



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 will be happy to help you. We look forward to working with you in monitoring your child's dental health.

Today's Date: _____

PATIENT INFORMATION

Child's Name: _____ Birthdate: _____
Last First Middle

Nickname: _____ Gender: Male Female _____

Mailing Address: _____
Street City State Zip

Preferred Phone #: _____

If you would like to receive email and cell phone confirmations for your appointments please enter information here:

Best Cell: _____ Cell #2: _____ E-mail: _____

What is the reason for your child's dental visit? _____

Whom may we thank for referring you to us? _____

School Attending: _____ Grade: _____

PARENT/GUARDIAN INFORMATION

Parent/Legal Guardian Name: _____ Parent/Legal Guardian Name: _____

Home Address: _____ Home Address: _____

City: _____ Zip: _____ City: _____ Zip: _____

Phone #: _____ Phone #: _____

Cell #: _____ Cell #: _____

D.O.B.: _____ SSN: _____ D.O.B.: _____ SSN: _____

Employer: _____ Employer: _____

Occupation: _____ Occupation: _____

Bus. Phone #: _____ Bus. Phone #: _____

Person responsible for payment of account: _____

INSURANCE INFORMATION

Primary Insurance

Subscriber Name: _____

Group/Policy #: _____

Insurance Co.: _____

Secondary Insurance

Subscriber Name: _____

Group/Policy #: _____

Insurance Co.: _____

In order to comply with most insurance companies, we ask that you sign below so that we may keep your signature on file. I authorize release of any information relating to this claim.

Payment Policy

Payment/co-payment is due at time services are rendered.

Our office will submit insurance forms for you, however, submission of forms is not a guarantee of payment. **You, as the parent/legal guardian, are ultimately responsible for all treatment charges.**

Signed Insured Person

Signature of Parent/Legal Guardian

Child's Name: _____
Last First Middle

Date: _____

DENTAL HISTORY

Will today be child's first visit to a dentist? Yes No
If not, date of last dental exam: _____ Dentist: _____
Date of last x-rays: _____

Does child brush daily?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	History of cavities?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does child use fluoride toothpaste?	<input type="checkbox"/>	<input type="checkbox"/>	History of discolored teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Does child floss daily?	<input type="checkbox"/>	<input type="checkbox"/>	History of jaw noise?	<input type="checkbox"/>	<input type="checkbox"/>
Is fluoride taken in any other form?	<input type="checkbox"/>	<input type="checkbox"/>	Any mouth habits:		
Describe: _____			Thumb sucking?	<input type="checkbox"/>	<input type="checkbox"/>
Has child complained of tooth pain?	<input type="checkbox"/>	<input type="checkbox"/>	Nail-biting?	<input type="checkbox"/>	<input type="checkbox"/>
Has child complained of sensitive teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Mouth-breathing?	<input type="checkbox"/>	<input type="checkbox"/>
History of gum infection?	<input type="checkbox"/>	<input type="checkbox"/>	Pacifier?	<input type="checkbox"/>	<input type="checkbox"/>
History of injury/trauma to teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Sleeping with bottle?	<input type="checkbox"/>	<input type="checkbox"/>
History of crowding/orthodontics?	<input type="checkbox"/>	<input type="checkbox"/>	Grinding?	<input type="checkbox"/>	<input type="checkbox"/>
Any dental anxiety/unhappy experiences?	<input type="checkbox"/>	<input type="checkbox"/>			

HEALTH HISTORY

Date of Last Physical: _____ Physician: _____

Is your child currently breast or bottle feeding?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Explain: _____
Any history of concussion in the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>	
Are child's immunizations up-to-date?	<input type="checkbox"/>	<input type="checkbox"/>	
Has child ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	Explain: _____
Has child ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Explain: _____
Is child currently receiving any medications?	<input type="checkbox"/>	<input type="checkbox"/>	Please list: _____
Does child have any allergies?	<input type="checkbox"/>	<input type="checkbox"/>	Please list: _____
Is child allergic to any drugs/medications?	<input type="checkbox"/>	<input type="checkbox"/>	Please list: _____
Bone breaks or bone surgery (scoliosis, plating, pins, screws) placed in the last two years?	<input type="checkbox"/>	<input type="checkbox"/>	Explain: _____

Has patient had any of the following conditions:

ADD / ADHD / Sensory (circle all that apply)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Down Syndrome	Yes <input type="checkbox"/>	No <input type="checkbox"/>
A.I.D.S. / H.I.V.	<input type="checkbox"/>	<input type="checkbox"/>	Emotional Impairment / Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Impairment	<input type="checkbox"/>	<input type="checkbox"/>
Autism / Spectrum Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur/Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Bladder Problems	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Prolonged Bleeding/Transfusions/	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots/ Dyscrasias	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Problems	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Physical Disabilities	<input type="checkbox"/>	<input type="checkbox"/>
Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>
Cleft Lip / Palate	<input type="checkbox"/>	<input type="checkbox"/>	Social Impairment	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Birth Defects /Down Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	Speech Issues	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions / Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Digestive/ Reflux Issues	<input type="checkbox"/>	<input type="checkbox"/>	Other _____		

Please explain any of the above for which your response was YES: _____

Child's Name:

CONSENT FOR DENTAL TREATMENT

The dentists (Dr. Joy John, Dr. Kierstin Kerr, Dr. Amanda Peer and Dr. Lauren Murphy) & staff at Duxbury Children's Dentistry do everything possible to minimize or completely prevent risks and side effects of treatment. You have a right to accept or reject dental treatment. Prior to consenting, you should consider the benefits and risks of the procedure, alternative treatments or the option of no treatment. Do not consent unless all of your questions have been answered and you have acknowledged your willingness to accept known risks and complications no matter how slight the risks. Procedure risks may include swallowing/inhaling of saliva or dental materials, pain or sensitivity, damage to adjacent tooth/filling/sealant material, bleeding, inflammation, infection, allergy and/or reaction to dental materials. Risks for fillings or extractions may also include nerve exposure, tooth fracture, bruising, bite trauma after numbing, temporary or permanent numbness, and/or reaction to local/topical anesthetics. Most of these are uncommon, but patients should be aware prior to providing consent. By signing, you are allowing any of these dentists to diagnose and treat your child.

- I consent for my child to receive a cleanings, dentist examinations, fluoride treatment and x-rays. If I wish not to consent to any of the above I agree to inform the provider prior to every appointment.
- Should I agree to a treatment plan, I consent to allow the providers at this office to do sealants, fillings and/or other common procedures within the standards of care for the duration of my time as a patient at Duxbury Children's Dentistry. If I wish not to consent to any of the above I agree to inform the provider prior to every appointment.
- I understand that if I allow another caregiver to attend appointments that information may be shared with that person and you have the right to request confidentiality per HIPPA.
- I understand that drugs and medications including, but not limited to, antibiotics, analgesics and other medicines can cause allergic reactions causing redness, swelling of tissues, pain, vomiting or anaphylactic shock (severe allergic reaction).

Parent Signature: _____

Date: _____

Print Parent Name: _____

Provider Signature: _____

Date: _____

I consent to my child attending appointments by themselves or with **another caregiver**. _____ **Parent Initials**
Name(s) of Caregiver(s) allowed to bring in child _____

FINANCIAL POLICY

The primary goal at Duxbury Children's Dentistry is to provide quality dental care for your child. Inherent in our relationship with your child is a financial relationship with you as the child's parent/guardian. As such, arrangements for the financial aspect of your child's dental care are coordinated/made directly with you. Please make sure you have reviewed the pre-treatment estimation forms. These forms are informational and can be used should you contact your insurance company to see which portion(s) they will cover. Beware of insurance companies that claim that they cover 80% of restorative treatment because it may be that the amount they cover actually becomes 20-40% with hidden stipulations and deductibles. It is your responsibility to understand your insurance plan.

1. X-Rays may be emailed at no charge to our patients. There are fees associated with x-rays or records provided in other forms. Please see our website www.duxburychildrensdentistry.com to view our policy and procedure for this service.
2. Payment in full is due at the time services are rendered. We accept cash, personal checks, MasterCard, American Express and Visa. In some instances, you may arrange for a payment plan with our office. The cost to you for such a plan is initially \$20.00 and there is a \$10.00 per month maintenance fee until a zero balance is reached. Late fees are \$35.00 per month. Payment plans must be paid off within six months. Plans extending longer than six months will be subject to a \$20.00 per month maintenance fee. We encourage patients to use credit cards, however, we do not want financial concerns to interfere with important care for your child. Please speak to our staff if this is something you wish to arrange.
3. Patients who have dental insurance: Your insurance benefits are determined by the type of plan chosen by you and/or your employer. Duxbury Children's Dentistry has no say in the selection or determination of your insurance benefits, terms of your policy, determination of your benefits, and/or method of reimbursement. Our office will make every attempt to assist you with understanding your benefits; however, it is ultimately your responsibility to be knowledgeable about your plan as well as the deductibles, maximum allowances, and other provisions within said plan. Duxbury Children's Dentistry will submit claims to your insurance company in a timely manner and will submit pre-treatment estimates to your insurance company. Should you choose to complete your child's care without receiving an estimate from your insurance company it is your responsibility to contact your carrier with any questions. We reserve the right to collect an estimation of what we feel will be due and will refund or credit you any money that was overestimated and reserve the right to bill for what was not collected on the day of service. If you are concerned about your co-pays it is wise to make appointments for all non-urgent care at least three weeks after your cleaning in order to allow processing time of the estimates.
4. Accounts more than 90 days past due will incur a late charge up to \$30.00 per month until a zero balance has been reached. Families carrying a balance for more than 1 year may be subject to dismissal from the practice and/or subject to a collection agency.

