Horne & Miner
PEDIATRIC DENTISTRY

PATIENT INFORMATION

Child's First Name:_____Middle Name:_____Last Name:_____

Name Your Child Goes By:_____Date of Birth:_____Gender: ( )Male (Female

Person Responsible for Account: ( ) Mother ( ) Father ( ) Legal Guardian ( )Other _____

Address: _____City: _____State: _____Zip Code: _____

Home Phone:_____Cell Phone:_____Email: _____

Parent's Marital Status: ( ) Married ( ) Single ( ) Widowed ( ) Divorced ( )Separated

Who Is Primarily Responsible for the Child: ( )Mother (Father (Legal Guardian ( )Other: _____

Name of MOTHER OR Legal Guardian:_____Employer: _____

Work Phone:_____Date of Birth:_____Social Security#: _____

Name of FATHER:_____Employer: _____

Work Phone:_____Date of Birth:_____Social Security#:_____

EMERGENCY CONTACT:_____Relationship to Child:_____Phone#: _____

What Phone # Do You Prefer We Call for Appointment Reminders/Confirmation: _____

Does The Patient Have Siblings That Are Patients Of Our Office:If So, List Names and Birthdates: _____

Is Patient Covered by Medicaid or CHIP? If So, What Is Their Member ID#: _____

Is Patient Covered by Dental Insurance? _____If So, What Is The Name Of The Policy Holder: _____

Insurance Name _____

Policy Holders Address: _____

Is Patient Covered by Secondary Dental Insurance? _____ If So, What Is The Name Of The Policy Holder: _____

Insurance Name _____Policy Holders Address: _____

Who Is Accompanying The Child Today? _____Do You Have Legal Custody Of The Child? ( )Yes ( )No

Whom May We Thank For Referring You To Our Office? _____

Is There Anything You Can Tell Us About Your Child To Help Us "Connect" With Them (Hobbies, Interests, Favorite Character, etc.)?

Does your child participate in any recreational activities? ( ) Yes ( ) No If Yes, please list:

Because your child is a minor, it becomes necessary that a signed consent is obtained from a parent or legal guardian prior to any and all necessary dental service. The signature of a parent or legal guardian below, authorizes the completion of all agreed upon dental services and the use of those methods appropriate thereto. This consent shall remain in full force and effect until cancelled by either party. Furthermore, I will be responsible for any bill incurred on this child for dental treatment.

Parent/Legal Guardian Signature _____ Date _____

Parent/Legal Guardian Printed Name _____Relationship to Patient_____

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Patient Name: _____ Date of Birth: _____

HEALTH HISTORY

Name of Child's Pediatrician/Physician:_____Phone # of Pediatrician/Physician: _____

Please Check If Your Child Has Ever Been Diagnosed or Treated For Any Of The Following:

	Yes	No		Yes	No
Asthma	( )	( )	Down's Syndrome	( )	( )
ADHD/ADD	( )	( )	Cerebral Palsy	( )	( )
Autism	( )	( )	Cleft Lip/Palate	( )	( )
Anemia/Bleeding Disorder	( )	( )	HIV/Aids	( )	( )
Epilepsy/Seizures	( )	( )	Diabetes	( )	( )
Seasonal Allergies	( )	( )	Hepatitis (if so, tYPe—)	( )	( )
Mental Delays	( )	( )	Heart Disease	( )	( )
Personality/Social Disorder	( )	( )	Heart Murmur	( )	( )
Neurological Disorder	( )	( )	Cancer/Tumors	( )	( )
Eating Disorder	( )	( )	Liver Disease	( )	( )
Acid Reflux/GERD	( )	( )	Kidney Disease	( )	( )
Physical Delays	( )	( )	Visual Impairment	( )	( )
Speech Impairment	( )	( )	Hearing Impairment	( )	( )
Thyroid Disorder	( )	( )	High Blood Pressure	( )	( )
Other	( )	( )			

If you answered YES to any of the above, please explain:

_____

_____

Is your child currently taking any medication? ( ) No ( ) Yes If Yes, please list below.

Drug Name	Reason Taken

Is your child allergic to any medications? ( ) Yes ( ) No If Yes, please list: _____

Is Your Child Allergic to Latex? ( )Yes ( )No

DENTAL HISTORY

Is This Your Child's First Dental Visit? ( )Yes ( )No

Is Your Child Experiencing Any Dental Pain or Discomfort? ( )Yes ( )No If YES, Please Explain: _____

Do You Have Any Concerns Regarding Your Child's Teeth? ( )Yes ( )No If YES, Please Explain: _____

Is Your Child A Thumbsucker? ( )Yes ( )No Does Your Child Take A Pacifier? ( )Yes ( ) No Is Your Child Currently Taking A Bottle Or Breast Feeding? ( )Yes ( )No

Does Your Child Have Potential Fears About The Dentist? ( )Yes ( )No If YES, Please Explain: _____

_____

Has Your Child Suffered Any Injuries To Their Mouth Or Teeth? ? ( )Yes ( )No If YES, Please Explain: _____

_____

Parent/Legal Guardian Signature _____ _____ Date _____

Parent/Legal Guardian Printed Name _____Relationship To Patient _____

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SCHEDULING GUIDELINES & RESPONSIBLITIES

The Doctors and Staff at our office have put much effort and time into designing our scheduling system to provide your child with excellence in Pediatric Dental Care. In the course of designing our schedule it has become necessary to make our patient's parents responsible for certain aspects of their appointments. We strive to be considerate of our patients when scheduling, we ask that our patients be considerate of our schedule too.

As a courtesy to our patients we provide a confirmation call through the use of an automated phone calling system. At times though, technical reasons may keep this system from confirming appointments. For that reason, we require that our patients be responsible for their appointment time.

We understand that time and unforeseen occurrence befall all people, but whenever possible we require a 24-hour notice to change an appointment.

Missed appointments are wasted time where the doctors could have provided care for someone else. Due to the number of patients that we desire to see it has become necessary to implement the following policy. During a series of appointments, if the patient misses 2 appointments without calling in advance, it will be necessary to dismiss the patient from our practice. And after that time we will only see the patient on an emergency basis for the following 30 days.

We appreciate your cooperation in this area. By signing this form, you agree to adhere as closely as possible to our appointment requirements.

Thank you and we look forward to serving your child's dental needs.

SIGN **DATE**

Patient Name: _____ Date of Birth: _____

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FINANCIAL POLICY

At our office, we plan to work together to achieve one common goal and that is for your kids to grow up feeling confident about their smiles. We promise to properly communicate all that is needed to obtain that goal, including our financial policy.

Payment in full for office visits and treatment is expected at the time service is rendered, unless prior arrangements are made or you have insurance. Patients with dental insurance must provide our office with accurate dental insurance information in advance.

INSURANCE

We can file most major PPO dental insurances. In the event we are not a provider for your dental insurance, we will file the claims as an out-of-network provider for you. This means that at the time of service, you are required to pay the difference of what the insurance company is estimating not to pay. This includes deductibles, co-payments and any service performed that is not covered by your policy. If any balance is remaining after insurance has paid, a statement will be sent to you requesting that you pay the remaining balance. In some instances, some insurance companies will not reimburse our office. This will require you to be responsible for the full cost of each visit at the time service is provided.

By signing this form, I am authorizing assignment of benefits and payment from my child's dental insurance directly to Horne & Miner Pediatric Dentistry. I am also authorizing Horne & Miner Pediatric Dentistry to furnish my insurance company with any and all information that may be contained in my child's medical and dental records that relates to procedures performed in the office of Horne & Miner Pediatric Dentistry.

Again most insurance companies do not tell us EXACTLY what they will pay, so we are giving you our best estimate.

TREATMENT PLANS

Prior to beginning and completing any restorative treatment, we will provide you with the best cost estimate of our total fee, your estimated insurance coverage, and your estimated out-of-pocket fees. Please remember, these are only estimates and may change during the course of treatment. In order to provide your child with the best treatment option, changes in treatment plans may occur. You will be notified prior to any treatment plan modification along with any fee change incurred.

For your convenience, we accept cash, personal checks, debit cards, and most major credit cards. If a check is returned for insufficient funds, a $35 charge will be applied to your account. We cannot accept responsibility for negotiating a disputed claim and allow a maximum for 30 days from the date service is rendered for your insurance company to clear account balances. If your insurance company does not pay within 30 days from the date service is rendered, you will be responsible for full payment. A late fee of 2% of the balance will be charged per month to unpaid balances over 60 days past due. If after 90 days from the date of service and attempts have been made to collect any outstanding balances, parents/legal guardians not fulfilling their financial obligation will be sent to collections, which you will be responsible for any collection and legal fees.

Any questions you have may be directed to our office and we will be happy to assist you! We are looking forward to beginning a wonderful relationship with you and your child.

I have read and understand the above financial policy set forth by Horne & Miner Pediatric Dentistry and agree to be held responsible for the terms and conditions mentioned above.

Signature of parent/legal guardian _____Date _____

Print Name _____Relationship to patient _____