Child Health/Dental History Form

American Dental Association
www.ada.org

Patient's Name (LAST / FIRST / INITIAL)	Nickname	Date of Birth
Parent's/Guardian's Name	Relationship to Patient	
Address (PO OR MAILING ADDRESS / CITY / STATE / ZIP CODE)		
Phone (Home / Work)		Sex M ❑ F ❑

Have you (the parent/guardian) or the patient had any of the following diseases or problems? ❑ Yes ❑ No
1. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3.Cough that produces blood?
If you answer yes to any of the three items above, please stop and return this form to the receptionist.

Has the child had any history of, or conditions related to, any of the following:

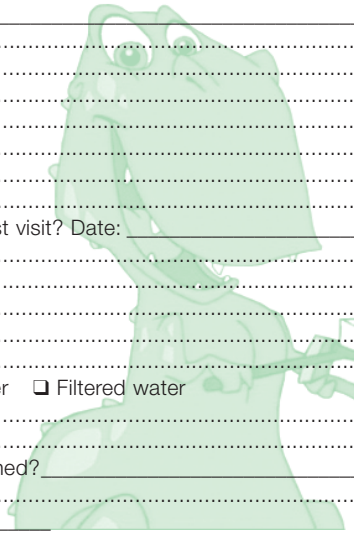
❑ Anemia	❑ Cancer	❑ Epilepsy	❑ HIV +/AIDS	❑ Mononucleosis	❑ Thyroid
❑ Arthritis	❑ Cerebral Palsy	❑ Fainting	❑ Immunizations	❑ Mumps	❑ Tobacco/Drug Use
❑ Asthma	❑ Chicken Pox	❑ Growth Problems	❑ Kidney	❑ Pregnancy (teens)	❑ Tuberculosis
❑ Bladder	❑ Chronic Sinusitis	❑ Hearing	❑ Latex allergy	❑ Rheumatic fever	❑ Venereal Disease
❑ Bleeding disorders	❑ Diabetes	❑ Heart	❑ Liver	❑ Seizures	❑ Other_____
❑ Bones/Joints	❑ Ear Aches	❑ Hepatitis	❑ Measles	❑ Sickle cell	

Please list the name and phone number of the child's physician:

Name of Physician _____ Phone _____

Child's History

		Yes	No
1.	Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? If yes, please list: _____	❑	❑
2.	Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____	❑	❑
3.	Is the child allergic to anything else, such as certain foods? If yes, please explain: _____	❑	❑
4.	How would you describe the child's eating habits? _____		
5.	Has the child ever had a serious illness? If yes, when: _____ Please describe: _____	❑	❑
6.	Has the child ever been hospitalized?	❑	❑
7.	Does the child have a history of any other illnesses? If yes, please list: _____	❑	❑
8.	Has the child ever received a general anesthetic?	❑	❑
9.	Does the child have any inherited problems?	❑	❑
10.	Does the child have any speech difficulties?	❑	❑
11.	Has the child ever had a blood transfusion?	❑	❑
12.	Is the child physically, mentally, or emotionally impaired?	❑	❑
13.	Does the child experience excessive bleeding when cut?	❑	❑
14.	Is the child currently being treated for any illnesses?	❑	❑
15.	Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: _____	❑	❑
16.	Has the child had any problem with dental treatment in the past?	❑	❑
17.	Has the child ever had dental radiographs (x-rays) exposed?	❑	❑
18.	Has the child ever suffered any injuries to the mouth, head or teeth?	❑	❑
19.	Has the child had any problems with the eruption or shedding of teeth?	❑	❑
20.	Has the child had any orthodontic treatment?	❑	❑
21.	**What type of water does your child drink?** ❑ City water ❑ Well water ❑ Bottled water ❑ Filtered water		
22.	**Does the child take fluoride supplements?**	❑	❑
23.	**Is fluoride toothpaste used?**	❑	❑
24.	How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____	❑	❑
25.	Does the child suck his/her thumb, fingers or pacifier?	❑	❑
26.	At what age did the child stop bottle feeding? Age _____ Breast feeding? Age _____		
27.	Does child participate in active recreational activities?	❑	❑



NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature _____ Date _____

For completion by dentist
Comments _____

For Office Use Only: ❑ Medical Alert ❑ Premedication ❑ Allergies ❑ Anesthesia Reviewed by _____
Date _____

Form S707

To Reorder call 1-800-947-4746
or go online at www.adacatalog.org

Financial Policy

Patient Name: _____

We believe our patients deserve the best possible dental care we can provide. In an effort to maintain this high quality of care, it is vital that you read and understand the following regarding your financial obligation and insurance.

Please Read and Initial Each Paragraph:

Financial Obligation

_____ Payment for professional services is due at the time dental treatment is provided. You, the patient, are ultimately responsible for the total cost of your dental treatment.

Patients with Dental Insurance

_____ We file dental insurance claims ONLY AS A COURTESY to our patients. We are not responsible for what benefits your insurance company pays on a claim. We only assist you in ESTIMATING your portion of the cost of treatment. We at no time guarantee what your insurance will or will not do with each claim. We assume no responsibility for any errors in filing your claim or for the accuracy of the estimate provided by our office.

_____ It is your responsibility to know whether or not you have exceeded your allowable limits, both in regards to benefit maximums and frequency limitations. Furthermore, if your insurance company chooses to pay benefits based on an alternative, lower-cost procedure than was actually performed, you will be billed for the difference.

_____ If we have received all of your insurance information 24 hours prior to your appointment, we will be happy to file your claim as a courtesy to you. If we have ***NOT***, however, you will be expected to pay for all services at the time of the appointment. We will then provide you with a claim form so that you can submit to your insurance company for direct reimbursement.

_____ We make no claim as to whether our office is in network with your insurance company. It is the patient's responsibility to verify in-network participation and coverage.

_____ If your insurance company has not paid your claim in 30 days, or fails to pay for any services rendered, our office will bill you for the balance, and it will be your responsibility to deal directly with your insurance company for reimbursement. If your balance is not paid within a total of 60 days, a finance charge of 1.5% will be added to your account each month until the balance is fully paid. If your insurance company subsequently reimburses our office for payment you have already made to our office, we will send you a refund or establish an account credit.

Cancellation Notice

_____ Since we have reserved a specified time for your appointment, other patients were denied that day and time. We therefore require a 48-Hour advance notice for ALL cancellation or rescheduling of appointments. If you cancel or reschedule your appointment with less than a 48-hour notice, or no show, you will be charged a $75 cancellation fee.

I have read, understood and agree in full to the above policies.

_____ _____

(Signature) (Date)

INSURANCE FACTS

Fact 1 - NO INSURANCE PAYS 100% OF ALL PROCEDURES
Dental insurance is meant to be an aid in receiving dental care. Many patients think that their insurance pays 90%-100% of all dental fees. This is not true! Most plans only pay between 50%-80% of the average total fee. Some pay more, some pay less. The percentage paid is usually determined by how much you or your employer has paid for coverage or the type of contract your employer has set up with the insurance company.

Fact 2 - BENEFITS ARE NOT DETERMINED BY OUR OFFICE
You may have noticed that sometimes your dental insurer reimburses you or the dentist at a lower rate than the dentist's actual fee. Frequently, insurance companies state that the reimbursement was reduced because your dentist's fee has exceeded the usual, customary, or reasonable fee ("UCR") used by the company.

A statement such as this gives the impression that any fee greater than the amount paid by the insurance company is unreasonable or well above what most dentists in the area charge for a certain service. This can be very misleading and simply is not accurate.

Insurance companies set their own schedules and each company uses a different set of fees they consider allowable. These allowable fees may vary widely because each company collects fee information from claims it processes. The insurance company then takes this data and arbitrarily chooses a level they call the "allowable" UCR Fee. Frequently this data can be three to five years old and these "allowable" fees are set by the insurance company so they can make a net 20%-30% profit.

Unfortunately, insurance companies imply that your dentist is "overcharging" rather than say that they are "underpaying" or that their benefits are low. In general, the less expensive insurance policy will use a lower usual, customary, or reasonable (UCR) figure.

Fact 3 - DEDUCTIBLES & CO-PAYMENTS MUST BE CONSIDERED
When estimating dental benefits, deductibles and percentages must be considered. To illustrate, assume the fee for service is $150.00. Assuming that the insurance company allows $150.00 as its usual and customary (UCR) fee, we can figure out what benefits will be paid. First a deductible (paid by you), on average $50, is subtracted, leaving $100.00. The plan then pays 80% for this particular procedure. The insurance company will then pay 80% of $100.00, or $80.00. Out of a $150.00 fee they will pay an estimated $80.00 leaving a remaining portion of $70.00 (to be paid by the patient). Of course, if the UCR is less than $150.00 or your plan pays only at 50% then the insurance benefits will also be significantly less.

MOST IMPORTANTLY, please keep us informed of any insurance changes such as policy name, insurance company address, or a change of employment.

Office Policy
Concerning Dental Insurance Benefits

We believe our patients deserve the best possible dental care we can provide. In an effort to maintain this high quality of care, we would like to share this information with you regarding your dental insurance.

Your dental insurance is a tremendous benefit that your employer provides for you. Many times, understanding your benefits is confusing at best! We will do our best to assist you in this manner, but please keep in mind we are a third party; we have limited access to information regarding your dental benefits. **It is impossible for us to guarantee any payment from your insurance company.** Many plans have specific restrictions that you, the patient need to be aware of and you should consult your dental insurance handbook for details.

Regardless of what we calculate as your dental plan benefit in dollars, **we must stress the fact that you, the patient are responsible for the TOTAL cost of your dental treatment.** We are happy to extend to you the courtesy of filing your insurance claim to your primary insurance company for direct reimbursement. We do sometimes at our discretion resubmit claims in order to dispute an insurance decision; however, we cannot guarantee payment. Every dental claim will be submitted with the necessary x-rays and narrative.

Please keep in mind that your insurance company will never guarantee your benefits or tell us exactly what they will pay directly to us. This is why we can only estimate your portion.

We ask that you pay your estimated portion and deductibles at the time of service. If your insurance company has not paid your claim in 60 days, the balance will be billed to you and we ask that you deal directly with your insurance company for reimbursement.

Thank you for your understanding and cooperation.

Date: _____

Patient Name: _____

Signature: _____