DENTAL SURGEONS & ASSOCIATES
419 NORTH CHESTNUT ST.
SCOTTDALE, PA 15688

CHILD PATIENT INFORMATION

Welcome to our office! We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

PATIENT NAME: _____ DOB:_____ SEX:_____ SOCIAL SECURITY #_____

HOME ADDRESS:_____CITY:_____STATE:_____ZIP:_____

PARENT'S/ GUARDIAN'S NAME: _____ RELATIONSHIP _____

PARENTS HOME PHONE:_____ PARENTS MOBILE PHONE:_____ OK TO TEXT Y or N

EMERGENCY CONTACT NAME (other than parent):_____NUMBER:_____

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE:_____MEMBER #_____

SUBSCRIBERS NAME:_____DATE OF BIRTH_____SS#_____

SECONDARY DENTAL INSURANCE: _____MEMBER #_____

SUBSCRIBERS NAME:_____DATE OF BIRTH: _____SS#_____

CHILD'S MEDICAL DOCTOR:_____DATE OF LAST VISIT TO MEDICAL DOCTOR:_____

NAME OF PREVIOUS DENTIST:_____DATE OF LAST DENTAL VISIT:_____

REFERRED TO US BY:_____

DENTAL HEALTH HISTORY

How would you describe the child's eating habits? _____

Is this your child's first visit to a dentist? ..... Y or N

If not the first, when was the last visit to a dentist? _____

Has the child had a problem with dental treatment in the past? ..... Y or N

Has the child ever had dental radiographs (x-rays)? ..... Y or N

Has the child ever suffered any injuries any injuries to the mouth, head or teeth? ..... Y or N

Does the child have any problems with loosing baby teeth or eruption of adult teeth? ..... Y or N

Has the child had any orthodontic treatment? ..... Y or N

Is fluoride toothpaste used? ..... Y or N

How many times are the child's teeth brushed per day? _____ When are they brushed? _____

Does the child suck his/her thumb, fingers, or pacifier? ..... Y or N

At what age did the child stop bottle feeding? Age _____ Breast feeding? Age _____

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive, or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses on this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use information to discriminate.

MEDICAL HEALTH HISTORY QUESTIONS:

Does the child have or has had, any of the following?

Height_____Weight_____

Cancer	Y or N
Bladder conditions	Y or N
Ear aches	Y or N
Diabetes	Y or N
Growth problems	Y or N
Hearing problems	Y or N
Hepatitis	Y or N
HIV / AIDS	Y or N
Epilepsy	Y or N
Seizures	Y or N
Fainting	Y or N
Liver problems	Y or N
Kidney problems	Y or N
Measles	Y or N
Mononucleosis	Y or N
Mumps	Y or N
Rheumatic fever	Y or N
Sickle cell	Y or N
Thyroid conditions	Y or N
Tobacco or drug use	Y or N
Arthritis	Y or N
Anemia	Y or N
Bleeding disorder	Y or N
Blood transfusion (date) _____	Y or N
Active tuberculosis	Y or N
Persistent cough greater than 3 weeks	Y or N
Cough that produces blood	Y or N
Asthma	Y or N
Chronic sinusitis	Y or N
Heart problems	Y or N
Serious illness or hospitalized	Y or N
Had general anesthetic	Y or N
Any inherited problems	Y or N
Speech difficulties	Y or N
Physically, mentally, or emotionally impaired	Y or N

Specify: _____

Are you allergic or had reactions to any of the following?

Local anesthetics	Y or N
Penicillin	Y or N
Clindamycin	Y or N
Sulfa drugs	Y or N
Aspirin	Y or N
Acetaminophen	Y or N
Ibuprofen	Y or N
Codeine	Y or N
Demerol	Y or N
Reaction to metals	Y or N
Latex	Y or N

"list all others"_____

_____

_____

PLEASE LIST ALL CURRENT DRUGS/MEDICATIONS including vitamins, supplements, and fluoride:

_____

_____

_____

_____

_____

Female Teens

Are you pregnant	Y or N
How many weeks _____	
Are you nursing	Y or N
Taking contraceptives	Y or N

If so, please specify: _____

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Information Release Form (HIPPA)

Authorization for additional disclosure: I am the "Person Representative" of and have legal authority to make health care decisions about the following minor patient:

Patient's Name: _____ **Date of Birth:** ____/____/____
(FIRST) (MI) (LAST)

As a personal representative of the above named patient (generally parent or legal guardian), I authorize the following individuals to accompany my child and have access to health information including diagnosis, records, examination rendered, and claims information

Name _____ relationship _____

Name _____ relationship _____

Name _____ relationship _____

Name _____ relationship _____

This release of information will remain in effect until terminated by me in writing.

X Parent/Guardian Signature _____ **Date** _____

Messages

( ) You may leave a detailed message

( ) Please leave a message asking me to return the call

X Parent/Guardian Signature _____ **Date** _____

Acknowledgement Of Our Notice Of Privacy Practices

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Dental Surgeon's & Associates Notice of Privacy Practices. By signing below I am "only" giving acknowledgement that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

X Parent/Guardian Signature _____ **Date** _____

Honesty policy:

I certify that I have read and understand all information in this agreement. The information that I provided on these forms is accurate to the best of my knowledge. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I have made in the completion of this form.

X Parent/Guardian Signature _____ **DATE** _____

Financial Agreement

Thank you for choosing Dental Surgeons & Associates! Our goal is to help patients understand their treatment needs as well as their financial responsibility before treatment begins. It is our desire to make dental treatment affordable to all of our patients. Please review the following policies and procedures:

Payment Policy: **Payment is due at the time services are rendered. If you have dental insurance, your estimated co-pay plus deductible is due at the time of service. If no insurance is involved, payment is expected at each visit.**

- We accept cash, personal checks with proper ID, money orders and most major credit cards.
- You will be responsible for a check returned by the bank of $35.00.
- Financing is available through Care Credit with prior approval.
- You will be responsible for any and all costs incurred in the collection of your debt (i.e. collection agency fees, court fees and/or attorney fees).
- You understand that any treatment involving a Lab's fabrication, will incur a fee within 60 days of the case being received, even if you decide not to continue with the agreed treatment.
- **MINOR PATIENTS:** In the case of divorced or separated parents, it is YOUR responsibility to have financial arrangements made according to the divorce decree before treatment begins.

Dental Insurance: **As a courtesy we will gladly file your claims and accept assignment of dental insurance benefits provided you agree the following:**

- You must provide us with an insurance card and/or all the information necessary to verify your coverage and file your claim.
- Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you; not your insurance company.
- You are responsible to pay our fees; not what your insurance company allows or considers "usual, customary and reasonable"(UCR), all of which vary from one company to another.
- Although we may estimate your insurance benefits we are not responsible for their accuracy. Knowledge of your benefits as well as benefit amounts, limitations, exclusions, waiting periods, etc. is entirely YOUR responsibility. Receiving our services indicates your acceptance of responsibility to pay regardless of our estimate. Every effort will be made to help you with the insurance, including completing a Benefit Limitations Exception Form, but what is not covered is your responsibility.
- All charges not paid by your insurance company are your responsibility regardless of the reason for nonpayment. Not all services we provide are covered benefits. Benefits differ from one company to another. Fees for non-covered services, along with deductibles and copayments are due at the time of treatment.
- Treatment provided at another dental office during your current plan year may alter your co-payment due for services in our office. In such cases we are not able to track whether or not you have reached your yearly maximum benefits. Please call your insurance company if this applies to you.
- There are many factors in determining patient responsibility where coordination of benefits between two insurance companies is involved. We will provide you with the most accurate information available to us but CANNOT guarantee what your out of pocket expense will be.
- Please understand that our responsibility is to provide you with treatment that best meets your needs, not to try to match your care to insurance plan limitations. We reserve the right to withhold further treatment if there is an outstanding balance on your account.
- We reserve the right to terminate professional treatment of any patient when scheduled appointments are not kept.
- **I have read and understand this document in its entirety; outlining the office and financial policies of Dental Surgeons and Associates and agree to these terms.**

*NEW POLICY EFFECTIVE 1/27/2023 *

- Appointments-
  Please call our office to confirm your appointment within 24 hours of your appointment time. If we do not hear from you, your appointment will be canceled and filled.
- Missed /Broken Appointments-
  After 3 missed/broken appointments, your next appointment will be scheduled at 8am. If you continue to show for 8 am appointments we will then schedule you at a later time in the day. If you fail to keep this you will be put on a permanent 8am schedule.

Signature of patient of parent/guardian: _____

Date: _____