Capital City Pediatric Dentistry

www.capitalcitypediatricdentistry.com

Welcome to our practice! Please, complete this form as accurately as possible. It is important for us to have this information in order to provide the best possible care for your child. Your privacy is important to us. The information you share with us will remain strictly confidential.

PATIENT INFORMATION

Patient's Name: ❑Male ❑Female

Preferred Name: Birth date:

DENTAL HISTORY

Previous Dentist: City: Office Phone #:

Date of Last Exam: Last Cleaning: Last X-rays:

Does or has patient:

Have any pain with the teeth, mouth, or jaws? ❑YES ❑NO
Suffered any injuries to teeth or jaw? ❑YES ❑NO
Play a musical instrument that touches lips? ❑YES ❑NO
Suck thumb, fingers or pacifier? ❑YES ❑NO
Have any other habits of concern? ❑YES ❑NO
Please, describe:

Have speech problems? ❑YES ❑NO
Breathe mostly through the mouth? ❑YES ❑NO
Have a parent who had braces? ❑YES ❑NO
Have habits that cause orthodontic problems? ❑YES ❑NO
Ever seen an orthodontist before? ❑YES ❑NO
If YES, doctor's Name:

What kind of water does the patient drink? ❑City Water ❑Well Water ❑Bottled Water ❑Other:

Has patient ever had complications following dental treatment? ❑YES ❑NO If YES, please describe:

Does patient have to be pre-medicated with an antibiotic prior to receiving dental care? ❑YES ❑NO

MEDICAL HISTORY

Physician's Name: City: Date of last physical:

Office Phone #: Pharmacy: Phone #:

What do you rate this patient's overall health? ❑Excellent ❑Good ❑Fair ❑Poor Immunizations current? ❑YES ❑NO

Please check YES *or* NO *to indicate if patient has, has had, or has been diagnosed with any of the following:*

AIDS / HIV ❑YES ❑NO
Anemia ❑YES ❑NO
Asthma ❑YES ❑NO
Bone Disorder ❑YES ❑NO
Diabetes type ___ ❑YES ❑NO
Dizziness or Fainting ❑YES ❑NO
Endocrine ❑YES ❑NO
Hearing Impaired ❑YES ❑NO
Heart Condition ❑YES ❑NO
Heart Murmur ❑YES ❑NO

Hepatitis type ___ ❑YES ❑NO
Hernia Repair ❑YES ❑NO
Kidney Disorder ❑YES ❑NO
Latex Allergy ❑YES ❑NO
Latex Sensitive ❑YES ❑NO
Liver Disorder ❑YES ❑NO
Mitral Valve Prolepses ❑YES ❑NO
Nervous Disorders ❑YES ❑NO
Prolonged Bleeding ❑YES ❑NO
Prone to colds ❑YES ❑NO

Prone to ear infections ❑YES ❑NO
Prone to sore throats ❑YES ❑NO
Psychiatric Care ❑YES ❑NO
Rheumatic Fever ❑YES ❑NO
Seizures ❑YES ❑NO
Sinus Trouble ❑YES ❑NO
Tonsils and/or adenoids removed ❑YES ❑NO
Tuberculosis ❑YES ❑NO
Ulcer ❑YES ❑NO
Vision Impaired ❑YES ❑NO

Other medical condition not listed above:

Medications:

Allergies:

Has patient ever been hospitalized? ❑YES ❑NO If YES, please describe:

FEMALE ONLY

Is patient on any type of prescribed birth control? ❑YES ❑NO If YES, please, specify:

Is patient pregnant? ❑YES ❑NO If YES, what is the due date? Is patient nursing? ❑YES ❑NO

By signing below, I certify that the information provided above is accurate and true to the best of my knowledge.

Signature:	Date:
Print Name:	Relationship to patient:

Patient's Name: Birth date:

Reason for today's visit: ❑Routine Check-up ❑Evaluation of specific concern:

REFERRAL SOURCE

How did you hear about our practice? ❑Internet, website:

❑Doctor, name: ❑Patient, name:

❑Insurance Co, name: ❑Other:

RESPONSIBLE PARTY(S)

Patient lives with: ❑Father ❑Mother ❑Legal Guardian

For Legal Guardians, can you provide legal documentation? ❑YES ❑NO

Father:	Mother:
Address:	Address:
City State Zip:	City State Zip:
Home phone #: ( )	Home phone #: ( )
Work phone #: ( )	Work phone #: ( )
Mobile phone #: ( )	Mobile phone #: ( )
Email:	Email:

Other than the persons named above, are there other individuals authorized to make **treatment / financial** decisions for this patient? ❑YES ❑NO

Name: Relationship to patient:

Name: Relationship to patient:

INSURANCE INFORMATION

Insurance Co: Insurance phone #: ( )

Insurance Address:

Policy Holder: Relationship to patient:

Policy # Social Security #: Birth date:

Employer / Group Name: Group #:

EMERGENCY CONTACTS

Name: Phone #: ( ) Relationship to patient:

Name: Phone #: ( ) Relationship to patient:

PATIENT PHOTO DISPLAYING CONSENT

If this patient presents no cavities at routine check up visits, may we display his / her photo on our No Cavity Club board? ❑YES ❑NO

ACKNOWLEDGMENT

By signing below, I certify that the information provided above is accurate and to the best of my knowledge. In the event that there is any issue regarding custody of a minor patient, I understand that Capital City Pediatric Dentistry must be provided with court-sanctioned custody papers that clearly describe custody arrangements and designates one individual who is authorized to consent treatment and who is financially responsible for incurred charges. Capital City Pediatric Dentistry reserves the right to defer or refuse treatment. I also acknowledge that I have received, read and understood the practice's Office Policies and Financial Policies.

Signature: Date:

Print Name: Relationship to patient:

Capital City Pediatric Dentistry

www.capitalcitypediatricdentistry.com.

OFFICE POLICIES

Patient's Name: Birth date:

WHAT YOU SHOULD EXPECT DURING YOUR APPOINTMENT

To expedite the timely start of your appointment, we require that you arrive at our office **15 minutes prior** to the scheduled appointment time to complete paperwork and present your insurance card. Please have your child visit the restroom before entering the office. When you arrive, please sign your child in at front desk by checking in with one of our appointment coordinators. This staff member will announce the patient's arrival, review your paperwork and insurance card, and collect any necessary co-payments.

Appointments vary in length from 15 to 60 minutes. We take pride in the fact that we take our time with all children who enter our practice and ask your patience in this regard. If your child is not called back within 10 minutes of his / her appointment time, please notify a staff member. Since we work very hard to keep our appointment schedule running as planned, we ask that you return the courtesy by ensuring that you're on time for your appointment. **We understand that delays can occur, but if your child is more than 15 minutes late for his / her appointment, we may need to reschedule the visit for the next available day / time. We will make every effort to see your child on a work-in basis, but many times this simply is not possible. If you're going to be late for your appointment, please call the office, so we can advise you if we need to reschedule.**

Due to the size of our reception area and the number of patients we see every day, we ask that no food / drink be brought into the office and that only one parent / guardian accompanies the child to the appointment, unless otherwise instructed. If your child is 5 years old or younger, you will be asked to accompany him / her to the treatment bay for their first appointment; older children are encouraged to leave parents behind in the reception area. It has been our experience that older children receiving treatment (even those with special needs) are usually more cooperative when parents remain in the reception area. OSHA regulations and liability concerns prohibit us from allowing siblings in the treatment bay; these children can remain in our reception area, where there are kid-friendly activities to keep them occupied. If you have questions or concerns you wish to discuss with the doctor, the dental assistant will call you back at the conclusion of the visit for a brief consultation. **Parents/Guardians please understand that treatment in a pediatric office is sometimes rendered in an open bay. Therefore, there are times where your child's treatment may be discussed with you in the bay. If there is no opposition to this please initial beside this statement. _____**

After your child's appointment is over, you should check out with our front desk staff before departing. At this time, you will be asked to settle your child's account with us and schedule his / her next visit. While we are sensitive to the needs of working parents, the demands that schools place on children, the inconvenience caused by picking children up from school for appointments, and participation in sports or extracurricular activities, we cannot always accommodate requests for specific dates, days of the week, or after-school appointments.

APPOINTMENT NO-SHOWS, CANCELLATIONS & RESCHEDULING

It is our office policy regarding appointments that all patients practice common courtesy. If you are unable to keep an appointment time, please provide a 24 hours notice (preferably 48 hours). Patients who give less than 24 hours notice when rescheduling or who do not show for an appointment will incur a $25.00 charge and be counted as a broken appointment. Any family with 2 such instances noted within any 1 year period will be asked to make arrangements with another dental practice for further pediatric care.

Our appointment reminder service is a courtesy; ultimately, the responsibility lies with you to verbally confirm your appointment at least 24 hours in advance. For this reason, we must have current telephone numbers on file for you at all times. If we cannot verbally confirm your appointment, we reserve the right to offer your time slot to someone else.

IN-OFFICE DENTAL SURGERY & BEHAVIOR MANAGEMENT SERVICES

If your child is to be sedated for the appointment, it is very important that your child does not have anything to eat 8 hours before the surgery and drink only clear liquids (7-Up, Jell-O, apple juice) up to 2 hours before the appointment. **Your child should not eat / drink anything in the 2 hours immediately before the appointment.** Research shows that sedating a child on a full stomach decreases the effectiveness of the medications and increases the chances of nausea / vomiting. If these directions are not adhered to, then it is in the child's best interest to reschedule the appointment. To preserve your child's safety, other behavior management techniques may be needed (i.e. papoose board) to complete his / her treatment. Prior to using these techniques, the dentist will consult with the parent / guardian. If use of these techniques becomes necessary, there is an additional $42.00 fee.

ACKNOWLEDGEMENT

I hereby acknowledge that I have read, understand, and agree to adhere to Capital City for Kids Dentistry's Office Policies as outlined above.

Signature:	Date:
Print Name:	Relationship to patient:

Capital City Pediatric Dentistry

www.capitalcitypediatricdentistry.com.

FINANCIAL **POLICIES**

Patient's Name: Birth date:

PAYMENT TERMS

In our practice, our foremost concern is patient care. We strongly believe that financial considerations should not be an obstacle to obtaining dental services necessary to restoring and / or preserving good oral health. We are sensitive to the fact that our patients have different needs in fulfilling their financial obligations, and we are happy to provide flexible payment options wherever possible to facilitate treatment. We accept payments using cash, cashier's checks, money orders, or Visa / MasterCard debit / credit cards and American Express credit card. Personal checks from persons holding North Carolina driver's licenses may be accepted, but these are processed through an electronic system similar to a debit card transaction. Personal checks cannot be accepted from financial institutions who do not participate in this electronic network. If your check cannot be processed electronically, either due to system incompatibility or lack of account funds, you must provide an alternative form of payment. We **DO NOT FILE SECONDARY INSURANCES,(including Medicaid)**. Please inform our office if your child has a secondary insurance so that we are able to help you with the process of filing the secondary claim.

Any fees quoted to you in advance of the visit are only an estimate; actual fees incurred will be determined at the conclusion of each visit or when payment from insurance is received. Account balances delinquent over 30 days are subject to a $25.00 finance charge per month. Checks returned for insufficient funds will be assessed a $35.00 service charge plus any other applicable fees assessed to us by our financial institution.

FINANCIAL OBLIGATIONS RELATED TO INSURANCE

We file insurance claims as a courtesy. While we do our best to verify coverage for all services rendered, you, as the policyholder, are ultimately responsible for understanding the benefits and limitations of your coverage. Most insurance companies have strict limitations related to the timing and frequency of covered procedures, so we encourage you to educate yourself as much as possible on this subject. **You are responsible for all services not covered by your insurance, including but not limited to co-payments, deductibles, and non-covered services.** In instances where non-covered services are rendered, you are responsible to pay 100% of these charges at the time services are rendered.

Self-Pay: If you do not have dental insurance, or if you choose to file claims for treatment yourself, you must pay 100% of the charges at the time services are rendered.

State-Sponsored Insurance Programs: We accept assignment of benefits from Medicaid and North Carolina Health Choice (NCHC). For most appointments, patients with Medicaid insurance will have no out-of-pocket costs except when non-covered services are rendered (i.e., sedation medications, behavior management services, Mavla Stop, and re-cementation or re-impression of space maintainers). Patients with NCHC will be responsible for applicable co-pays at the time of the appointment. **Medicaid/NCHC patients undergoing procedures that require services not covered by their insurance must pay these fees at the time of the appointment**.

Private Insurance Programs: We accept assignment of benefits from most major dental insurance carriers, but we require patients with private insurance (excluding MetLife and Delta Dental) to pay 30% of the services rendered at each appointment regardless of how we anticipate the insurance company to reimburse the claim. Once the claim is filed, it generally takes six to eight weeks for us to receive reimbursement. Depending upon your plan's coverage, you may be entitled to a refund after the claim is paid. Reimbursements to patients are paid out on the 15th and 30th of each month (NO EXCEPTIONS).

MetLife: We are a Preferred Provider with MetLife, which means that subscribers are entitled to discounted fees for some (but not all) services rendered. Patients with MetLife insurance will only be required to pay the portion of the visit that is not expected to be reimbursed by the insurance company. Once the claim is filed, it generally takes six to eight weeks for us to receive reimbursement. If MetLife does not pay the claim as your coverage indicates they should have, you will be FULLY RESPONSIBLE for the non-covered portion.

Delta Dental: We are a Premiere Provider with Delta Dental, which means that subscribers are entitled to discounted fees for some (but not all) services rendered. Patients with Delta Dental insurance will only be required to pay the portion of the visit that is not expected to be reimbursed by the insurance company. Once the claim is filed, it generally takes six to eight weeks for us to receive reimbursement. If Delta Dental does not pay the claim as your coverage indicates they should have, you will be FULLY RESPONSIBLE for the non-covered portion.

If the patient's insurance has changed, you must notify us at least 3 business days prior to the appointment, so that appropriate verification of coverage can take place. If you do not provide this notification, you must pay in full for the dental services provided at the appointment.

ACKNOWLEDGEMENT

I hereby acknowledge that I have read, understand, and agree to adhere to Capital City for Kids Dentistry's Financial Policies as outlined above.

Signature:	Date:
Print Name:	Relationship to patient: