JACKSON PEDIATRIC DENTISTRY

To provide the safest and most comprehensive dental care for your child, we ask for your cooperation in completing our detailed questionnaire.

Date: _____ **Child's name:** _____ **Nickname:** _____

Birthdate:_____ **Gender: M F Home Phone**:_____ **Cell Phone:** _____

Address: _____ **Apt. #:** _____ **City:** _____

State: _____ **Zip code:** _____ **Email:** _____

Physician's Name: _____ **Physician's Phone:** _____

Pharmacy: _____ **Pharmacy Phone:** _____

Who can we thank for referring you to our office? _____

Child primarily lives with: _____ **Relationship to child:** _____

Is your child presently under the care of a physician for any reason? Yes No

If yes, explain: _____

Treatment Consent

The permission of a parent or legal guardian is necessary for dental treatment of a minor. As a minor child, it is necessary that a signed permission be obtained from a parent or legal guardian before any dental care can begin. As a parent or legal guardian of the above patient, I acknowledge that the above information is correct and grant "Jackson Pediatric Dentistry, P.C." permission to provide my child's dental and related medical/surgical treatment as deemed necessary, including digital radiographs (x-rays), diagnostic, restorative, oral surgery, and patient management techniques that are reasonable, necessary and advisable. Protective restraints are used when a child might harm themselves or when certain procedures may jeopardize their health and welfare without such restraints. I also authorize the administration of anesthetics or analgesics that are advisable by Dr. Mikhly, such as nitrous oxide (laughing gas).

I have given an accurate report of this patient's physical and mental health history. I have also reported any prior allergic or unusual reactions to medications, latex, foods, or metals, and any other disease or condition, including pregnancy.

I agree to inform Dr. Mikhly and the staff of "Jackson Pediatric Dentistry, P.C." of any changes in the medical history. This authorization is valid until revoked by me in writing.

_____ _____ _____

SIGNATURE RELATIONSHIP TO CHILD DATE

INSURANCE INFORMATION

Primary

Insurance company name: _____ Group#: _____ ID#: _____

Policy owners name:_____ DOB:_____ SSN: _____

Address: _____ Phone: _____

Relationship to child: _____ Employer: _____

Secondary (If applicable)

Insurance company name: _____ Group#: _____ ID#: _____

Policy owners name:_____ DOB:_____ SSN: _____

Address: _____ Phone: _____

Relationship to child: _____ Employer: _____

We value your busy schedule and strive to see patients at their scheduled appointment times: we ask you to extend the same courtesy. Whenever possible please provide a minimum of 24 hours advance notice when requesting a scheduling change so that we can arrange care for our other patients experiencing urgent dental needs.

MEDICAL HISTORY

If your child has or ever had any of the following conditions, please check "Yes" below. Please explain any conditions to the doctor.

Patient Name: _____ Date: _____

Y	N	Condition	Y	N	Condition
		ADD/ADHD			Hearing impairment
		Aids/HIV			Heart disease
		Asthma			Heart Murmur
		Autism			Hemophilia
		Behavioral Problems			Hepatitis/Liver disease
		Birth Defects			High blood pressure
		Bleeding Gums			Kidney disease
		Blood transfusions			Mentally Handicapped
		Bone/Joint problems			Metallic implant/Shunts
		Brain injury			Pins/Rods
		Cerebral palsy			Premature birth
		Cancer/Tumor			Prolonged bleeding when cut
		Chemical dependency			Psychiatric care
		Chemotherapy/radiation			Rheumatic fever
		Chicken Pox			Sickle cell disease
		Child abuse			Sore Throats
		Cleft palate/lip			Speech Impairment
		Cold sores/Canker sores			Surgery of any kind (specify) _____
		Developmentally delayed (age level): ____			Thyroid Disease
		Diabetes			Tonsillitis
		Earaches/Ear Infections			Transplants, Organ (specify)_____
		Epilepsy/Seizure disorder			Tuberculosis
		Eye conditions			Other (specify)_____

Does your child have any allergies to medicines, latex, foods, or metals? ☐ **Yes** ☐ **No**

Explain: _____

Physician Signature: _____

Dental History

Is this your child's first dental visit? ☐ Yes ☐ No

Previous Dentist: _____ **Phone number:** _____

Date of last visit: _____ **Date of last x-rays:** _____

Has your child experienced any unfavorable reaction from previous dental or medical care?

☐ Yes ☐ No **Explain**: _____

How often does your child brush? _____

Is Fluoride Toothpaste used? ☐ Yes ☐ No **Is dental floss used?** ☐ Yes ☐ No

Is brushing supervised? ☐ Yes ☐ No **Does a parent do the brushing?** ☐ Yes ☐ No

Does any member of the family have decay or fillings? ☐ Yes ☐ No

Explain: _____

Does your child receive (check all that apply):

☐ **Tap water** ☐ **Well water** ☐ **Bottled water** ☐ **Fluoride rinse** ☐ **Fluoride tablets/drops**

Has there been any injuries to your child's teeth or jaws? ☐ Yes ☐ No

Explain: _____

History of (check all that apply): Circle those that are ongoing currently.

☐ **Breast feeding** ☐ **Thumb sucking** ☐ **Bottle habits** ☐ **Pacifier**

☐ **Sippy cup** ☐ **Teeth grinding/clinching**

Has your child had recent dental pain? ☐ Yes ☐ No

Explain: _____

Does your child have a specific dental problem that needs attention? ☐ Yes ☐ No

Describe:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received or been offered a copy of this office's
Notice of Privacy Practices.

Please print name: _____

Signature: _____

Date: _____

Financial Policy

If you have insurance, we will do all we can to maximize your benefit. Dental Insurance is a contract between you, your employer, and your insurance carrier. Your dental insurance is not a contact between your insurance carrier and your doctor, unless your doctor is a provider for your insurance carrier and has contracted to a specific fee schedule with your carrier. The estimated payment for the primary policy will be due at the time of service.

On treatment visits, we are usually able to accept your insurance if you obtain prior approval from our office. If we accept your insurance, we will have you pay your estimated portion not covered by insurance (we will determine for you). If your insurance pays more than your account balance, we will send you a refund immediately.

No procedure performed on the human body can be guaranteed, as such payment is due and fees are non-refundable regardless of treatment outcome.

NON-INSURED PATIENTS: All fees are payable on the day service are rendered.

Please circle your method of payment: Check Cash Visa MasterCard Discover Amex

Financial Agreement: I have read understand, and agree to the financial policy set forth by Jackson Pediatric Dentistry. I understand that this office has not contracted with any insurance company and will file my insurance as a courtesy. I understand that insurance benefits given at the time of service are only estimates and that I am responsible for the payment of this account. I understand that as soon as my insurance carrier issues a payment, or after 60 days, any unpaid portion of my claim will be due. I authorize my insurance carrier to issue benefits directly to this office and also the release of any information necessary to process the dental insurance. If the use of a third party becomes necessary to secure payment, I agree to be responsible for any and all collection charges incurred, which includes 35% of my outstanding balance and cost of collections, which include court costs and attorney fees.

Parent/ Guardian Signature: _____ **Date:** _____