No		

**If your child has been diagnosed with a heart murmur, we require written documentation from the child's physician stating if a premedication is required or not required.

Please explain "yes" answers ☐ If yes

Has your child ever had any serious illness not listed above? ○ Yes ○ No If yes

Is your child allergic to any of the following?

Penicillin	○ Yes ○ No	Amoxicillin	○ Yes ○ No	Codeine	○ Yes ○ No
Latex	○ Yes ○ No	Metals	○ Yes ○ No	Local Anesthetics	○ Yes ○ No

Any other allergies not listed? ○ Yes ○ No If yes

Does your child have a pediatrician or family physician? If yes, the doctor's name/phone number ○ Yes ○ No If yes

Is your child seeing a specialist(ex: cardiologist) if yes, doctor's name/phone number ○ Yes ○ No If yes

Did your child have health problems at birth or during infancy? ○ Yes ○ No If yes

Is your child currently taking any type of medications or drugs? ○ Yes ○ No If yes

Has your child ever had any unfavorable reactions to food, drugs, medicines or anesthesia? ○ Yes ○ No If yes

Is your child on a special diet?(ex: gluten free) ○ Yes ○ No If yes

Has your child ever been hospitalized/surgery? ○ Yes ○ No If yes

Do you think your child will be a cooperative patient? ○ Yes ○ No

If no, why?

Is there any additional information you would like us to know about the patient?

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 medical status.

Signature of Patient, Parent or Guardian:

X Date:_____