



Michelle H. Edwards, DDS, MSD

www.babytoothcenter.com

Patient Information (please print)

Child's Full Name: _____ Name Called By: _____

Age _____ Birth date _____ / _____ / _____ Sex: M _____ F _____ Place of Birth _____

Child's Home Address: _____

City _____ State _____ Zip Code _____ Hm Phone () _____

Siblings (Names and Ages): _____

Name of School/Day Care: _____

Parent/Guardian Information (please print)

Parent/Guardian Name _____ Relationship to Patient: _____

S.S. # _____ - _____ - _____ Date of Birth: _____

Mobile Phone () _____

Parent/Guardian Name _____ Relationship to Patient: _____

S.S. # _____ - _____ - _____ Date of Birth: _____

Mobile Phone () _____

Parent's Marital Status _____ Married / Divorced / Separated / Widowed / Remarried / Single

Primary Insurance/Financial Information and Agreement (please print)

Dental coverage? _____ Yes _____ No Insured's Name _____

Insured's Employer _____ ID # _____

Name of Ins. Company _____ Insured's Date of Birth _____

Secondary Insurance/Financial Information and Agreement (please print)

Secondary Dental coverage? _____ Yes _____ No

Insured's Name _____

Insured's Employer _____ ID # _____

Name of Ins. Company _____ Insured's Date of Birth _____

Emergency Contact- Friend or Relative Not Living with You

Name _____ Relationship _____ Phone () _____

Address _____ Zip Code _____

Would you like to confirm appointments by e-mail? Yes / No **E mail:** _____

Would you like to receive text message reminders? Yes / No () _____

X _____ Date _____

Signature of Parent, Insured, Guarantor, or Responsible Party

Medical History

Child's Name: _____ **Age:** _____

Please Check All That Apply. Does your child currently have/previously have any of the following health problems?

__ Asthma/Hay Fever	__ Anemia or Blood Disorders	__ Speech/Learning/Hearing problems
__ Accidents or severe infections	__ Blood Transfusion	__ Psychological/Emotional Problems
__ Arthritis or Rheumatism	__ Cancer	__ Pneumonia or Tuberculosis
__ Prolonged Bleeding/Bruises easily	__ Cerebral Palsy	__ Sickle Cell
__ Convulsions/Seizures/Fainting/Epilepsy	__ Diabetes/Blood Sugar Problems	__ Hepatitis A,B,C or Liver Problems
__ Eating Disorder	__ Glandular/Hormonal Problems	__ Kidney or Bladder Problems
__ High/Low Blood Pressure	__ HIV+/AIDS	__ Jaundice

Allergies (Food, Dust, Drug, Latex) _____

Rheumatic Fever/ Rheumatic Heart Disease: **Y / N** Congenital Heart Disease or Heart Murmur: **Y / N**

Any pending/recent surgeries? _____ Any current/recent injuries? _____

Are your child's Immunizations Current? _____ Please explain any other medical concerns / Current

Medication(s): _____

Child's Physician _____ Phone () _____

Address _____ Date of Last Exam _____

What is your Child's Current Weight? _____ What is your Child's Current Height? _____

Dental History

Date of Last Dental Visit _____ by Dr. _____

Was your child breastfed? **Yes / No** Until what age? _____ Does your child still take the bottle or sippy cup? **Yes / No**

What does your child drink? _____

Does your child brush daily? **Yes / No** How Often? _____ Does your child brush before going to bed? **Yes / No**

Do you assist your child with Brushing? **Yes / No** Is Dental Floss used? **Yes / No**

Please indicate with a YES or leave blank if NO. Does your child have any of the following Mouth Habits?

__ Thumb Sucking __ Mouth Breathing __ Pacifier __ Nail Biting __ Finger Sucking __ Grinding

How does your child receive Fluoride?

- | | | | |
|---------------------------------------|-------------------------------------|----------------------------------|--------------------------------------|
| <input type="checkbox"/> Water Supply | <input type="checkbox"/> Toothpaste | <input type="checkbox"/> Tablets | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Dentist | <input type="checkbox"/> Vitamins | <input type="checkbox"/> None | |

How did you find out about our office? _____

Child's attitude towards dentistry: _____

Reason for today's visit / Chief Concerns: _____

I hereby certify that all of the above information is correct and true. Due to the above-named child being a minor, it is necessary that this signed permission is obtained from a parent or guardian before any and/or all necessary dental treatment can be commenced. I have read this practice's policy statement on privacy of patient's healthcare information. I authorize the release of any and all medical and dental information pertinent to my treatment to my other treating healthcare providers.

Signature: _____ **Date** _____

Relationship to Patient _____



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Financial Policy

Payment for professional services is due at the time dental treatment is provided. To better serve you, we have multiple payment options available.

Insurance Benefits

The Children's Dental Center is a participating provider with Delta Dental Premier, Anthem 300 Plan, and Cigna Radius Network. We accept all insurances. However, we are not in network with all insurances. It is our pleasure to submit your dental claims electronically for you. We need all pertinent insurance information and a copy of your insurance card by the first appointment. If you do not have the insurance information, you will need to pay for services rendered that day and your insurance company will reimburse you.

Please keep in mind that we do not have a contract with your insurance company, only you do. It is important for you to be familiar with your insurance benefits. You are responsible for fees not covered by the insurance company. Please keep in mind all co-pays and deductibles are determined by your dental insurance company and will be collected at the time of treatment. We are more than happy to assist in estimating treatment plans for your child, but remember they are only estimates. We have no control on how your insurance company handles the claims. No insurance company guarantees payment for services. Dental insurance is meant to be an aid when receiving dental care. No insurance pays 100% of all procedures. If you have reached your dental maximum, you are expected to pay at the time of the appointment for services rendered. We will be happy to assist you with payment options.

Delinquent Accounts, Failed & Cancelled Appointments

A \$35.00 fee will be assessed for all return checks. Account balances after 60 days are subject to a 1.5% re-billing fee that will be added to your account each month until paid. Account balances that exceed 90 days may be pursued through a third party collections agency. All expenses incurred in the collections process such as reasonable Attorney fees and reasonable Collection Agency fees, court fees and filing fees. will be the account holder's responsibility. Appointment times are reserved especially for you. Our practice is dedicated to quality care and exceptional service. We respect the importance of your time and work very hard to schedule appointments that accommodate the busy scheduling needs of all our patients. Please allow 24 hour cancellation notice so that we may have the opportunity to offer that time to another patient. A charge of up to 50% of the planned procedure may be assessed in an appointment is failed. Our schedule is carefully designed to make everyone's experience a pleasant one. If you are more than 15 minutes late, you may be asked to wait until the doctor is available or to reschedule your appointment. We reserve the right to dismiss a patient after the third failed appointment.

Parent, Guardian or Responsible Party Signature:

_____ Date

Parent, Guardian or Responsible Party Signature (please print)

_____ Date



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Thank you for choosing Children’s Dental Center! We strive to deliver the best and most comprehensive dental care available. An important part of this goal is making the cost of optimal care as easy and manageable for our patients by offering several payment options.

Payment Options

You can choose from the following:

- Cash, personal check, Visa, MasterCard or Discover
- No interest¹ payment plans² from Care Credit, Chase Health Advance and Citi Health Card
 - Allow you to pay over time with NO INTEREST
 - Convenient, low monthly payment plans² also available
 - No annual fees or pre-payment penalties

Please note:

- Children’s Dental Center requires payment at the time of service. This includes all co-pays and deductibles.
- For patients with dental insurance, we are happy to work with your carrier to maximize your benefits and directly bill them for reimbursement for your treatment³.
- If you have any questions, please do not hesitate to ask. We are here to help you get the dental care you want or need.

To make transactions simpler for you, we offer to keep your credit card under your account on file here. This reduces phone calls and statements sent to you. We will provide a courtesy email or phone call to inform you of your balance and that we will charge your credit card automatically. No one other than the financial coordinator at Children’s Dental Center will have access to your personal information. Your information will be scanned into your account and promptly shredded.

Account #: _____
 Exp. Date: ____/____ 3 digit Security Code ____
 Type of Card: () VISA () MasterCard () Discover

I have read and understand the Financial Policy of the Children’s Dental Center. Children’s Dental Center has my permission to charge the balance of account after all insurance payments have been made³.

Parent, Guardian or Responsible Party **Date**

Patient’s Name (please print)

¹If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.
²Subject to credit approval
³If we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits.