Castleton Pediatric Dentistry

WELCOME TO OUR DENTAL PRACTICE

Thank you for your expression of confidence in us by choosing our office to provide your child's dental health needs. We look forward to the opportunity to be of service to you. Listed below is important information about our office and a few of our policies.

All patients are expected to keep their scheduled dental appointments. Any cancellation of an appointment must be made at least 24 HOURS PRIOR to the appointment time.

Failure to keep scheduled appointments not only delays the necessary care for your child but the time we have reserved in the office goes unused for others who also need appointments. With that in mind, no additional appointments will be offered after a failed/cancelled appointment without 24 hours notice.

We want you to know that your child is important to us and we will make every effort to provide the highest quality care. Thank you for your support of our policies!

Patient's Name

_____

Parent/Guardian's Signature

_____

Date

_____

The following information and health history are necessary for the adequate treatment and understanding of your child. Thank you for completing it in full.

Patient's Name_____ Nickname_____ Age_____
Sex_____ Race_____ Date of Birth_____ Place of Birth_____
Patient's Address _____ City _____ State _____ Zip Code _____
Father's Name _____ Social Security # _____ Date of Birth _____
His Address (if different) _____ City _____ State _____ Phone _____
Employer _____ Work Phone _____
Mother's Name _____ Social Security # _____ Date of Birth _____
Her Address (if different) _____ City _____ State ____ Phone # _____
Employer _____ Work Phone _____
Patient's Cell # (if applicable)_____ Dad's Cell # _____ Mom's Cell # _____
With whom does patient live _____
Other children in family – names and ages _____
Closest relative besides parents, including phone #_____
May we contact you by email? If so, please give us your email address_____
Who referred you to our office? _____

HEALTH HISTORY

Today's Date _____ Child's Physician _____

PLEASE CIRCLE YES OR NO

Yes /No Is your child in good health?
Yes /No Does your child have regular medical exams?
Yes/No Is your child up to date with immunizations?
Yes/No Is your child presently taking medicine?
If so, what and why? _____
_____
Yes/No Has your child experienced any unfavorable Reaction to medicine?
If so, what?_____
Yes/No Is your child presently undergoing medical Treatment? _____
Yes/No Has your child been hospitalized since birth?
Date_____ Reason_____
Yes/No Is this your child's first dental visit?
If not, date of last dental care_____

Yes/No Has your child had an unfavorable experience In a dental office?
Yes/No Is your child a finger sucker?
Yes/No Does your child use a pacifier?
Yes/No Was your child bottle fed?
Age discontinued _____
Yes/No Was your child breastfed?
Age discontinued _____
Yes/No Does your home have city water?
Yes/No Does your child take a fluoride supplement?

CIRCLE ANY OF THE FOLLOWING THAT PERTAIN TO YOUR CHILD:

Heart Condition	Tuberculosis
Lung Problem	Asthma
Brain Injury	Allergies
Liver Problem	Developmental Delay
Kidney Problem	Mental Disorder
Epilepsy	Emotional Disorder
Diabetes	Nervous Disorder/ADHD
Cerebral Palsy	Autism
Bleeding Disorder	Speech Disorder
Sickle Cell Anemia	Hearing Disorder
Hepatitis	Vision Disorder
HIV/AIDS	None

List all known ALLERGIES:_____
_____
_____
_____
_____
_____
_____
Purpose of this appointment? _____
_____
_____
_____
_____
_____

CONSENT

Your child is a minor therefore it is necessary that signed permission be obtained from a parent or legal guardian before any necessary dental service can be started. I hereby grant permission for diagnostic procedures, dental treatments, and patient management techniques as found necessary by Dr. Charles Poland and staff for the patient named above. I will be responsible for the cost of this dental care and any collection or attorney fees incurred.

SIGNED: _____

CASTLETON PEDIATRIC DENTISTRY
ORAL HEALTH RISK ASSESSMENT

Child's Name_____ Date of Birth_____ _____

HISTORY

	YES	NO
Was child premature?	___	___
Was child's birth weight low?	___	___
Did mother have any problems during pregnancy?	___	___
Were there any complications during birth?	___	___
Has child ever taken amoxicillin or tetracycline	___	___
Last time mother saw a dentist?	_____	
Last time mother had a cavity?	_____	
Last time father saw a dentist?	_____	
Last time father had a cavity?	_____	

DIET AND NUTRITION

	YES	NO
Does child sleep with a bottle for naps or bedtime?	___	___
Does child use a bottle or sippy cup other than mealtime?	___	___
Does child have any diet restriction?	___	___
How long was child breastfed?	_____	

FLUORIDE ADEQUACY

	YES	NO
Does your home have well water?	___	___
If so, has it been tested for fluoride?	___	___
Does your home have a reverse osmosis filtration system?	___	___
Do you use bottled water?	___	___
Do you know the fluoride level of the water in your home?	___	___
Does your child use fluoridated toothpaste?	___	___

ORAL DEVELOPMENT AND HABITS

	YES	NO
Does your child use a pacifier?	___	___
Does child suck thumb or finger(s)?	___	___
Does child grind teeth during the day or night?	___	___
Has child experienced any teething problems?	___	___
Child's age, in months, when first tooth erupted?	_____	

ORAL HYGIENE

	YES	NO
Do you brush child's teeth every day with a toothbrush?	___	___
Do you floss child's teeth several times per week?	___	___
Is this your child's first visit to the dentist?	___	___
If no, child's age at first dental visit?	_____	

PATIENT ELIGIBILITY WAIVER &
FINANCIAL RESPONSIBILITY FORM

The purpose of this form is to help our patients understand dental insurance, eligibility,coverage, our office policy and medical services.

It must be understood that:

* We render our services on the basis that insurance companies may or may not pay for all, or a portion of our charges.
* Authorizations for dental treatment from your insurance company do not guarantee full payment for the service.
* Not all insurance companies/third party payors pay for all services, each policy has its own particular stipulations regarding covered services, or amount of coverage.
* All insurance companies state that verification of coverage is not a guarantee of coverage or payment. Actual benefits are determined by your insurance company after a claim is received.
* Patients are personally responsible for knowing and understanding their own insurance policy, eligibility and coverage.
* Patients are responsible for payment of outstanding deductibles and co-insurance amounts **at time of service.** Co-payments will be collected at the time of service.
* Patients are financially responsible for payments of all non-authorized procedures and non-covered services.
* Any appointment missed or not cancelled more than 48 hours in advance will incur a $50.00 charge.
* Returned checks are subject to a $35.00 fee
* Changes in insurance coverage must be reported to our staff promptly to avoid financial responsibility.

The patient or patient's legal representative hereby acknowledges that he/she is eligible for dental insurance benefits and coverage. That in the event of ineligibility for coverage of plan benefits, as well as all non non-authorized procedures and non-covered services, he/she understands and agrees to be fully financially responsible for payment of all costs incurred during the delivery of dental services, and agrees to pay all charges.

_____ _____

signature of Patient or Guardian Date

_____ _____

Witness Date