

Welcome! We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining you child's dental health.

Patient's Information

Date _____

Child's Name _____ Male or Female _____

Age _____ Date of Birth _____ Nickname _____ School _____

Home Address _____ Phone _____
Street City State Zip

Whom may we thank for referring you? _____

Parent's Information

Father's Name _____ Soc. Sec. # _____ Date of Birth _____

Address _____ Phone _____
(If different from patient's) Street City State Zip (If different from patient's)

Father's Occupation _____ Employer _____

Work Phone _____ Ext _____ Driver's License # _____

Mother's Name _____ Soc. Sec. # _____ Date of Birth _____

Address _____ Phone _____
(If different from patient's) Street City State Zip (If different from patient's)

Mother's Occupation _____ Employer _____

Work Phone _____ Ext _____ Driver's License # _____

Person responsible for Account _____

Is your child covered by your dental insurance plan? Yes No

Primary Dental Insurance

Insurance Co. Name _____ Insurance Co. Phone _____

Insurance Co. Address _____

Group # (plan, local or policy #) _____ Insured's Name _____

Secondary Dental Insurance

Insurance Co. Name _____ Insurance Co. Phone _____

Insurance Co. Address _____

Group # (plan, local or policy #) _____ Insured's Name _____

Please Complete Reverse Side

The medical and dental history questions provide us with important information to evaluate, diagnose and treat your child. Please answer all questions. If there are any questions that you do not understand, please ask us for help. We will be happy to assist you. All information is held in the strictest of confidence. Thank you for taking the time in this regard, it helps us to provide superior care.

Medical History

Child's Physician _____ Phone _____ Date of last Exam _____

Is your child presently under medical care? Yes No If yes, explain _____

Is your child currently taking medications? Yes No Reason _____

Please list all medications _____

Does your child have allergies or reactions (medications, drugs, foods, anything) Yes No Allergic to _____

Has your child ever been hospitalized? Yes No Reason _____ Date _____

Has your child ever had surgery Under general anesthesia? Yes No Reason _____ Date _____

Has your child ever had a blood transfusion? Yes No Date _____

Has your child ever had any of the following medical problems?

Yes No Heart Disease	Yes No Liver Problems	Yes No Cancer
Yes No Heart Murmur	Yes No Kidney Problems	Yes No Tuberculosis
Yes No Congenital Heart Defect	Yes No HIV+/AIDS	Yes No Bone Problems
Yes No Rheumatic Fever	Yes No Epilepsy	Yes No Asthma
Yes No Bleeding Disorder	Yes No Diabetes	Yes No Hearing Loss
Yes No Hemophilia	Yes No Hepatitis	Yes No Vision Loss

Other Medical Conditions _____

Characterize your child's mental development. Normal 1-2 Years Behind More than 2 years Behind

Dental History

Why did you bring your child to the dentist today? _____

Has your child ever been to the dentist? Yes No Date of last dental visit _____

Characterize your child's past dental experiences. _____

Briefly describe your child's oral hygiene routine. _____

Does your child have a finger, thumb or pacifier habit? Yes No

Does your child's jaw make noise or is there pain associated with jaw movement? Yes No

Briefly describe any past dental trauma. _____

Circle all water sources your child uses. Tap tap/filtered well bottled bottled w/fluoride

Has your child ever taken fluoride supplements? Yes No

I understand the information given is correct to the best of my knowledge and it is my responsibility to inform this office of any changes in my child's medical condition.

Signature of parent or guardian _____ Date _____

FINANCIAL POLICIES

Thank you for choosing Dayspring Pediatric Dentistry as your dental provider. We are committed to your treatment being a successful experience. We will work very hard to make sure your claims are filed accurately and promptly.

Missed Appointments

We kindly ask that you give a 24-hour notice to cancel an appointment. As a courtesy, we will try to confirm all appointments two business days prior to the appointment. However, it is your responsibility to be aware of scheduled appointments. There is a \$50 fee for any missed appointments or appointments cancelled with less than a 24-hour notice.

Insurance

The amount of dental benefits you receive is determined by your employer, your union, or your insurance company, not by us. The premiums you pay and the benefits you receive are directly related and vary significantly from plan to plan. We cannot render treatment on the assumption that our fees will be paid by your insurance company. Our usual, customary, and reasonable fees often times do not correspond to your insurance company's fees. You are responsible for payment regardless of the insurance company's arbitrary determination of usual and customary rates.

It is your responsibility to review your insurance policy and to understand your specific dental benefits. The more you know about your specific plan, the better we can serve you. We are here to help you and explain any insurance information you may not understand and to assist you in the reimbursement process through communication with your insurance company. We will do everything that we can to help you receive your benefits. To ensure that you are reimbursed as quickly as possible, we will electronically file your insurance form for you.

Ultimately, the person accompanying the child is personally responsible for payment in full at the time services are rendered. We do not take assignment of benefits. If we have received all of your insurance information on the day of the appointment, we will be happy to file your claim for you. You must be familiar with your insurance benefits, as we will require payment for the estimated amount insurance is not expected to pay. By law your insurance company is required to pay each claim within 30 days of receipt. We file all insurance electronically, so your insurance company will receive each claim within days of the treatment. You are responsible for any balance on your account after 30 days, whether insurance has paid or not. We will be glad to send a refund to you if your insurance pays us.

Divorce Decrees

This office is not a party to your divorce decree. The responsibility for minors rests with the accompanying adult.

Outstanding Balances

In the event a bill is not paid within 90 days, information that is necessary for collection purposes will be forwarded to our professional collection company, First Federal Credit Control, Inc and the family will be released from the practice. All account's over 60 days past due will receive a \$5 rebilling fee per month.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. Please keep a copy of this agreement for your own records. **I have read the Financial Policy. I understand and agree with this Financial Policy.**

Signature of responsible party

Date

Dr. Kyle E. Pedersen, D.D.S., P.C. Dayspring Pediatric Dentistry

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

You May Refuse to Sign This Acknowledgement

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

Please Print Name

Signature

Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices but acknowledgement could not be obtained because:

- ___ Individual refused to sign
- ___ Communication barriers prohibited obtaining the acknowledgement
- ___ An emergency situation prevented us from obtaining acknowledgement
- ___ Other (Please Specify)
