Ronald L. Poulos, DDS
Dentistry for Children

Welcome To Our Office!

Today's Date _____

Child's Name _____ Sex: M F Nickname _____

Birthdate _____ Age _____ Home Phone _____

Address _____

Email Address _____

Siblings Names & Ages _____

Responsible Party

Mother Birthdate ____/____/____ Social Security No. _____ - ____ - _____

Last Name _____ First Name _____ M.I. _____

Address _____ Home Phone _____ Cell _____

City _____ State _____ Zip Code _____

Employed By _____ Work Phone _____

Employer Address _____

Father Birthdate ____/____/____ Social Security No. _____ - ____ - _____

Last Name _____ First Name _____ M.I. _____

Address _____ Home Phone _____ Cell _____

City _____ State _____ Zip Code _____

Employed By _____ Work Phone _____

Employer Address _____

Parent's Marital Status: (Circle one) Married Divorced Separated Single

Legal Guardian: (Circle one) Mom Dad Other (Please Name) _____

Person Financially Responsible For Child _____ Phone _____

Address _____

Emergency Contact: Name _____ Phone _____

Dental Insurance

Primary Insurance Co. _____ Group No. _____

Address _____

Policy Holder _____ Relation To Patient _____

Secondary Insurance Co. _____ Group No. _____

Address _____

Policy Holder _____ Relation To Patient _____

Whom May We Thank For Your Referral _____

I Accept Responsibility For This Account _____
Signature of Parent or Guardian

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Health History

Patient's Physician _____ Phone # _____

Physician's Address _____

1. Is your child under the care of a physician for any illness or health problem? ..... ❑ Yes ❑ No
2. Does your child have or ever had any of the following health conditions?

Abnormal Bleeding Problems	❑ Yes	❑ No	Fainting	❑ Yes	❑ No
Aids or Aids Related Complex	❑ Yes	❑ No	Hearing Problems	❑ Yes	❑ No
Allergies	❑ Yes	❑ No	Heart Murmur	❑ Yes	❑ No
Anemia	❑ Yes	❑ No	Heart Problems	❑ Yes	❑ No
Asthma or Other Respiratory Problems	❑ Yes	❑ No	Hepatitis, Jaundice or Liver Problems	❑ Yes	❑ No
Arthritis	❑ Yes	❑ No	High Blood Pressure	❑ Yes	❑ No
Artificial Limb or Implant	❑ Yes	❑ No	Hyperactivity	❑ Yes	❑ No
Bladder Disorder	❑ Yes	❑ No	Kidney Disorders	❑ Yes	❑ No
Blood Disorder	❑ Yes	❑ No	Learning Disability	❑ Yes	❑ No
Blood Transfusion	❑ Yes	❑ No	Developmental Disability	❑ Yes	❑ No
Cancer	❑ Yes	❑ No	Premature Delivery	❑ Yes	❑ No
Cerebral Palsy	❑ Yes	❑ No	Pregnancy	❑ Yes	❑ No
Convulsions or Seizures	❑ Yes	❑ No	Radiation Therapy	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No	Rheumatic Fever or Heart Disease	❑ Yes	❑ No
Ear, Nose or Throat Problems	❑ Yes	❑ No	Tuberculosis	❑ Yes	❑ No
Emotional Problems	❑ Yes	❑ No	Hyper or Hypo Thyroidism	❑ Yes	❑ No

Please explain "yes" answers _____

_____

_____

3. Does your child have any disease, syndrome or handicap not listed above? ..... ❑ Yes ❑ No

   If yes, describe _____
4. Is your child taking any over the counter drugs or prescription medications? ..... ❑ Yes ❑ No

   If yes, name of medication(s) _____
5. Has your child had any allergies or any adverse side affects to any drugs or medications, including local anesthetic, penicillin, codeine, fluoride, etc.? ..... ❑ Yes ❑ No

   If yes, name of medication(s) _____
6. Has your child ever been hospitalized? ..... ❑ Yes ❑ No
7. Has your child ever had any surgeries? ..... ❑ Yes ❑ No
8. Has your child or any relative had a problem with general anesthesia? ..... ❑ Yes ❑ No

Doctor Notes _____

_____

_____

_____

_____

_____

_____

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Dental Information

1. Is this your child's first visit to the dentist? ..... ❑ Yes ❑ No
2. Has your child complained about dental problems? ..... ❑ Yes ❑ No
3. When was your child's last trip to the dentist? ..... ❑ Yes ❑ No

   Name of previous dentist _____
4. Has your child had an unhappy dental experience? ..... ❑ Yes ❑ No
5. Who brushes your child's teeth? _____ How Often? _____
6. Do you drink well water, city water or bottled water? _____
7. Is your child going to sleep with a bottle? ..... ❑ Yes ❑ No
8. What does the bottle contain: ❑ Water ❑ Milk ❑ Formula ❑ Juice ❑ Other
9. Is your child presently breast feeding? ..... ❑ Yes ❑ No
10. Any oral habits (thumb sucking, pacifiers, nail biting, etc.)? ..... ❑ Yes ❑ No
11. Any history of injuries to mouth, teeth, or head? ..... ❑ Yes ❑ No

    If yes, describe injury _____

The statements on both sides of this form are, to the best of my knowledge true and correct. I agree to report any health changes to the Doctor prior to any treatment. I hereby authorize the Doctor and staff to provide examinations, x-rays and procedures to diagnose oral and dental disease and to provide necessary dental services.

_____ _____ _____

Patients Name *Signature of Parent or Legal Guardian* *Date*

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

I, _____, acknowledge that I have been given the opportunity to read a copy of this office's Notice of Privacy Practices, and I am aware that a copy will be made available at my request.

_____ _____
(Please Print Name) (Date)

_____
(Signature)

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment count not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (please Specify)

FINANCIAL/INSURANCE INFORMATION

We appreciate you allowing us to provide dental care for your child. We value our relationships with you and believe that the best relationships are based upon trust and open, honest communication. Through this communication, we offer up front information regarding payment and insurance reimbursement.

Upon your first visit to our office, we will request a copy of your dental benefits information card. Please remember to bring this information with you. This information will be kept in your child's record. It is important to notify us of any changes to your dental coverage, as this will expedite reimbursement of benefits.

While we accept all dental insurance plans, we are only contracted and considered in-network with Dental Care Plus and Delta Dental Premier. Being out of network does not always mean you do not have benefits. You may contact your HR department or your insurance company, to see what out-of-network benefits are available on your plan. We strive to help you make the optimal use of your dental insurance plan.

As a courtesy to our patients, we will be happy to file your insurance claims. Your insurance is a contract between **you, your employer, and your insurance company.** With the complexity of insurance policies and constant changes made by the insurers and employers, keeping up to date is challenging. Neither employers nor insurance companies notify us of changes. Insurance companies have decided that it is the **member's responsibility to know their insurance limitations.** However, if we do not have your current information, the claim will be rejected and unfortunately, **you will be immediately responsible for your balance.** It is time consuming and costly for our office to reprocess rejected claims due to incorrect insurance information, due to this there will be a $10 fee for resubmission of insurance claims due to incorrect or lack of information. Insurance companies are very reluctant to speak with us directly regarding your individual plan, however it is their job to answer all of your questions when you call. Upon your request, we are happy to submit a pre-determination of benefits when treatment is proposed to better estimate coverage.

Questions you should ask your insurance carrier:

1. If I am out of network, what is my benefit level?
2. What services are covered and frequency?
3. Are bite wings and fluoride covered two times per year?
4. Do I have a co-pay or deductible? What is my annual maximum?
5. Have there been any changes to claims mailing address, group or subscriber ID numbers?

Any amount not covered by your insurance is company will be payable at the time services are rendered. These fees include deductibles, estimated co-pays, or procedures not covered by your policy. We allow a maximum of 30 days for your insurance company to clear any claim. Any unpaid portions will be your responsibility after this period. Our current management software will automatically transfer accounts with greater than 45 day balances to an outside collection agency.

Children of divorced/separated parents:
Unless you give us a signed, notarized court order to keep on file, the parent who brings the child to their visit will be considered ultimately financially responsible for the account in our office.

For your convenience, we accept cash, checks, and the following major credit cards: Visa, MasterCard, and Discover. All returned personal checks will be assessed a **$35** management fee.

To help provide cost effective care to our patients, we offer long and short-term financing programs, through an outside financial institution for both dental and orthodontic treatment. Please feel free to inquire about these various payment programs.

Please remember, our office is always here to help you. Please feel free to contact us with any questions you may have.

I have read and understand the Financial and Insurance Guidelines for Pediatric Dentistry of Anderson

PARENT /LEGAL GUARDIAN SIGNATURE_____DATE_____

PATIENTS NAME (PLEASE PRINT)_____