growing smiles
PEDIATRIC DENTISTRY
Carisse Corns DDS, Board Certified Pediatric Dentist

PATIENT INFORMATION

Name:_____ **Nickname:**_____ **DOB:**_____ **Gender:** ☐ M ☐ F
Street Address:_____ **City:**_____ **State:**_____ **Zip:** _____
Primary number for appointment confirmations: _____ **Email:** _____
Who is accompanying the child today?
Name:_____ **Relation:** ☐ Biological ☐ Adopted ☐ Foster ☐ Nanny ☐ Other: _____

PARENT INFORMATION

GUARDIAN (I)

Name:_____ **Gender:** ☐ M ☐ F
DOB:_____ **SS#:** _____
Marital Status: ☐ Single ☐ Married ☐ Domestic Partnership
☐ Separated ☐ Divorced ☐ Widowed
Home: _____ **Cell:** _____
Email: _____
☐ *Check box if Address is same as patient's listed above.*
Street Address: _____
City:_____ **State:**_____ **Zip:** _____
Employer: _____
Work: _____

GUARDIAN (II)

Name:_____ **Gender:** ☐ M ☐ F
DOB:_____ **SS#:** _____
Marital Status: ☐ Single ☐ Married ☐ Domestic Partnership
☐ Separated ☐ Divorced ☐ Widowed
Home: _____ **Cell:** _____
Email: _____
☐ *Check box if Address is same as patient's listed above.*
Street Address: _____
City:_____ **State:**_____ **Zip:** _____
Employer: _____
Work: _____

Who does the patient live with? : ☐ Guardian 1 & 2 ☐ Guardian 1 ☐ Guardian 2 ☐ Other: _____

DENTAL INSURANCE INFORMATION

PRIMARY COVERAGE

Name of Insured: _____
DOB:_____ **SS#:** _____
Employer: _____
Phone: _____
Insurance Co.: _____
Street Address: _____
City:_____ **State:**_____ **Zip:** _____
Phone: _____
Group/Policy #: _____
I.D. #: _____

SECONDARY COVERAGE

Name of Insured: _____
DOB:_____ **SS#:** _____
Employer: _____
Phone: _____
Insurance Co.: _____
Street Address: _____
City:_____ **State:**_____ **Zip:** _____
Phone: _____
Group or Policy #: _____
I.D. #: _____

REFERRAL INFORMATION

Please share with us how you heard about our office…

☐ Sibling(s):_____
☐ Friend:_____
☐ Pediatrician/Physician:_____
☐ Dentist/Dental Office:_____
☐ Insurance:_____
☐ School/Daycare:_____
☐ Other: _____

☐ Google
☐ Website
☐ Facebook
☐ Angie's List
☐ Print Ad (magazine, newspaper, etc.): _____
☐ Community Event: _____

DENTAL HISTORY

DENTAL CONCERNS

What is the primary reason for today's visit? : ☐ Cleaning ☐ Trauma/Dental Emergency ☐ Consult for Decay (Cavities)

Has your child ever been to the dentist? : ☐ Yes ☐ No **(If Yes) Previous/Present Dentist:** _____

Date Last Exam:_____ **Date Last X-rays:** _____

Describe your child: ☐ Outgoing ☐ Shy ☐ Stubborn ☐ Anxious ☐ Frightened ☐ Age appropriate

How would you expect your child to behave in our office? _____

How may we help make this visit a positive experience for your child? _____

DENTAL HABITS

Does your child currently… (Check all that apply)

☐ Suck Thumb/Finger ☐ Suck/Bite Lips ☐ Bite/Chew Nails ☐ Bottle Feed Until what age? _____

☐ Use Pacifier ☐ Clench/Grind Teeth ☐ Mouth Breather ☐ Breast Feed Until what age? _____

HYGIENE ROUTINE

(Check all that apply)

☐ Fluoride Toothpaste ☐ Consume Fluoridated Water ☐ Brushing by Child:_____/day ☐ Brushing by Parent:_____/day

☐ Fluoride Mouthwash ☐ Dental Floss:_____/week ☐ Snacks between Meals --*Type of snacks*:_____

MEDICAL HISTORY

Are immunizations current? : ☐ Yes ☐ No

Child's physician:_____ **Phone:**_____ **Date Last Exam:** _____

History of Hospitalizations / Operations / Emergency Room Care / Recent Illnesses (explain)**:** _____

_____

Current Medications: _____

Has your child been diagnosed and/or treated for any of the following? (Check all that apply)

☐ Blood Disorder/Anemia
☐ Abnormal Bleeding/Hemophilia
☐ Immune Disorder/HIV/AIDS
☐ Cancer/Tumor/Leukemia
☐ Heart Murmur/Defect/Surgery
☐ Epilepsy/Seizures/Convulsions
☐ Cerebral Palsy
☐ Kidney Problems
☐ Liver Disease/Jaundice/Hepatitis
☐ Diabetes
☐ Stomach/GI Disorders

☐ Premature/Low Birth Weight
☐ Asthma/Reactive Airway Disease
☐ Mental/Cognitive/Social Delay
☐ Congenital Birth Defects
☐ Cleft Lip/Palate
☐ Autism Spectrum
☐ ADD/ADHD
☐ Eating Disorder
☐ Speech Disorder
☐ Vision Problems
☐ Hearing Problems/Deaf

ALLERGIES:

☐ Medication: _____
☐ Food: _____
☐ Seasonal
☐ Hives
☐ Latex
☐ Other (specify): _____
☐ Comments/Details: _____

_____
_____
_____

I affirm the above information I have given is correct to the best of my knowledge. It will be held in confidence and it is my responsibility to inform this office of changes in the child's medical status. I authorize the dental staff to perform all necessary dental treatment the patient may need. I understand Growing Smiles Pediatric Dentistry may use and disclose pertinent health information and dental records to coordinate and manage dental care and related services to one or more health care providers or other dental specialists. I authorize the release of all information necessary to secure benefits such as obtaining reimbursement for services, confirming coverage, bill or collection activities and utilization review. I understand I am responsible for the full balance of the account regardless of my dental benefits and directly assign Growing Smiles Pediatric Dentistry all insurance payments otherwise payable to me. In case of default, I agree to pay all reasonable costs and fees associated with the collection of the account balance, including but not limited to third party collection fees, court filing fees and attorney fees. I affirm my signature represents my agreement to all of the terms mentioned above.

SIGNATURE_____**RELATIONSHIP TO CHILD**_____ **DATE** _____

Growing Smiles Pediatric Dentistry, PC
Carisse Corns, DDS
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ACKNOWLEDGEMENT FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES

(YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT)

I, _____, have received or reviewed a copy of this office's Notice of Privacy Practices.

Please Print Patient Name_____
Parent/Guardian Signature _____
Date _____

Growing Smiles Pediatric Dentistry may leave protected Health Information (including patient's name, diagnosis, date of service) on the following:

- o Answering machine/voicemail: Phone Number_____
- o Text message: Phone Number _____
- o Email for dental appointment: email address:_____
- o Other _____

AUTHORIZATION TO RELEASE INFORMATION

This section is used to obtain authorization to release information regarding you and/or your child covered under the Privacy Act to people other than yourself. I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself and/or my child(ren).

_____

Print Name Relationship Phone Number

_____

Print Name Relationship Phone Number

_____

Print Name Relationship Phone Number

FOR OFFICE USE ONLY

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

- o Individual refused to sign
- o Communications barriers prohibited obtaining the acknowledgement
- o An emergency situation prevented us from obtaining acknowledgement
- o Other (please specify):

_____

FINANCIAL POLICY

Our office is committed to providing you with the highest quality dental care using only the best material and technology available. Our Clinical and Business Teams work closely together to provide a positive environment for visits to our office and assistance with financial requirements. A member of our Business Team will be delighted to discuss our options with you!

Payment Due: The full balance of treatment is due at the time services are rendered. For your convenience we accept cash, check, debit card, most major credits cards and CareCredit®.

Financial Responsibility: The individual bringing the child to our office and authorizing treatment is legally responsible for payment of all charges. We cannot send statements to other persons.

Statements: If you have a balance on your account, we will send you a statement in the mail. It will show your previous balance, any new charges, and any payments or credits applied to your account. We are on a 30-day billing cycle.

Past Due Accounts: Unless prior arrangements have been approved in writing by our office, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the due date printed on the statement. *An interest rate of 1.5% per month may be charged on any balance that goes beyond 60 days.* If necessary, accounts that are not paid within ninety (90) days may be referred to a collection agency. If your account is turned over to collections, the responsible party(ies) will be responsible for all cost of collections, including court costs and attorney fees.

Insurance: We are happy to file dental claims for our families who have dental insurance. In general, we will file claims to any company that will pay us directly and does not restrict coverage to a list of participating providers. *Filing your insurance is not a guarantee of payment*. Please understand the contract for dental insurance is between you and your insurance company. Any dispute of coverage needs to be handled through the insurance company directly by you. Please understand the parent or guardian has the final responsibility for payment of any services rendered. Our doctor recommends treatment based on your child's needs, not on what insurance will pay. Therefore, we will do everything possible to maximize your benefits.

Your complete insurance information/card must be presented and updated as necessary, prior to rendering services . Most benefits will be verified before billing your insurance company. Accurate and complete insurance information must be provided so we may assist you in filing your claim promptly.

In the event that your insurance has not paid your account within 45 days, the balance may be transferred to your account. We reserve the right to discontinue or refuse to file a claim.

We are a participating provider with the following companies: **Delta Dental Premier**.

Other Insurances: Some insurance plans will make payments directly to the member. For these instances payment in full will be collected on the day that treatment is provided.

Required Payments: At treatment visits, we collect a percentage of the total cost of treatment, determined by an **ESTIMATION** of what your insurance will cover, plus any deductible required by your insurance. In the event of underpayment, we will send you a statement in the mail. In the event of overpayment on your part, you will be reimbursed by check in the mail.

Divorce/Separation: The parent or guardian who brings the child for their initial visit is responsible for payment independent of what a divorce decree or custody arrangement may state. Reimbursement must be made between the divorced parents. We will not intervene.

Returned Checks: There is a $35.00 fee for any checks returned by the bank.

CareCredit®: A convenient alternative to credit cards, cash or checks, CareCredit® is a health care card that is exclusively utilized for dental and medical services. They offer flexible payment options that fit your timetable and budget. For additional information, contact us or visit

www.carecredit.com.

Initial: _____

APPOINTMENT POLICY

Children tend to do better in the dental office when they are not tired. Therefore, we schedule morning appointments, especially for pre-school or nervous children. For many children, just a simple filling at the end of a long day, when they are tired, can seem like a major ordeal. Please keep in mind, one of our goals is providing dentistry that is as pleasant as possible for your child. Also keep in mind a dental appointment is an excused absence from school.

A parent or legal guardian (with official documentation) must be present in the office during the initial examination and/or any restorative appointments.

When we schedule an appointment for your child, that time is reserved solely for your child. We do not double book and we take pride in the fact because we value your time, as much as we hope you value ours. We make every effort to see your child at the time scheduled. For this reason, it is very important that you have your child in the office at the time scheduled. If you are more than 10 minutes late, it may be necessary to reschedule your child's visit.

First Visit: Please plan to arrive 15 minutes before your scheduled appointment. This will allow time for parking, to complete any additional paperwork, present your insurance card and see your child on time.

Cancelling or Rescheduling: To avoid missed appointment fees we request cancellations be made 48 hours prior to the appointment. In doing so, this appointment time may then be made available to another family. A charge of $50.00 will be applied for two broken appointments. A broken appointment is considered a "no show" or cancelling an appointment with less than 48 hours notice.

Effective Date: Once you have signed this policy, you agree to all the terms and conditions contained herein and the agreement will be in full force and effect.

Initial: _____

I have read the above policies and understand my obligations with Growing Smiles Pediatric Dentistry for my child's dental care. I affirm my signature represents my agreement to all of the terms mentioned above.

Guardian Print Name: _____

Guardian Signature: _____ **Date:** _____