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Arrowhead Lakes Dentistry

Welcome

Thank you for giving us the opportunity to serve your child's dental needs. Please fill out this form completely.

Child 's Name: _____ (Last / First / MI)

❑ Male ❑ Female

Child's preferred name: _____

Birthdate ____/____/____ SS#: _____

Email: _____

Home Address: _____ (Street / Apt No.)

_____ (City / State / Zip)

Home # (____) _____ School Grade: _____

Full Time Student? NO Yes -- School Attending: _____

Who is accompanying the child today?

Name: _____ Relation: _____

Do you have legal custody of this child? ❑ Yes ❑ No

Where & when are best times to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

Parent's Information

❑ Mother ❑ Step Mother ❑ guardian

Name: _____ Birthdate ____/____/____

Work # (____) _____ Home # (____) _____

Cell # (____) _____

Employer: _____

SS#: _____ Driver Lic # _____

❑ Father ❑ Step Father ❑ guardian

Name: _____ Birthdate ____/____/____

Work # (____) _____ Home # (____) _____

Cell # (____) _____

Employer: _____

SS#: _____ Driver Lic # _____

Neighbor or Relative not living with you:

Name: _____ Realtion: _____

Work # (____) _____ Home # (____) _____

Address: _____ (Street / Apt No.)

_____ (City / State / Zip)

Today's Date ____/____/____

Person Responsible for Account: ❑Father ❑ Mother

❑ Other: _____

Work # (____) _____ Home # (____) _____

Billing Address _____ (Street / Apt. No.)

_____ (City / State / Zip)

Relation: _____ SS#: _____

Birthdate: ____/____/____ Driver Lic #: _____

Employer: _____

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____ (Street)

_____ (City / State / Zip)

Insurance Co. Phone # (_____) _____

Group # (Plan, Local or Policy#) _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____/____/____ Insured ID# _____

Insured's Employer: _____

Employer's Address: _____ (Street)

_____ (City / State / Zip)

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____ (Street)

_____ (City / State / Zip)

Insurance Co. Phone # (_____) _____

Group # (Plan, Local or Policy#) _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____/____/____ Insured ID# _____

Insured's Employer: _____

Employer's Address: _____ (Street)

_____ (City / State / Zip)

Has your child ever had any of the following diseases or medical problems? (Please circle the option that applies)

Yes No Abnormal Bleeding
Yes No ADD / ADHD
Yes No Allergies
Yes No Anemia
YES No Any Hospital Stays
Yes No Any Operations
Yes No Artificial Joints
Yes No Asthma
Yes No Blood Disease
Yes No Breathing Problems
Yes No Cancer-Chemotherapy
Yes No Circulatory Problems
Yes No Colitis
Yes No Congenital Heart Disease
Yes No Cosmetic Surgery
Yes No Diabetes
Yes No Emphysema
Yes No Epilepsy
Yes No Fainting spells
Yes No GERD
Yes No Handicaps / disabilities
Yes No Hearing Impairment
Yes No Heart Disease
Yes No Hepatitis
Yes No HIV+ or AIDS
Yes No Injury to Head or Face
Yes No Kidney Problems
Yes No Liver Disease
Yes No Psychiatric Problems
Yes No Radiation Therapy
Yes No Rheumatic Fever
Yes No Seizures
Yes No Sinus Problems
Yes No Thyroid Problems
Yes No Tuberculosis (TB)

Please list any serious medical conditions that your child have ever had or explain any "yes" answers from the list above: _____

_____

_____

Is your child allergic or had an adverse reaction to any of the following?

Yes No Aspirin
Yes No codeine
Yes No Dental Anesthetics
Yes No Erythromycin
Yes No Jewelry / Metals
Yes No Latex
Yes No Penicillin
Yes No Tetracycline

Please list any other drugs or materials that your child is allergic or has had an adverse reaction to: _____

_____

Is your child taking any prescription drug, over-the-counter medication, or supplement?

Please list each one: _____

_____

__ _____

Your child's current physical health is (please circle):

Good Fair Poor

Yes No Has a physician recommended that your child needs to take Antibiotics before dental treatment?

Yes No Is your child currently under a physician's care?

If so, please explain: _____

_____

Physician's Name: _____

Phone #: (____) _____

Dental History

Why did you bring your child to the dentist today? _____

_____

_____

How would you rate your child's current dental Health?

Good Fair Poor

Date of last dental visit: _____

Concerning your child:

Yes No currently in pain?
Yes No gums ever bleed?
Yes No teeth sensitive to hot, cold, or chewing?
Yes No any complication with any previous dental work?
Yes No ever had any head, neck, or jaw injury?
Yes No Ever had orthodontic treatment (braces)?
Yes No Ever had any oral surgery?
Yes No humb sucking or other oral habit?
Yes No Mouth breather?
Yes No like to change anything about the smile?

If so, please explain: _____

How many times a day do you brush your teeth? _____

How many times a week do you Floss? _____

Is there anything else you want us to know about your child's medical and dental Health?_____

_____

_____

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that My child may need during diagnosis and treatment with my informed consent.

_____ _____

signature of Parent or Guardian Date

Office Policy

In order to serve you better, please be aware of the following office policies:

It is mandatory to have a copy of your driver's license or other government-issued identification and any insurance cards. Please present them when you check in at your first visit, we will copy the cards and return them to you.

All fees, insurance deductibles, and/or insurance co-payments are due at the time of service unless prior arrangements have been made with the office management.

We offer to bill your insurance carrier for you as long as we have complete billing information and your signature on file. Therefore, your signature below acknowledges the following:

- you assign directly to Arrowhead Lakes Dentistry, PC all insurance benefits otherwise payable to you,
- you understand that you are responsible for payment of services rendered,
- you understand that you are responsible for paying any co-payment and deductible that your insurance does not cover,
- you authorize Arrowhead Lakes Dentistry, PC to release all information necessary to secure the payment of benefits, and
- you authorize the use of this signature on all your insurance submissions, whether manual or electronic.

It is important to know that regardless of your insurance coverage, all fees are ultimately your responsibility. We attempt to provide for you accurate estimates of insurance benefits: however, you are responsible for all treatment fees regardless the accuracy of our estimates or the estimates of the insurance company.

Any unpaid balances over 90 days old will incur a finance charge of 1.50% per month. A $25.00 fee is charged for all returned checks. Any collection and/or legal fees will be your responsibility. Costs of collection include, without limitation, all fees charged by a collection agency as well as attorney's fees, small claims court costs, and any other expenses incurred in an effort to collect the account. When appropriate, credit bureau reports may be obtained.

Please notify us if a full set of dental xrays or a panoramic xray have been taken within the last 3 years. Most insurance companies will not pay for another set within a 3 to 5 year period. Since your authorization would be necessary, it is your responsibility to obtain readable xrays from previous dental offices. Our office does not use the amalgam (silver) fillings. We provide the composite resin, tooth-colored fillings. Some insurance companies will only allow a percentage payment towards the silver.

We will try to reach you the day before your appointment to confirm the appointment. However, the confirmation is a courtesy and you are responsible to keep your appointment whether or not you were contacted. Please cancel any appointment 24 hours prior to the appointment. There is a $30.00 per hour charge for all missed dental appointments without 24 hours notice of cancellation.

_____ _____

Signature of Parent or Guardian Date