Southern Maine Pediatric Dentistry

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Patient Information

Patient _____ Date_____

Name child would like to be called _____ Date of Birth _____ Age_____ Sex_____

Address_____ City _____ Zip_____

Home Phone_____Cellular Phone _____ Email _____

School_____ Grade _____

Names and ages of other children in family _____

1. Parent/Guardian _____ Employer_____

Social Security #_____ Work Phone_____

2. Parent/Guardian _____ Employee_____

Social Security#_____ Work Phone _____

Who has legal custody of patient?_____

Person responsible for payment of account?_____ Date of Birth_____

Whom may we thank for referring you to us?_____

What is the reason for your child's dental visit?_____

Financial information

Please be aware that the parent bringing the child to our office is responsible for payment of all charges. We cannot send statements to other persons. We ask that you pay the cost of the initial examination and any necessary dental x-rays on the day of that appointment. Please understand that financial arrangements are made directly with you. For the convenience of our patients, the following outlines our financial policies:

1. Payment is due in full for each appointment as services are rendered. We accept cash, personal checks, Mastercard, Visa, American Express and Discover. A charge of $30.00 will be assessed on checks returned for any reason. You will be responsible for payment of all costs and fees incurred, including attorney's fees, should collection efforts be made in order to fulfill a debt.
2. Dental Insurance: It is our policy to not accept assignment of benefits for dental insurance other than Delta Dental PPO. The type of plan chosen by you and/or your employer determines your insurance benefit s. As such, we have no say in the selection of your insurance company, we have no control over the terms of your contract, the method of reimbursement or the determination of your insurance benefits. Any reimbursements by your insurance company other than those we directly participate with should be made directly to you according to the terms of your contract with them.
3. Pre-treatment Authorization: Some insurance companies recommend an estimate of the work to be done and the fees to be charged before determining their benefits to you. If so, we will provide you with the pre-treatment fee estimate. In this case, it will be up to you to determine if you wish to proceed with the treatment before the insurance benefit is determined.
4. Fillings: Our dental material of choice is a white (composite resin) filling. Please be aware that your insurance company may not pay for a resin filling at the same level as a silver (amalgam filling). The co-payment is your responsibility. In some cases, the dentist may recommend placing a silver crown instead of a resin filling.
5. Nitrous Oxide (Laughing Gas): Nitrous oxide is not always covered by dental ins. We thank you for your payment the date of service.
6. Appliances: The entire cost of the appliance must be paid on the day your child's impressions are taken. This is necessary because our Office must pay the laboratory bills when appliances are ordered, not when they are completed.
7. Emergency Treatment: All emergency treatment must be paid in full at the time the service is rendered.
8. Cancelation Policy: We require 24 hours' notice if you wish to cancel, 48 hours for siblings booked together on the same day. After your second failed appointment, you will be assessed a failed appointment fee and/or be dismissed from the practice.

Please remember, even if you have insurance coverage, you are responsible for payment of your account. Please realize that your insurance coverage is a relationship between you, the insured patient, and your insurance company. Your understanding and cooperation with this matter is greatly appreciated. You are helping us keep our overhead expenses, in the form of direct and labor costs, down. In addition, you are helping keep your fees as low as possible. Past due accounts are subject to a monthly service charge and will be turned over for collection by an outside agency.

You agree to pay any and all attorney fees associated with the collection of monies due. I have read and understand my obligation.

Signature: _____ Date: _____

Insurance Information

Primary Policy Holder: Name: _____

SS# _____

Insurance Carrier: Name: _____

Group/Policy #: _____

Employer of Insured: Name: _____

Patient ID# _____

I authorize my insurance to pay directly to my dentist if my insurance plan is Delta Dental PPO or Mainecare*. If I am covered by any other plan, I will pay in full when services are rendered. I understand that all policies are different and I am responsible for knowing my plan provisions. I understand I will be responsible for all co-payment, deductible, and rejected charges.*

Signature: _____ Date: _____

Mainecare

Does your child have Mainecare or Medicaid? ☐ Yes ☐ No

Signature: _____ Date: _____

Notice of Privacy Practices HIPAA

Disclosure of Health Information

We use and disclose health information about your child for treatment, payment, and healthcare operations. We may disclose your child's information to a healthcare provider treating him/her. You may give us written authorization to disclose health information to anyone for any purpose. This may be revoked in writing. We need written permission before any health information is disclosed to any caregivers besides the child's legal guardian. In the event of an emergency we will disclose information based on our professional judgment. We may use your child's health information to obtain payment for services. We will not use health information for marketing purposes. If we suspect a possible victim of abuse, neglect, or domestic violence we may disclose your child's health information as the law requires. We may disclose your child's health information to provide you with appointment reminders or treatment recommendations (such as voicemails, texts, postcards, emails or letters).

Patients Rights

Access: You have the right to look at or get copies of your health information. If you request copies we will charge you for each page for staff time to locate and copy the information, and postage if you want the copies mailed.
Restriction: You have the right to request that we place additional restrictions on our use or disclosure of information.
Alternative Communication: You have the right to request that we communicate with you about your health history in alternative means
Amendment: You have the right to request that we amend your health information. We may deny your request under certain circumstances.

Questions and Complaints

If you are concerned that we may have violated your privacy rights, or disagree with a decision we made about access to your health information or in response to a request to amend or restrict the disclosure of health information you may submit a written complaint to the US Department of Health and Human Services. If you have any further questions about our privacy practices please contact Dr. Wignall.

Signature: _____ Date: _____

MEDICAL HISTORY

☐Yes ☐ No Is your child in good health? Name of child's physician_____Phone _____

Date of last physical exam _____

☐Yes ☐No Has your child ever had a health problem? _____

☐ Yes ☐ No Are your child's immunizations up-to-date?_____

☐Yes ☐ No Has your child had any operations? _____

☐ Yes ☐ No Is your child currently taking any medications? Please give medication, doses and reason ._____

_____

Please check if your child has been diagnosed and/or treated for any of the following:

☐AIDS/HIV	☐ Diabetes	☐Hepatitis	☐ Tuberculosis	☐ Mental delays
☐ Epilepsy / Seizures	☐Kidney Disease	☐ Physical delays	☐ Asthma	☐ Excessive Bleeding
☐ Liver Disease	☐Congenital birth defects	☐ Cerebral palsy	☐ Social delays	☐ Blood Disorder Transfusion
☐ Frequent Headaches	☐Rheumatic fever	☐ Cleft lip / palate	☐ Speech / hearing problems	☐Cancer / Tumors
☐ Heart Condition / Murmur	☐Stomach / GI disease	☐ Frequent infections	☐ Anemia	☐Other
☐ Autism	☐ ADD/ ADHD	☐ Asperger's	☐ Allergies	

Please elaborate on any items checked_____

_____

Was your child: ☐breast fed ☐bottle fed At what age was it stopped?_____

OFFICE USE ONLY

I verbally reviewed the medical and dental information above with the parent / guardian and patient named herein
Initials _____Date: _____

Comments

FLUORIDE HISTORY

☐ Yes ☐No Is your home water supply fluoridated?
☐ Yes ☐No Does your child use fluoride toothpaste?
☐ Yes ☐ No Does your child use a fluoride supplement? *Dose:* ☐*0.25mg* ☐ *0.50mg*☐*1.00mg*
☐ Yes ☐ No Do you give your child any other forms of fl uoride?
What? _____ Amount?_____

DENTAL HISTORY

☐ Yes ☐ No Has your child ever been to the dentist? Date of Last Dental Visit? _____
Name of dentist:_____
☐ Yes ☐ No Has your child ever had dental x-rays? Date:_____
☐ Yes ☐ No Do you think your child will react well to dental treatment? Explain: _____
☐ Yes ☐ No Does your child suck a finger, thumb or pacifier? Ages when?_____
☐ Yes ☐ No Does your child brush his/her teeth? How often?_____
☐ Yes ☐ No Do you or your child use dental floss? How often?_____
☐ Yes ☐ No Does your child have snacks between meals? _____
☐ Yes ☐ No Have your child's teeth ever been injured? When? Which? _____
Treatment?_____
☐ Yes ☐ No Does your child's jaw make noise and is pain associated with the sounds?_____

Please check if your child is having problems with any of the following:

☐ Cavities	☐Toothache	☐Sensitive teeth
☐ Surgical Mouth Treatment	☐ Gum Infections	☐ Color of teeth
☐ Orthodontics	☐ Jaw Sounds	☐ Other

Comments: _____
_____
_____

Consent For Dental Treatment

I request and authorize Dr. Wignall and her staff to examine and provide my child with comprehensive dental treatment including fillings, crowns, extractions and nitrous oxide, if required. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Wignall to diagnose and/or treat my child's dental condition. I will allow photographs to be taken of my child and/or my child's teeth for diagnostic or educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr. Wignall will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone. I agree that I will remain on site during this child's dental appointment. I understand that I will be responsible for any charges incurred on this child for dental treatment.

Signature: _____ Date: _____