ARLiNgToN
PEDIATRIC DENTISTRY

Date_____

Patient Information

Name of Minor/Child_____
(First) (Middle) (Last)

Nickname _____ Hobbies _____

Date of Birth _____ Age _____ Gender M____ F____

Address _____
Street APT# City State Zip Code

Home Phone (_____)_____

School Name_____ School Phone (_____)_____

Whom may we thank for referring you? _____

Family Information

Have any family members been patients of our office in the past? If so, please list: _____

Mother's / Guardian's Name_____ Date of Birth_____

Email_____ Marital Status: Married / Single / Divorced / Other

Occupation_____ Employer_____

Cell (_____) _____ Work (_____)_____

Father's / Guardian's Name_____ Date of Birth_____

Email_____ Marital Status: Married / Single / Divorced / Other

Occupation_____ Employer_____

Cell (_____) _____ Work (_____) _____

Dental Insurance Information

Primary Plan _____ Plan Phone # (_____)_____

Subscriber's Name _____ Relationship to Patient _____

Subscriber Soc.Sec.#_____ Subscriber Date of Birth _____

Policy ID # _____ Group # _____

Employer _____
(Name / Address)

Secondary Plan _____ Plan Phone # (_____)_____

Subscriber's Name _____ Relationship to Patient _____

Subscriber Soc.Sec.#_____ Subscriber Date of Birth _____

Policy ID # _____ Group # _____

Employer _____
(Name / Address)

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Dental History

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

If no, please provide previous dentist information and reason for the visit_____

_____

Has your child had any recent complaints about any dental problems? Yes___ No___. If yes please explain:
_____

Does your child take fluoride in any form? Yes___ No___. Mouth rinse/gel/bottled water / toothpaste /Other _____

Has your child had or have a history of any of the following? Please check all that apply:

- ☐ Abscess
- ☐ Bad Breath
- ☐ Behavioral Issues
- ☐ Bleeding or Sore Gums
- ☐ Breastfeeding
- ☐ Grinding or Clenching
- ☐ Mouth Breathing
- ☐ Nail biting
- ☐ Pacifier
- ☐ Sippy cup
- ☐ Snoring
- ☐ Speech Problems
- ☐ Thumb or Finger Sucking
- ☐ Other:_____

Medical History

Child's Physician _____
(Name) (Phone)

Date of the last examination _____ Is your child currently under a physician's care Yes___ No___

Is your child taking any medications at this time? Yes___ No___. If yes, please list:_____

_____

Has your child ever been hospitalized? Yes___ No___. If yes, please explain when and why_____

_____

Has your child ever had a surgery? Yes___No___. If yes, please explain:_____

_____

Allergies

☐ Penicillin ☐ Amoxicillin ☐ Latex ☐ Sulfa Other_____

Has your child had any history of or difficulty with any of the following? If yes, please check all that apply.

- ☐ ADHD / ADD
- ☐ Aids / HIV
- ☐ Anemia
- ☐ Asthma
- ☐ Autism
- ☐ Bladder Problems
- ☐ Bleeding Disorder
- ☐ Bone Disorder
- ☐ Cancer
- ☐ Cerebral Paralysis
- ☐ Chicken Pox
- ☐ Convulsions/Epilepsy
- ☐ Diabetes
- ☐ Ear Infection
- ☐ Eczema
- ☐ Head Injury
- ☐ Hearing Disability
- ☐ Heart Condition
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Mononucleosis
- ☐ Mumps
- ☐ Respiratory Issues
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sinus Problems
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Tumor
- ☐ Vision Disability
- ☐ Other_____

Is the patient currently taking birth control pills? Yes___ No___. Is the Patient currently Pregnant? Yes___ No___

ARLINGTON
PEDIATRIC DENTISTRY

Office Policies & Financial Agreement

Thank you for choosing our office for your child's dental care. In order to build a trustworthy relationship for years to come we ask you to take a minute to familiarize yourself with our appointment and payment policies.

1. Appointment times are reserved exclusively for your child and are scheduled at a time best suited for the treatment indicated. We make every effort to see patients on time and request that you extend the same courtesy to us by arriving on time for your appointment.

2. We ask that you inform us of any changes to your appointment time at least two business days in advance or we will consider the appointment broken and charge your account $50.00 per broken appointment. If you find that you are running late please call our office to tell us so. Otherwise we may not be able to see your child. We reserve the right to decline scheduling any future appointments for your child if there is a history of late or broken appointments.

3. The office contacts patients by automated phone calls and text message to confirm appointments. We also may contact you via email. Please let us know if you wish to opt out of one or more of these communication options.

4. A parent must accompany each minor to a visit to our office. Contact our office if you wish to assign another adult to accompany your child. You may choose whether or not to remain in the waiting area during your child's dental appointment. Children almost do better in treatment without parents present but we are open to having **one parent** accompany your child.

5. Payment for professional services is due at the time dental treatment is provided. The person accompanying the patient is responsible for any payment due so please come prepared to pay your deductible, co-payment, and any fees not covered by your insurance on the day of the appointment. A fee of $25.00 will be charged for returned checks

6. We will file a claim and bill your insurance for you if we are a participating provider. We will provide you with an estimate in writing of your out-of-pocket responsibility. We always try to maximize your benefits but we highly recommend that you contact your insurance company to review your benefits.

7. For patients covered by insurance plans with which we do not participate (*out-of-network provider)*, we will provide you with a claim for filing so that you may be reimbursed by your insurer. Payment for services will be charged in full on the day service is rendered.

8. If your insurance plan does not cover any portion of the services rendered, the remaining balance becomes your responsibility and is due upon receipt of the explanation of benefit document. If your insurance company does not pay our claim with 45 days of filing a claim then the account balance becomes your responsibility. After your insurance pays its portion of the treatment we send a statement to your address on record. We ask that you pay the bill within 14 days of the statement date or a fee of $5.00 will be assessed. An additional $5.00 late fee will be charged to your account for every 30 days your account is past due.. An account which is 60 days past due will be transferred to a collection agency and assessed a charge of $50.00 in addition to any legal and court fees.

9. After completion of dental treatment you may be entitled to a refund. You may choose to keep the credit balance with us for use towards future dental care or have the amount refunded to you. Refund checks are issued in the name of the signer of this document and mailed to the address on record.

Please keep us informed of any insurance changes such as policy name, insurance company address, or a change of employment, phone numbers and change of personal address.

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Privacy Policy

Effective April 14, 2003, the federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA's requirements, a copy of our Notice of Privacy Practices is posted for your review and a copy is available at your request. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices. From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Authorization and Consent to Treat Patient and adhere to Office Policies

To the best of my knowledge all the information above is complete and accurate. I understand that it is my responsibility to inform Arlington Pediatric Dentistry should my child have a change in health.

I am the parent/legal guardian of _____ and there are no court orders in
Please print patient's name

effect that prohibit me from signing this consent. I understand it is my responsibility to inform Arlington Pediatric Dentistry of any change in legal status of parents or guardians.

I hereby authorize Arlington Pediatric Dentistry to perform necessary dental services for the child named above. I understand that a parent or person authorized by me in writing must be present when treatment is rendered.

I also authorize Arlington Pediatric Dentistry to disclose patient information to insurance companies and their agents for the purpose of obtaining payment for services and determining insurance benefits.

I agree to pay all related professional charges. Fees not covered by my dental insurance will be promptly paid upon notification from the office according to the financial policy above. I have read and understood this document in its entirety including the office and financial policies and agree to abide by them in full.

I acknowledge that I have reviewed a copy of the Notice of Privacy Practices.

_____ _____
Please print name Parent or Guardian Date

_____ _____
Signature of Parent or Guardian Date

Staff Initials_____

Other Contacts

Whom should we contact if we are unable to contact you ?

Name_____ Relationship_____ Phone (_____)_____

Name_____ Relationship_____ Phone (_____)_____