Patient Information *Date_____*

*Child's Name*_____*Birthdate*_____*Gender___M___F*

*Nickname*_____*SS#*_____

*Responsible Party Name*_____ *Relationship*_____

*Address*_____, _____

Email address_____

*Home Phone*_____ *Cell Phone*_____ *Work Phone*_____

*Name of School*_____

*Hobbies*_____

Whom may we thank for referring you to our Orthodontic Practice*?*_____

Medical History

*Physicians Name:*_____*Phone Number*_____

Has your child been hospitalized or had a major operation? ____Yes ___No If Yes:

Has your child ever had a serious head or neck injury? ___Yes___ No If Yes:

Is your child taking any medications, pills or drugs ___Yes ___No If Yes:

Does your child take, or have taken Phen-Fen or Redux? ___Yes ___No

Was your child born prematurely/experienced complications at birth? ___ Yes __No

*Is your child **allergic** to any medications? ___ Yes ___ No If yes, explain*_____

*Does your child have any other allergies?___ Yes ___ No If yes, explain*_____

Does your child require antibiotics before dental treatment? ___ Yes ___ No

Other

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

AIDS/HIV Positive	*___Yes ___ No*	*Hemophilia*	*___ Yes ___ No*
Anaphylaxis	*___ Yes ___ No*	*High Blood Pressure*	*___ Yes ___ No*
Anemia	*___ Yes ___ No*	*Hives or rash*	*___ Yes ___ No*
Angina	*___ Yes ___ No*	*Hypoglycemia*	*___ Yes ___ No*
Artificial Joint	*___Yes ___ No*	*Kidney Problems*	*___ Yes ___ No*
Asthma	*___ Yes ___ No*	*Leukemia*	*___ Yes ___ No*
Blood Transfusion	*___ Yes ___ No*	*Liver Disease*	*___ Yes ___ No*
Blood Disease	*___ Yes ___ No*	*Lung Disease*	*___ Yes ___ No*
Breathing Problem	*___ Yes ___ No*	*Rheumatic Fever*	*___ Yes ___ No*
Cancer	*___ Yes ___ No*	*Sexually Transmitted Disease*	*___ Yes ___ No*
Cold Sores/Fever Blisters	*___ Yes ___ No*	*Sickle Cell Disease*	*___ Yes ___ No*
Congenital Heart Disorder	*___ Yes ___ No*	*Sickle Cell Trait*	*___ Yes ___ No*
Diabetes	*___ Yes ___ No*	*Sleep Apnea*	*___ Yes ___ No*
Drug Addiction	*___ Yes ___ No*	*Strep Throat*	*___ Yes ___ No*
Epilepsy or Seizures	*___ Yes ___ No*	*Tonsillitis*	*___ Yes ___ No*
Excessive Bleeding	*___ Yes ___ No*		
Fainting/Dizziness	*___ Yes ___No*		
Glaucoma	*___ Yes ___ No*		
Heart Murmur	*___ Yes ___ No*		

Dentist Notes

Are there any other disabilities, handicaps or any medical problems that we need to be aware of?

_____

Dental History

*Previous Dentist*_____ *Phone Number*_____
*Date of last dental visit?*_____
Has your child had difficulty with previous dental visits? If yes, Please explain

_____
_____

*How often does your child brush?*_____
*How often does your child floss?*_____
Is your child's water fluoridated? ___ *Yes* ___ *No*
Does your child suck thumb/finger ___*Yes* ___ *No*
Does your child Bite/Chew nails? ___ *Yes* ___ *No*
Does your child grind teeth? ___ *Yes* ___ *No*
Does your child clench jaws? ___ *Yes* ___ *No*
Are you interested in braces? ____ *Yes* ___ *No*

Has the patient begun Puberty, and/or Menstruation (Period)? If so, at what age did this begin?

_____

What are some of the main concerns that you would like the orthodontics to accomplish?

_____

Has the patient ever been evaluated for orthodontic treatment? If so where?

_____

Have the patient's tonsils or adenoids been removed? If so, when and by what doctor?

_____

Does the patient have speech problems? If yes, please explain.
_____

To your knowledge, is the patient missing or extra permanent teeth? Yes or No
Has the Patient ever had an injury to: (select all that apply)

- *Teeth*
- *Mouth*
- *Chin*

Primary Insurance

*Insured's Name*_____
*Relationship*_____
*Birthdate*_____
*SS#*_____
*Employer*_____
*Occupation*_____
*Insurance Company*_____
*Group #*_____
*Member ID #*_____
*Insurance Company Address*_____

_____
*Insurance Company Phone #*_____

Secondary Insurance

*Insured's Name*_____
*Relationship*_____
*Birthdate*_____
*SS#*_____
*Employer*_____
*Occupation*_____
*Insurance Company*_____
*Group #*_____
*Member ID #*_____
*Insurance Company Address*_____

_____
*Insurance Company Phone #*_____

Emergency Contact *In the event of an emergency, whom should we contact other than yourself?* _____

*Relationship*_____ *Phone #*_____

Authorization & Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize the dental staff to perform necessary dental services my child may need.

I also authorize the Dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance carrier to pay directly to the Dentist or Dentist group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf of my dependents.

_____ _____

Signature of patient (or parent/guardian if minor) *Date*

_____ _____

Signature of Dentist *Date*

Office Policies for Summerville Pediatric Dentistry and Orthodontics

Appointment Policy

Your child is unique and special to us, and appointment times are reserved exclusively for each patient. Out of respect to you and your busy schedule, we reserve this specific time slot for your child's care and make every effort to see them at that appointed time. We appreciate your promptness and ask that you not change your appointment unless absolutely necessary. If you do need to change an appointment, we ask that you give us at least 48 hours notice so that we may make the time slot available to another patient. We realize that unexpected things can happen but ask for your assistance with this regard.

Financial Policy

A missed appointment fee of **$25** will be applied to your account with less than 24 hours notice of cancellation. Repeated failure to keep your appointments without notice may result in our office discontinuing treatment for your children. **Initials _____**

In the event that your account is sent to collections for non-payment you will be responsible for that amount plus any fees that the collection agency charges our office to collect. **Initials_____**

All fees for orthodontic dental services are expected to be paid at the time of treatment. For your convenience, we accept Care Credit, Visa, MasterCard, Cash and personal checks.

Dental Insurance

We are glad to assist you in obtaining the maximum benefit from your dental insurance plan. Once your coverage has been verified, we will accept assignment of payment from your insurance company. Please know that insurance will not guarantee payments therefore, any amount that they do not pay will be your responsibility. Most plans only cover a portion of the dental fee, which means you will be responsible for your deductible and the estimated co-payment. Your co-payment is expected to be paid at the time of treatment**. For your convenience, our office will gladly process your insurance on your behalf, understanding that the agreement you have with your insurance company is between you and them.** Therefore, you are responsible for any claims which remain outstanding after 60 days, and a finance charge may be applied to any balance due after this time. Payment will be expected on any such claims, and no further attempt will be made by our office to collect from the insurance company in this event.

The parent or guardian who brings the child to the appointment will be responsible for payment in full. All statements will be sent to this individual. We will not bill a third party other than insurance companies.

If you have any questions regarding this policy, please speak with someone from our office prior to treatment. We will not alter financial arrangements once treatment has been started.

I have read the above financial policy and understand my obligation to Summerville Pediatric Dentistry and Orthodontics.

Please **print** child(ren's) name(s) _____

_____ _____

(Responsible party signature) (DATE)

Acknowledge of Statement of Privacy

I acknowledge that a copy of the Statement of Privacy Practices for the office of Summerville Pediatric Dentistry and Orthodontics is available to me. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices is also posted in the facility.

Summerville Pediatric Dentistry and Orthodontics reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. A copy of the revised Statement of Privacy Practices will be available upon request and will be posted in the facility.

I give my permission to Summerville Pediatric Dentistry and Orthodontics to use my and/or my child's picture on their website for educational purposes.

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

ANY MEMBER OF MY IMMEDIATE FAMILY	YES	NO
SPOUSE ONLY	YES	NO
OTHER (PLEASE SPECIFY):_____	YES	NO

Dr. Katie Bullwinkel, DMD, MS
405 West 5th North St. • Summerville, SC 29483 • (843) 821-6433