

WELCOME



Tell Us About Your Child Today's Date: _____ Child's Name: _____ Last First MI Address: _____ Street Apt.# City State Zip Child's Birthdate: ____/____/____ Child's Age: _____ Nickname: _____ <input type="checkbox"/> Male <input type="checkbox"/> Female	General Information Who is accompanying the child today? Name: _____ Relation: _____ Do you have legal custody of this child? <input type="checkbox"/> Yes <input type="checkbox"/> No School: _____ Grade: _____ Hobbies: _____ Whom may we Thank for referring you? <input type="checkbox"/> Sibling <input type="checkbox"/> Google <input type="checkbox"/> Friend <input type="checkbox"/> Other: _____ Other siblings: _____
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Parent's Information

Person Responsible for Account: _____ Parent's Marital Status Single Married Partnered Widowed Divorce Separated

<input type="checkbox"/> Father <input type="checkbox"/> Step Father <input type="checkbox"/> Guardian Name: _____ DOB: _____ Address: (If different than child's) SSN# Street Apt.# City State Zip Hm#:(____) _____ Cell#:(____) _____ WK#:(____) _____ Other#: _____ Email: _____ Employer: _____ If you have <u>Dental Insurance Coverage</u> for the Child, please fill out below: Insurance Co. Name: _____ Insurance Address: _____ City State Zip Insurance Phone:(____) _____ Group# (Plan, local, or Policy#): _____	<input type="checkbox"/> Mother <input type="checkbox"/> Step Mother <input type="checkbox"/> Guardian Name: _____ DOB: _____ Address: (If different than child's) SSN# Street Apt.# City State Zip Hm#:(____) _____ Cell#:(____) _____ WK#:(____) _____ Other#: _____ Email: _____ Employer: _____ If you have <u>Dental Insurance Coverage</u> for the Child, please fill out below: Insurance Co. Name: _____ Insurance Address: _____ City State Zip Insurance Phone:(____) _____ Group# (Plan, local, or Policy#): _____
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Release

I certify that my child is covered by _____ Insurance Co. and I assign all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature of Parent or Guardian

Date

Dental History

1. What is your primary concern about your child's oral health?

2. Has your child ever been examined or treated by another dentist? Y N

a. If YES: Date of first visit: _____ Date of last visit: _____
Reason for last visit _____

b. Where x-rays taken of the teeth or jaw?

Date of most recent xrays: _____

c. Has your child ever had a difficult dental appointment? Y N
If YES, describe _____

3. Does your child have a history of any of the following?

If YES, please describe:

- a. Cavities / decayed teeth Y N _____
- b. Toothache Y N _____
- c. Injury to teeth, mouth or jaws Y N _____
- d. Bleeding gums Y N _____
- e. Inherited dental characteristics Y N _____
- f. Mouth sores or fever blisters Y N _____
- g. Bad breath Y N _____
- h. Clinching/grinding his/her teeth Y N _____
- i. Jaw joint problems (popping, etc.) Y N _____
- j. Excessive gagging Y N _____
- k. Nail biting Y N _____
- l. Sucking habit Y N _____

If yes, which: Finger Thumb Pacifier other

4. How often does your child brush his/her teeth? _____ times per _____

a. Does someone help your child brush? Y N

5. How often does your child floss his/her teeth? _____ times per _____

a. Does someone help your child floss? Y N

6. What type of toothpaste does your child use?

- Fluoride toothpaste Training/non-fluoride toothpaste
- Other

7. What is the source of your drinking water at home?

- City/community supply Private well Bottled water

8. Please check all sources of fluoride your child receives:

- Drinking water Toothpaste Over-the-counter rinse
- Prescription FL (drops/tablets/rinse)
- Fluoride treatment in the dental office
- Fluoride varnish by pediatrician

9. How frequently does your child have the following?

- a. Candy or other sweets Rarely 1-2 times/day 3 > times/day
- b. Soft drinks (juices, soda, gatorades, energy drinks) Rarely 1-2 times/day 3 > times/day
- c. Snacks between meals Rarely 1-2 times/day 3 > times/day

Medical History

Name/phone number of **primary physician**: _____

Name/phone number of **specialists**: _____

Date of last visit and reason: _____

1. Is your child being treated by a physician at this time? Y N
If **YES**, please describe _____
2. Is your child taking any medication (prescription or over-the-counter), vitamins, or dietary supplements? Y N
List name, doses, frequency: _____
3. Has your child even been hospitalized, had surgery or a significant injury, or been treated in an emergency department? Y N
If **YES**, please list date & describe: _____
4. Has your child ever had a reaction to or problem with an anesthetic? Y N
If YES, please describe: _____
5. Has your child ever had a reaction or allergy to an antibiotic, sedative, or other medication? Y N
If **YES**, please list: _____
6. Is your child allergic to anything else (such as latex, metals, acrylic, food, nuts or dye)? Y N
If **YES**, please list: _____
7. Is your child up to date on immunizations against childhood disease? Y N
8. Does your child require antibiotics before dental treatment? Y N
9. Has your child ever experienced the following medical problems?
For each "**YES**", please provide details below.

- | | | | |
|-----------------------------|---|---------------------------------|---|
| Heart murmur | <input type="checkbox"/> Y <input type="checkbox"/> N | Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Sickle cell disease/trait | <input type="checkbox"/> Y <input type="checkbox"/> N | Congenital heart defect/disease | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Liver problems (hepatitis) | <input type="checkbox"/> Y <input type="checkbox"/> N | Enlarged Tonsils / Adenoids | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Behavioral problems | <input type="checkbox"/> Y <input type="checkbox"/> N | GERD (gastro esophageal) | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Lactose intolerance | <input type="checkbox"/> Y <input type="checkbox"/> N | Eczema | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Developmental disorders | <input type="checkbox"/> Y <input type="checkbox"/> N | Cerebral palsy, brain injury | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Sleep apnea/snoring | <input type="checkbox"/> Y <input type="checkbox"/> N | Autism/autism spectrum disorder | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Hydrocephaly | <input type="checkbox"/> Y <input type="checkbox"/> N | ADD/ADHD | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Cleft lip/palate | <input type="checkbox"/> Y <input type="checkbox"/> N | Diabetes, hyperglycemia | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Thyroid or pituitary issues | <input type="checkbox"/> Y <input type="checkbox"/> N | Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Convulsions/seizures | <input type="checkbox"/> Y <input type="checkbox"/> N | Abnormal bleeding (hemophilia) | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Cancer, tumor, other | <input type="checkbox"/> Y <input type="checkbox"/> N | Scarlet fever | <input type="checkbox"/> Y <input type="checkbox"/> N |
| HIV/AIDS | <input type="checkbox"/> Y <input type="checkbox"/> N | Pneumonia | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Birth defect | <input type="checkbox"/> Y <input type="checkbox"/> N | Handicaps/disabilities | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Tuberculosis | <input type="checkbox"/> Y <input type="checkbox"/> N | Hearing loss | <input type="checkbox"/> Y <input type="checkbox"/> N |

If YES to anything above please explain: _____

Are there any other medical conditions you feel we should be aware of?

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

Signature of Parent or Guardian

Date

I have verbally reviewed the medical/dental information above with the parent/guardian & patient named here. _____

Signature of Dentist

Date

Dentist's Comments: _____



We Make Kids Smile HIPAA Notice

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT A PATIENT MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY: We are required by federal and state law to maintain the privacy of our patients' health and dental information. We are required to give you this Notice about our privacy practices, our legal duties, and our patients' rights concerning their health and dental information. You may request a copy of our Notice at any time.

USES AND DISCLOSURES OF HEALTH AND DENTAL INFORMATION: We may use and disclose your health and dental information in order to render treatment, collect payment, administer our healthcare operations and comply with the law and legal actions.

PATIENT RIGHTS / ACCESS: You have the right to look at or receive copies of your health and dental records, and you may request that we provide your health and dental information to others with whom you have authorized us to share this information.

DISCLOSURE ACCOUNTING: You have the right to receive a list of instances in which we have disclosed your health or dental information with our business associates.

RESTRICTION: You have the right to request that we limit the information we share under certain circumstances, unless doing so would affect your care or violate a law.

ALTERNATIVE COMMUNICATION: You have the right to request that we communicate with you confidentially about your health and dental information by alternative means or at an alternative location.

AMENDMENT: You have the right to request that we amend your health and dental information under certain circumstances.

QUESTIONS AND CONCERNS: If at any time you would like to request more information about our privacy practices, or if you have any questions or concerns, please contact our office at 301- 645-6556. A more detailed explanation of our duties and your rights is attached for your review.



We Make Kids Smile

3460 Old Washington Road

Waldorf, MD 20602

Office Guidelines

Consent:

I authorize the doctor to obtain x-rays, study models, photographs and/or any other diagnostic aids deemed appropriate to make a thorough diagnosis. I will be given the opportunity to discuss the treatment plan with the treatment assistant and make any financial arrangements, if necessary, with the financial coordinator. The treatment plan and financial arrangement must be signed and agreed upon before any appointment(s) can be scheduled.

Missed Appointments:

48 hours notice is required to cancel any appointment: You will be assessed a fee of \$25.00 per family member for each appointment missed without notice.

Financial Responsibility:

1. All payments and co-payments are due at the time of service.
2. There is a fee for all returned checks. The fee is currently \$35.00, but is subject to change without notice dependent upon the charges incurred at the bank.
3. In the event of default, I promise to pay legal interest, collections cost, and related attorney's fees.

Payment Options:

1. Cash and checks
2. Credit Cards - Visa, MasterCard, Discover and American Express.
3. CareCredit

Dental Insurances:

We accept assignment of dental insurance benefits. However, we require your full deductible and/or co-payments to be made at the time of service. Please keep in mind that we can only estimate your portion. The balance of your account is your responsibility. We will not enter into a dispute with your insurance company over your claim. Please note that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and customary under your insurance plan. It is your responsibility to know your insurance benefit, and disclose them to us. We accept some secondary insurance, please confirm with a team member. If we are not participating providers with your secondary insurance we can provide you with the necessary paperwork. Our office participates with the major PPO plans, please confirm with a team member. We do not participate with any HMO plans. In addition, we do not participate with State Insurance, Medical Assistance or discounted programs.

If your insurance does not pay within 45 days, you will be held responsible for the full payment.

Late Arrivals: We ask that you make every effort to be at your scheduled appointment on time. If you are more than 15 minutes late, we have the option to **reschedule** your appointment or alter your scheduled treatment for the day.

Hospital: Children requiring dental treatment in a hospital setting will be required to pay a nonrefundable processing fee of \$272.00. This is a special service our office provides therefore require payment in full prior to your scheduled treatment date.

Nitrous Oxide (Happy Air): This service is used to reduce anxiety that a child may have at the time of visit. This is not a covered service by insurance companies, but highly recommended by our doctors when performing restorative and surgical procedures.

Parent Guidelines:

Parents must accompany all children to their appointments. You may choose for one (1) parent to remain at your child's side during his/her restorative appointment. Although we sense that some children do better without parents present, we are open to having you stay with your child. If you choose to be present, we suggest the following guidelines to improve the probability of a positive outcome:

1. Allow us to prepare your child.
2. Be supportive of the practices terminology.
3. Please be a silent observer - support your child with touches.
 - A. This allow us to maintain communication with your child.
 - B. Children will normally listen to their parents instead of us and may not hear our guidance.
 - C. You might give incorrect or misleading information.
4. If asked to leave, be ready to immediately walk away.
 - A. Many children will try to control the situation.
 - B. "Acting out" is normal, but unacceptable during restorative procedures.
 - C. This is intended to "short circuit" the control attempt.
 - D. We will continue to support your child at all times.

These are important ways that you can actively help in the success of your child's visit. We are confident that all will go well and hope these guidelines will help prepare you for your next visit.

Divorce Decree:

Regardless of your divorce, the accompanying adult is responsible for payment. Financial arrangements between parents or guardians must be made in advance. **We will not bill to a third party.**

Signature

Date