



75 John Roberts Road
 Suite 10B
 South Portland, Maine 04106
 Tel: 207-773-3111
 Fax: 207-773-3133

PATIENT INFORMATION

Patient _____ Date _____
 Address _____ City _____ Zip _____
 Home Phone _____ Cellular Phone _____ Email _____
 Relationship to Child? _____
 Who has legal custody of patient? _____

DENTAL INSURANCE

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: _____

HEALTH HISTORY

Yes No Is your child in good health? Name of child's physician _____ Phone _____
 Date of last physical exam _____

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

Yes No Is your child allergic to anything? _____

Yes No Any hospitalizations/Emergency Room Visits? Explain _____

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

- | | | | | |
|---|---|---|---|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Mental delays |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy / Seizures | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Congenital birth defects | <input type="checkbox"/> Physical delays |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Cerebral palsy | <input type="checkbox"/> Social delays |
| <input type="checkbox"/> Blood Disorder Transfusion | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Cleft lip / palate | <input type="checkbox"/> Speech / hearing problems |
| <input type="checkbox"/> Cancer / Tumors | <input type="checkbox"/> Heart Condition / Murmur | <input type="checkbox"/> Stomach / GI disease | <input type="checkbox"/> Frequent infections | <input type="checkbox"/> Other |

Please elaborate on any items checked _____

Any dental concerns you would like to discuss on this visit? _____

FINANCIAL POLICY

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 benefits. 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 insurance. 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.

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: _____