Welcome

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

1 Tell Us About Your Child

Today's Date: _____

Child's Name: _____
Last First MI

Child's Birthdate: ____/____/____ Child's Age: _____

Nickname: _____ ☐ Male ☐ Female

School: _____ Grade: _____

Hobbies: _____

Child's Home #: (_____)_____ SS #: _____

Child's Home Address: _____
Apt / Condo #

_____
City State Zip

2 General Information

Who is accompanying the child today?

Name: _____ Relation: _____

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

Whom may we Thank for referring you? _____

Other siblings: _____

Previous / Present Dentist: _____ Last Visit Date _____

Dentist's Phone #: (_____) _____

Relative or Friend not living with you:

Name: _____ Phone: (_____) _____

Address: _____
City State Zip

3 Parent's Information

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

☐ Mother ☐ Father ☐ Step Parent ☐ Guardian

Name: _____ Birthdate: ____/____/____

Address: (If different than Child's) Hm #: (_____) _____

_____

_____

SS #: _____ DL #: _____

Wk #: (_____)_____ Ext: _____ Cell/Other #: (_____) _____

Email: _____

Employer: _____

Employer's Address: _____

_____
City State Zip

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 ☐ Father ☐ Step Parent ☐ Guardian

Name: _____ Birthdate: ____/____/____

Address: (If different than Child's) Hm #: (_____) _____

_____

_____

SS #: _____ DL #: _____

Wk #: (_____)_____ Ext: _____ Cell/Other #: (_____) _____

Email: _____

Employer: _____

Employer's Address: _____

_____
City State Zip

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 #): _____

4 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

Continued on Back

5 Dental History

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

_____

_____

Has your child ever been prescribed Fosamax or any other bisphosphonate? If yes, when? _____ ☐ Yes ☐ No

Is the child currently in pain? ☐ Yes ☐ No

Does the child require antibiotics before dental treatment? ☐ Yes ☐ No

Has the child ever had a serious/difficult problem associated with previous dental work? ☐ Yes ☐ No

Is the child's water fluoridated? ☐ Yes ☐ No

Is the child taking fluoridated supplements? ☐ Yes ☐ No

Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Does the child brush his/her teeth daily? ☐ Yes ☐ No

Floss his/her teeth daily? ☐ Yes ☐ No

Child's Physician: _____

Phone #: _____ Date of Last Visit: _____

Is the child currently under the care of a physician? ☐ Yes ☐ No

Please describe the child's current physical health:

☐ Good ☐ Fair ☐ Poor

Please list all prescription / over the counter or herbal supplement drugs that the child is currently taking: _____

_____

Aside from items listed, please list all drugs/things that the child is allergic to:

_____

_____

Yes No Latex Yes No Metals/Nickel Yes No Plastic

6 Medical History

Has the child experienced the following medical problems?

Y N	Abnormal Bleeding / Hemophilia	Y N	Hearing Impairment
Y N	ADD/ADHD	Y N	Heart Murmur
Y N	AIDS/HIV+	Y N	Hepatitis
Y N	Anemia	Y N	High Blood Pressure
Y N	Any Hospital Stays/Operations?	Y N	Hives
Y N	Artificial Bones/Joints/Valves	Y N	Kidney Problems
Y N	Asperger Syndrome	Y N	Liver Problems
Y N	Asthma	Y N	Low Blood Pressure
Y N	Autism	Y N	Lupus
Y N	Cancer	Y N	Measles
Y N	Chicken Pox	Y N	Mitral Valve Prolapse
Y N	Congenital Heart Defect	Y N	Mononucleosis
Y N	Convulsions	Y N	Prosthetics
Y N	Diabetes	Y N	Rheumatic Fever
Y N	Epilepsy	Y N	Scarlet Fever
Y N	Exposed to HIV, but Neg.	Y N	Skin Rash
Y N	Handicaps/Disabilities	Y N	Tuberculosis (TB)

Are the child's immunizations current? ☐ Yes ☐ No

Anything you would like to discuss with the Doctor in private? ☐ Yes ☐ No

Please discuss any serious medical problems the child experiences/ed:

_____

_____

Does/did the child experience any of the following?

Y N	Breast Fed	Y N	Nursing Bottle Habits
Y N	Chewing on Objects	Y N	Speech Problems
Y N	Clenching/Grinding Teeth	Y N	Thumb/Finger Sucking
Y N	Lip Sucking/Biting	Y N	Tongue/Cheek Biting
Y N	Mouth Breather	Y N	Tongue Thrust
Y N	Nail Biting	Y N	Used Pacifier

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

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

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

Signature of Dentist Date

Dentist's Comments: _____

_____

Medical History Update

Has there been any change in your child's health status since their last visit? ☐ Y ☐ N

If Yes, please explain. _____

_____

Has there been any change in your child's health status since their last visit? ☐ Y ☐ N

If Yes, please explain. _____

_____

_____

Parent/Guardian Signature Date

_____

Dentist Signature Date

_____

Parent/Guardian Signature Date

_____

Dentist Signature Date

Dental Associates LLC
T/A: CARROLL COUNTY DENTAL SPECIALISTS
2029 Suffolk Road, Suite B
Finksburg, MD, 21048
(410) 861-3001

Important Insurance Information

We offer a valuable service to our patients; we file your insurance claims and predetermination of service for you at no cost. We also accept assignment on many insurance plans. This means we bill the insurance company, they pay us directly their portion of the fee, and we only collect a co-payment from the patient at the time of service. However, what makes this service very difficult is the fact that there are over 23,000 different insurance plans in the United States. Since our primary purpose is providing the highest quality dental care and service to our patients, it is not possible for us to know all there is to know about these plans.

The insurance policy is the legal contract between the policyholder (you) and the insurance company. The insurance must answer to you, they must respond to your requests, and they will often pay you much more readily and quickly than they will a doctor's office. This is important for you to know, because YOU are responsible for your insurance, not us. A doctor has no legal power to force an insurance company to pay. But you as the policyholder have a great deal of legal power and rights regarding your insurance.

Most dental plans have limitations and restrictions. No insurance policy pays 100% of all dental fees. Dental insurance is not meant to pay everything, it is only meant to be a supplement. Also even when a plan states that it covers a percentage of the fees – for example 80% - that is usually not entirely true. Most plans cover only 40-50% of the fees. The amount your plan pays is determined by how much your employer paid for the plan. We will help you determine the amount of coverage your plan offers for each service we provide for you.

Our policy is to help our patients as much as possible with any and all aspects of their dental care while here in our office. This includes insurance. We have developed financial policies over the years, which help us keep focused on our purpose – quality dental care and superior service. While we do everything we can to help out patients with their insurance companies, we sometimes need your help, because only you have the legal power to deal with your insurance company regarding certain issues.

We ask that you understand and agree to these policies, so we are able to serve you better. We don't want financial issues to come between you and the dental care you deserve.

(PLEASE SEE BACK OF PAGE)

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To Our Private Insurance Patients

We will prepare an estimate for the treatment that is to be performed. Please understand that this is only an estimate and is based on the accuracy of the information available to us by the insurance provider. Any difference in the estimate and the actual payment from the insurance company will be the patient's responsibility.

It is important to familiarize yourself with your dental benefits, so you are aware of all deductibles, co pays, maximums, and time restrains associated with your policy.

We would like you to understand fully that the responsibility for payment is yours.

To Our HMO Patients

The patient is responsible for eligibility in their insurance program.

Due to greatly reduced fees, all patient co-payments are due in full at the time of service.

Please review your individual plan benefits so you are familiar with your financial responsibility for any services we might perform for you.

All Patients

Patients without insurance are responsible for their full balance at the time of service.

All new patients under the age of 18 must be accompanied by their parent or legal guardian, so that all forms are completed and signed

We reserve the right to charge for broken or missed appointments without a 24-hour notice of cancellation. A fee of $15 per 15 minutes will be assessed for failure to given proper notice to the office. A $37.00 service charge will be applied for all returned checks.

I understand that Dental Associated, LLC, reserve the right to pursue delinquent accounts via a third party collection agency or attorney. In the event Dental Associates, LLC, refers my bill for collection, I agree to pay, for collection and/or legal services, an additional thirty percent (30%) of the amount owed.

Patient's Name _____

X _____ **(SEAL)** _____

Signature of Parent/Guardian **Date**

Carroll County Dental Specialists

Dental associates, LLC

ACKNOWLEDGEMENT OF RECEIPT 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

By Signing Above:

I authorize Dental Associates, LLC to discuss personal treatment and finances with the following individual(s):

_____ _____

Name Relationship

_____ _____

Name Relationship

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 refuse to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining the acknowledgment
- Other (please specify)

_____

_____

_____