



About Your Child

Child's Name _____

Name Child Prefers To Be Called _____

Age _____

Gender _____

Date of Birth _____

Address _____

City _____

State _____

Zip Code _____

Home Phone _____

Mobile Phone _____

Grade Level _____

Hobbies / Pets _____

Other Children and their ages _____

Referred to Our Office By (We Wish To Thank Them) _____

Parent's Marital Status:

Married Divorce Separated Widowed Single

Dental History

Yes No Is this your child's first visit to the dentist? If no, when was the last visit and what was done for your child.

Yes No Do you expect your child to be a cooperative patient? If no, please explain.

Yes No Do you have well water at home?

Yes No Does your child take fluoride tablets or vitamins with fluoride?

Yes No Has your child bumped any teeth? If so, when?

Yes No Has your child has a history of headaches, pain, popping or clicking of the jaws?

Yes No Does your child still have a night time bottle?

Yes No Does your child have a toothache?

Does your child have or has he or she had any of the following problems or habits?

Thumb Sucking How Long?..... Still Active Yes No
 Finger Habit How Long?..... Still Active Yes No
 Pacifier How Long?..... Still Active Yes No

Medical History

Is your child presently under the care of your family physician for any medical reason? Yes No If yes, explain _____

Family Physician's Name: _____

Address: _____

Phone Number: _____

• Is your child in good health? If no, explain Yes No

• Is your child under the care of a physician other than routine care? If yes, explain Yes No

• Does your child have any drug allergies? If explain Yes No

• Is your child taking any medications at this time? If yes, list. Yes No

• Has your child ever been hospitalized or treated in an emergency room for any particular trauma? When and for what reason? Yes No

• Does your child have, or has he or she had, any emotional, mental or nervous disorders? If yes, please explain. Yes No

• Have your child's tonsils and/or adenoids been removed? Yes No

• Does your child breathe through the mouth? If yes, Seldom Often Yes No

Please indicate if your child has had any of the following:

<input type="checkbox"/> Allergy to Penicillin	<input type="checkbox"/> Intellectual disability
<input type="checkbox"/> Anemia	<input type="checkbox"/> Latex allergy/sensitivity
<input type="checkbox"/> Asthma	<input type="checkbox"/> Liver problems or hepatitis
<input type="checkbox"/> Autism/Asperger's Syndrome	<input type="checkbox"/> Malignancies or leukemia
<input type="checkbox"/> Bleeding disorder	<input type="checkbox"/> Other drug allergy
<input type="checkbox"/> Bone disorder	<input type="checkbox"/> Physical handicap
<input type="checkbox"/> Cleft palate	<input type="checkbox"/> Positive for H.I.V.
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Radiation treatment
<input type="checkbox"/> Endocrine disorder	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Epilepsy, seizures	<input type="checkbox"/> Speech problem
<input type="checkbox"/> Hyperactivity/ADD/ADHD	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Heart ailment or murmur.	Type, if known _____

Is child under the care of a cardiologist or special physician for the problem? If so, whom _____

Phone _____

Please comment on any problems that were checked in the above areas _____

Do you consider your child to be:

• Advanced in the learning process Yes No
• Progressing normally Yes No
• A slow learner Yes No

Responsible Party

Mothers Full Name _____

Address _____

City _____ State _____ Zip Code _____

SS# _____ Birthdate _____

Home Phone _____ Mobile Phone _____

Business Phone _____ Employer _____

Occupation _____ Email Address _____

Dental Insurance Yes No

Insurance Company _____ Group or Plan Number _____

Insurance Company Phone _____

Father's Full Name _____

Address _____

City _____ State _____ Zip Code _____

SS# _____ Birthdate _____

Home Phone _____ Mobile Phone _____

Business Phone _____ Employer _____

Occupation _____ Email Address _____

Dental Insurance Yes No

Insurance Company _____ Group or Plan Number _____

Insurance Comp _____

Dental History

How often does your child brush? _____

Is tooth brushing supervised? Yes No

By whom? _____

Is dental floss used? Yes No

Does your child receive: Fluoride in vitamins

Fluoride tablets/drops Bottled water

Fluoridated water Well water

Financial Information

Methods of Payment:

Check or cash at time of treatment

Visa, MasterCard, American Express or Discover

Insurance form with co-payment at time of treatment

Other: _____

- Payment is expected at time of treatment.
- All emergency patients (being seen for the first time) are required to pay in full at time of treatment.
- Patients with insurance may pay their estimated portion, including deductible, at the time of service. It is the parents responsibility to see that the insurance company makes prompt payment. Any insurance balance over 60 days is due and payable by the parent.

If my account requires servicing by a collection agency or by an attorney, I understand that I will be liable for collection fees, attorney fees, and applicable court costs, in addition to my outstanding balance. I hereby authorize payment directly to Dentistry for Children, the group insurance benefits otherwise payable to me and authorize release of information regarding treatment to the insurance company.

SIGNED (Guarantor)

Nearest Relative/Friend

Name _____

Address _____

City _____ State _____ Zip Code _____

Phone Number _____ Relationship _____

In case you are not home, what is your neighbor's

Name _____ Phone Number _____

Acknowledgement of Notice of Privacy

**** YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT****

I, _____ (print name) have received a copy of this office's privacy practices.

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 barrier prohibited signing the acknowledgement

____ An emergency situation prevented from us obtaining acknowledgement

____ Other (please specify)

General Consent

Please read this form carefully. Should you have any questions, our staff will be happy to help you.

1. I hereby authorize and direct the dentist and/or dental auxiliaries to perform dental treatment with the use of any necessary or advisable radiographs (x-rays) and/or any other diagnostic aids in order to complete a thorough diagnosis and treatment plan. _____
Initials

2. I understand x-rays, photographs, models of the mouth, and/or other diagnostic aids used for an accurate diagnosis and treatment planning are the property of the doctors but copies of certain aids are available upon request. _____
Initials

3. In general terms, the dental procedure(s) can include but not limited to:

- A. Comprehensive oral examination, radiographs, cleaning of the teeth, and the application of topical fluoride.
- B. Application of resin "sealants" to the grooves of the teeth.
- C. Treatment of diseased, or injured teeth with dental restorations (fillings).
- D. Treatment of diseased or injured oral tissue secondary to traumatic injuries and/or accidents and/or Infections.

4. I understand that the doctor is not responsible for previous dental treatment performed in other offices. I understand that, in the course of treatment, this previously existing dentistry may need adjustment and/or replacement. I realize that guarantees of results or absolute satisfaction are not always possible in dental health service. _____
Initials

5. I certify that if I, and/or my dependents have insurance coverage I assign directly to the dentist all insurance benefits for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. _____
Initials

6. I have answered all of the questions about me or my dependent's medical history and present health condition fully and truthfully. I have told the dentist or other office personnel about all medical conditions, including allergies. I also understand if my dependent or I ever have any changes in health status or any changes in medication(s), I will inform the doctor at the next appointment. _____
Initials

I hereby acknowledge that I have read and understand this consent and the meaning of its contents. All questions have been answered in a satisfactory manner and I believe I have sufficient information to give this informed consent. I further understand that this consent shall remain in effect until terminated by me.

Patient Name

_____/_____/_____
Date of Birth

Parent / Guardia if a minor

_____/_____/_____
Relationship to Patient

Signature

_____/_____/_____
Date

Written Financial Policy

Thank you for choosing Pediatric Dental Care of Waltham. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

- **Cash, Check, Visa, Mastercard, American Express or Discover Card**
 - We offer a 10% discounts to patients who pay for their treatment plan in full prior to start of services (cannot be applied to co-pays).
- **Care Credit**
 - Convenient Monthly Payment Plans* 1
 - Allow you to pay over time
 - No annual fees or prepayment penalties

Pediatric Dental Care of Waltham requires payment prior to the beginning of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care provided and lab fees.

For plans requiring multiple appointments, alternative payment arrangements may be provided. For patients with dental insurance, we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.

Pediatric Dental Care of Waltham charges \$35 for returned checks and \$15 for accounts sent to collections.

You grant permission to us or our assignee, to telephone you to discuss this statement or your treatment. I understand that any fee estimate for this dental care can only be extended for a period of three months from the date of patient examination.

All emergency dental services, or any dental services performed without previous financial arrangements must be paid for at the time services are performed unless other arrangements are made.

I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. If you have any questions, please do not hesitate to ask.

Patient, Parent or Guardian Signature

_____/_____/_____
Date

Patient Name (Please Print)

Subject to credit approval

However, if we do not receive payment from your insurance carrier within 60 days or after we make 3 attempts, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier. If your account balance is not settled at the time of appointment, our office will invoice you for the balance on a monthly basis for up to 3 invoices. Any account that is over 90 days past due will be assigned to a collection agency for further billing.