Duxbury Children's Dentistry

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: _____
Home Address: _____
City: _____ Zip: _____
Phone #: _____
Cell #: _____
D.O.B: _____ SSN: _____
Employer: _____
Occupation: _____
Bus. Phone #: _____

Parent/Legal Guardian Name: _____
Home Address: _____
City: _____ Zip: _____
Phone #: _____
Cell #: _____
D.O.B.: _____ SSN: _____
Employer: _____
Occupation: _____
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: _____ Date: _____
Last *First* *Middle*

DENTAL HISTORY

	Yes	No
Will today be child's first visit to a dentist?	☐	☐

If not, date of last dental exam: _____ Dentist: _____

Date of last x-rays: _____

	Yes	No
Does child brush daily?	☐	☐
Does child use fluoride toothpaste?	☐	☐
Does child floss daily?	☐	☐
Is fluoride taken in any other form?	☐	☐
Describe: _____		
Has child complained of tooth pain?	☐	☐
Has child complained of sensitive teeth?	☐	☐
History of gum infection?	☐	☐
History of injury/trauma to teeth?	☐	☐
History of crowding/orthodontics?	☐	☐
Any dental anxiety/unhappy experiences?	☐	☐

	Yes	No
History of cavities?	☐	☐
History of discolored teeth?	☐	☐
History of jaw noise?	☐	☐
Any mouth habits:		
Thumb sucking?	☐	☐
Nail-biting?	☐	☐
Mouth-breathing?	☐	☐
Pacifier?	☐	☐
Sleeping with bottle?	☐	☐
Grinding?	☐	☐

HEALTH HISTORY

Date of Last Physical: _____ Physician: _____

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

Has patient had any of the following conditions:

	Yes	No
ADD / ADHD / Sensory (circle all that apply)	☐	☐
A.I.D.S. / H.I.V.	☐	☐
Anemia	☐	☐
Asthma	☐	☐
Autism / Spectrum Disorder	☐	☐
Autoimmune	☐	☐
Bladder Problems	☐	☐
Prolonged Bleeding/Transfusions/	☐	☐
Blood Clots/ Dyscrasias	☐	☐
Cancer	☐	☐
Cerebral Palsy	☐	☐
Cleft Lip / Palate	☐	☐
Congenial Birth Defects /Down Syndrome	☐	☐
Convulsions / Seizures	☐	☐
Diabetes	☐	☐
Digestive/ Reflux Issues	☐	☐

	Yes	No
Down Syndrome	☐	☐
Emotional Impairment / Mental Illness	☐	☐
Headaches	☐	☐
Hearing Impairment	☐	☐
Heart Murmur/Heart Condition	☐	☐
Hepatitis	☐	☐
Kidney Disease	☐	☐
Liver Disease	☐	☐
Muscular Problems	☐	☐
Physical Disabilities	☐	☐
Sinus Problems	☐	☐
Social Impairment	☐	☐
Speech Issues	☐	☐
Thyroid Problems	☐	☐
Tuberculosis	☐	☐
Other _____		

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

Child's Name: _____

Last *First* *Middle*

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 $35.00 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.

Child's Name: _____

Last *First* *Middle*

FINANCIAL POLICY (Continued)

5. Insurance companies do not cover the cost of Nitrous Oxide (laughing gas). Parents/guardians should be aware that a fee will be charged.

6. Duxbury Children's Dentistry's standard for filling teeth is a tooth-colored resin. If your child is having a filling in the back molars, insurance companies will often reimburse only at the amalgam (silver) filling rate. Your co-pay may be higher if you opt for tooth-colored fillings. The dentist is happy to discuss the pros and cons of both with you. To help determine what will be covered by your insurance provider, we can send a pre-treatment estimate.

7. Please be aware that appointment times are important not only to the efficient operation of our practice, but also to our patients. Broken appointments may be subject to a fee.

8. I authorize my insurance provider to pay directly to my dentist. I realize that benefits vary from provider to provider and that I am responsible for knowing the provisions of my particular plan. I agree that I am responsible for all fees including, but not limited to, co-payments, deductibles, and rejected charges.

By signing below, I confirm that I have read, understand and agree to the above terms and conditions.

Signature: _____ Date: _____

DISCLOSURE OF PROTECTED HEALTH INFORMATION

Health information about your child may be used/disclosed for the purpose of treatment, payment, and healthcare operations. We may disclose your child's information to a healthcare provider treating him/her. You may give us authorization to disclose health information to anyone for any purpose. Such authorization may be revoked in writing at any time. Your written permission, before any health information may be disclosed to someone other than the child's legal guardian, is required. In the event of an emergency, we will disclose information regarding your child based on our professional judgment. Your child's health information may be used to obtain payment for services. As required by law or if we suspect the possibility of abuse, neglect, or domestic violence, we may disclose your child's health information. Your child's health information may be disclosed in our attempts to provide you with appointment reminders and/or treatment recommendations (i.e. voicemails, text messages, letters, etc.). Information regarding your child's health will not be used for marketing purposes without your prior written consent.

By signing below, I confirm that I have read, understand and agree to the above.

Signature: _____ Date: _____

PATIENT RIGHTS

• You have the right to obtain copies of your child's health records and radiographs.

• You have the right to request that additional restrictions be placed on our use or disclosure of information.

• You have the right to request that we communicate with you about your child's heath history by alternative means and at other locations.

• You have the right to request that we amend your child's health information. Under certain circumstances, we may deny such a request.

• In the event that you are concerned we may have violated your privacy/right, you disagree with a decision we made about access to your child's health information, or you disagree with our response to your request for the amendment or restriction of disclosure of your child's health information you may submit a written complaint to the U.S. Department of Health and Human Services. If you have any further questions about our privacy practices, please contact Dr. Joy John.

By signing below, I confirm that I have read, understand and agree to the above.

Signature: _____ Date: _____

HIPPA

I, _____, have been offered a copy of Duxbury Children's Dentistry Notice of Privacy Practices. I am aware it can be viewed and printed at all times on our website at www.duxburychildrensdentistry.com.

Signature: _____ Date: _____