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:_____ □ Male □ Female

General Information

Who is accompanying the child today?

Name: _____ Relation: _____

Do you have legal custody of this child? □ Yes □ No

School: _____ Grade:_____

Hobbies:_____

Whom may we Thank for referring you? □ Sibling □ Google □ Friend

□ Other:_____

Other siblings:_____

Parent's Information

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

☐ **Father** ☐ Step Father ☐ Guardian

Name: _____ **DOB**:_____

Address: (If different than child's) SSN#

_____
Street Apt.#

_____
City State Zip

Hm#:(_____)_____ Cell#:(_____)_____

WK#:(_____)_____ Other#:_____

Email:_____

Employer: _____

If you have Dental Insurance Coverage for the Child, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____

_____
City State Zip

Insurance Phone:(_____)_____

Group# (Plan, local, or Policy#): _____

☐ **Mother** ☐ Step Mother ☐ Guardian

Name: _____ **DOB**:_____

Address: (If different than child's) SSN#

_____
Street Apt.#

_____
City State Zip

Hm#:(_____)_____ Cell#:(_____)_____

WK#:(_____)_____ Other#:_____

Email:_____

Employer: _____

If you have Dental Insurance Coverage for the Child, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____

_____
City State Zip

Insurance Phone:(_____)_____

Group# (Plan, local, or Policy#): _____

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 ☐ Rarely ☐ 1-2 times/day ☐ 3 > times/day
(juices, soda, gatorades, energy drinks)
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 <u>any medication</u> (prescription or over-the-counter), vitamins, or dietary supplements? ☐ Y ☐ N
List name, doses, frequency:_____
3. Has your child even been <u>hospitalized, had surgery</u> 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 <u>a reaction to or problem with an anesthetic</u>? ☐ Y ☐ N
If YES, please describe: _____
5. Has your child ever had a <u>reaction or allergy to an antibiotic, sedative, or other medication</u>? ☐ Y ☐ N
If **YES**, please list: _____
6. Is your child <u>allergic to anything else</u> (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 <u>require antibiotics before dental treatment</u>? ☐ Y ☐ N
9. Has your child ever experienced the following medical problems? For each "**YES**", please provide details below.

Heart murmur	☐ Y ☐ N	Asthma	☐ Y ☐ N
Sickle cell disease/trait	☐ Y ☐ N	Congenital heart defect/disease	☐ Y ☐ N
Liver problems (hepatitis)	☐ Y ☐ N	Enlarged Tonsils / Adenoids	☐ Y ☐ N
Behavioral problems	☐ Y ☐ N	GERD (gastro esophageal)	☐ Y ☐ N
Lactose intolerance	☐ Y ☐ N	Eczema	☐ Y ☐ N
Developmental disorders	☐ Y ☐ N	Cerebral palsy, brain injury	☐ Y ☐ N
Sleep apnea/snoring	☐ Y ☐ N	Autism/autism spectrum disorder	☐ Y ☐ N
Hydrocephaly	☐ Y ☐ N	ADD/ADHD	☐ Y ☐ N
Cleft lip/palate	☐ Y ☐ N	Diabetes, hyperglycemia	☐ Y ☐ N
Thyroid or pituitary issues	☐ Y ☐ N	Anemia	☐ Y ☐ N
Convulsions/seizures	☐ Y ☐ N	Abnormal bleeding (hemophilia)	☐ Y ☐ N
Cancer, tumor, other	☐ Y ☐ N	Scarlet fever	☐ Y ☐ N
HIV/AIDS	☐ Y ☐ N	Pneumonia	☐ Y ☐ N
Birth defect	☐ Y ☐ N	Handicaps/disabilities	☐ Y ☐ N
Tuberculosis	☐ Y ☐ N	Hearing loss	☐ Y ☐ 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 Financial 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 not be assessed a fee for your first missed appointment. A second missed appointment will result in a charge of $75.00 per family member and any dental appointments thereafter will require a 50% deposit dependent on the treatment needs. At the time of your third missed appointment, you will be charged a broken appointment fee of $75.00 and we may dismiss you from the practice.

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. Care Credit

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 no longer accept secondary insurance however we can provide you with the necessary paperwork.

_____ _____

Date Signature