Inspire Dental Group New Patient Form - Pediatric

Patient Name: _____ DOB _____

PEDIATRIC PATIENT INFORMATION

Name: _____ Date of Birth: (mm/dd/yyyy) _____

Nickname: _____ Gender (circle one): M F

Address: _____ Relationship to patient: _____

_____ Guardian Home Phone: _____

City: _____ Guardian Cell Phone: _____

State: _____ Zip: _____

Guardian email: _____

ADDITIONAL INFORMATION

Closest Relative NOT living with you: _____ Phone: _____

Emergency Contact Name: _____ Phone: _____

_____ _____

I was referred to Inspire Dental Group by: _____

Is he/she homeschooled? Yes ☐ No ☐

What is the name of the school your child attends? _____

Revised: 09/20/2018

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PARENT/GUARDIAN INFORMATION

INSURANCE INFORMATION- Complete for Primary Dental Insurance (and secondary, if applicable)

PRIMARY

Company Name: _____ Phone: _____

Address: _____ Policy/ Group Number: _____

_____

Insured's Name: _____ Relation: _____

Insured's SSN/ ID #: _____ Date of Birth: (mm/dd/yyyy) _____

Insured's Employer: _____ Phone: _____

Insured's Employer Address: _____

City, State, Zip: _____

SECONDARY

Company Name: _____ Phone: _____

Address: _____ Policy/ Group Number: _____

_____

Insured's Name: _____ Relation: _____

Insured's SSN/ ID #: _____ Date of Birth: (mm/dd/yyyy) _____

Insured's Employer: _____ Phone: _____

Insured's Employer Address: _____

City, State, Zip: _____

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DENTAL INFORMATION:

1. 1. Please check reason(s) for looking for dental care:

   ☐ First time to the dentist ☐ Accident/injury

   ☐ Routine visit ☐ Crowding of teeth

   ☐Changing dental offices ☐Toothache/swelling

   ☐ Other _____

2. 2. Has your child been to a dentist recently? Yes ☐ No ☐

   When was his/hers last visit? _____

   Have x-rays been taking recently? If so, when? _____

   How did your child react to them being taken? _____

3. 3. Which of the following forms of fluoride has your child had?

   ☐Fluoride tablets or in multiple vitamins

   ☐ Drinking water

   ☐Topical application to teeth

   ☐Toothpaste: brand _____.

   ☐ None

4. 4. Has your child's teeth ever been injured? Yes □ No □

   When? _____

   Which teeth? _____

   Were the teeth treated? Yes ☐ No ☐ If yes, how? _____

5. 5. Does your child have any of the following habits?

   ☐ Bottle to bed at night or during nap; what was in the bottle? _____

   ☐Thumb, pacifier or finger sucking

   ☐ Tongue thrusting

   ☐Lip sucking or biting

   ☐ Mouth grinding, or clenching

6. 6. Does your child play any sports? Yes □ No □

   If yes, does he/she wear a mouthguard? Yes ☐ No ☐

MEDICAL INFORMATION

7. Is a physician treating your child now for a specific illness? Yes □ No □

   If yes, for what? _____

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8. Please list all current medications: _____
   _____
   _____
   _____
3. Do you have any allergies? Yes □ No □
   If yes, please list: _____
4. Do you have any other disease, condition or problem not listed above that the doctor should know about?
   Yes ☐ No ☐
5. Has your child ever been hospitalized? Yes □ No □
   If yes for what? _____
6. Has your child ever had an operation? Yes □ No □
   If yes, what for? _____
   Was general anesthesia used? Yes ☐ No ☐
7. Are all your child's immunizations up to date? Yes □ No □
8. Does your child have history of any of the following conditions or diseases? (Circle all that apply)

Bleeding Problems	Headaches	Kidney Disease	Leukemia or Tumors
Heart Disease	Liver Disease	Seizures	Cystic Fibrosis
Cerebral Palsy	Headaches	Kidney Disease	Bleeding Problems
Liver Disease	Jaundice	Asthma	Diabetes
Immune Deficiency	Tuberculosis	Heart murmur	Other:

9. Does your child bruise easily? Yes □ No □
10. Does your child have a history of bleeding (ie: nose bleeds) or prolonged bleeding due to injury, surgery or cuts ext…? Yes □ No □

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Office Guidelines & Consent Form

Welcome to Inspire Dental Group! We are committed to providing superior patient care in a friendly and nurturing environment. At Inspire Dental Group, we realize that every person's financial situation is unique and we have worked very hard to provide a variety of payment options to help you receive the dental care you need to enjoy a healthy and confident smile.

Dental Insurance

We will file any and all forms necessary to see that you receive the full benefits of your coverage. You will be expected to pay your portion on the day of service. Any balances not paid by the insurance company become the patient's responsibility to pay at that time.

Payment Options

☑ Credit Card - For your convenience, we have made arrangements to accept payment by several major credit cards as well as bank debit cards

☑ Long Term-Interest Free Financing - Applications are available and can be quickly processed while you are in the office

☑ Payment Plan - If multiple appointments are required you may divide half of your payment at the start of treatment and the balance upon completion, or setup a recurring credit card charge

Financial Responsibility

☑ Co-pays are due at time of service

☑ There is a $35 charge for all returned checks

☑ There is a $50.00 charge for broken/cancelled non-surgical appointments and a $100 fee for surgical appointments when not allowing a 24-hour notice

☑ Provider reserves the right to charge a collection fee of 30% of the principal balance at the time of write off or dismissal to a third-party collection agency.

Consent

I authorize the doctor to obtain x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis. I will be given the opportunity to discuss my treatment plan and make financial arrangements before treatment is begun. If care is being rendered on a minor child, I authorize the doctor to obtain x-rays and to treat my child as needed. I understand that I will be given the opportunity to discuss the treatment with the doctor and that the parent or guardian who accompanies the child to the office is responsible for payment. Because there is growing evidence as to a periodontal systemic link which increases the risk of heart disease, stroke, uncontrolled diabetes, low birth weight babies and early term pregnancies and because treating periodontal disease has the potential to improve health and possibly even save lives, I am aware that Inspire Dental Group will notify my primary care physician as to my condition if appropriate.

I authorize Inspire Dental Group to discuss my treatment and any financial related matters with the following individuals.

Print Full Name	Relationship
Print Full Name	Relationship

My signature will authorize assignment of insurance benefits to this office. I acknowledge that I have been provided with a copy of the privacy policy of this office:

Print Full Name	Relationship
Print Full Name	Relationship