Children's Dental of Winona

Date _____

******ACCEPTING NEW PATIENTS UNDER AGE 17******
TO RECEIVE AN APPOINTMENT, ALL SECTIONS NEED TO BE ANSWERED OR MARKED N/A

Patient Name _____ Nickname _____
Birthdate _____Age _____ Gender: ☐ Male ☐ Female ☐ Other ☐ Decline to answer
Home Address _____
City_____State_____Zip_____ Primary Phone_____
Siblings (first and last names) _____
Pets/Hobbies/Interests _____ Primary Language Spoken _____
Interpreter Name (if used) _____Interpreter Phone _____
Who is accompanying the child for appointments?
Name _____Phone _____
Relationship _____ Do you have legal custody of this child? ☐ Yes ☐ No
(If not legal guardian, additional paperwork required)
How did you hear about our office? _____

Mother's Information
Relationship: ☐ Birth Mother ☐ Stepmother
☐ Adoptive Mother ☐ Foster Mother ☐ Guardian
Name _____
Birthdate __/__/__
Address (if different from patient)
_____
_____
Employer: _____
Home # _____Cell # _____
Work # _____ Ext. _____

Father's Information
Relationship: ☐ Birth Father ☐ Stepfather
☐ Adoptive Father ☐ Foster Father ☐ Guardian
Name _____
Birthdate __/__/__
Address (if different from patient)
_____
_____
Employer : _____
Home # _____ Cell # _____
Work # _____ Ext. _____

Emergency Contact Information
Name of nearest relative not living with you _____
Relationship _____ Phone _____

Government Assistance Insurance Information ☐ YES ☐ NO If yes, Select Plan and Enter ID
☐ Blue Plus or Minnesota Medical Assistance Enter Medicaid ID # _____
☐ Ucare or South County Health Alliance Enter PMI # _____

Private or Employer Based <u>Dental</u> Insurance Information ☐ YES ☐ NO If yes, Enter Plan Information
Primary
Policy Holder's Name _____Insured's Soc. Sec. # or ID # _____
Employer _____ Insurance Group #_____
Dental Insurance Company Name _____Insurance Phone # _____
Insurance Co. Address _____
Does the patient have dual dental coverage? ☐YES ☐NO If Yes, Please complete the section below
Secondary
Policy Holder's Name _____ Insured's Soc. Sec. # or ID # _____
Employer _____Insurance Group #_____
Dental Insurance Company Name _____Insurance Phone#_____
Insurance Co. Address _____

COMPREHENSIVE MEDICAL HISTORY

Name of Medical Doctor:_____Facility Name_____City/State:_____

List all medications that your child is taking:

_____ _____ _____
_____ _____ _____
_____ _____ _____

Is your child allergic to any of the following?

Y	N		Y	N	
☐	☐	Anesthetic	☐	☐	Silver
☐	☐	Tylenol	☐	☐	Latex
☐	☐	Nickel	☐	☐	Penicillin
☐	☐	Ibuprofen	☐	☐	Other _____

Does your child have any of the following medical conditions?

Y	N		Y	N	
☐	☐	Asthma or any Breathing/Lung related concerns	☐	☐	Kidney, Bladder, or Liver Disease
☐	☐	Blood Disorder or Anemia	☐	☐	Sleep Concerns, Snoring, Restless Sleep
☐	☐	Condition that requires Chemo or Radiation	☐	☐	Thyroid or Metabolic Disorder
☐	☐	Diabetes	☐	☐	Autism Spectrum or Other Sensory Disorder
☐	☐	Heart Murmur	☐	☐	Frequent Headaches, Migraines, or Sinus Problems
☐	☐	Heart Condition	☐	☐	Stomach, Intestinal, Eating or Weight Concerns
☐	☐	High Blood Pressure	☐	☐	Developmental Delay or Disorder
☐	☐	Muscle, Bone or Joint Problems	☐	☐	Hearing or Sight Impairment
☐	☐	Any Potentially Transmissible Disease (ie. HIV, MRSA, TB, etc.)	☐	☐	Behavioral, Emotional, or Psychiatric Concerns (i.e. ADHD)
☐	☐	Frequent Ear Infection History	☐	☐	Neurological Concerns or Seizure Disorder

Is there any other significant medical history pertaining to your child or his/her family that the dentist should be told about? If yes, please describe:

_____
_____

DENTAL HISTORY

Y	N		Y	N	
☐	☐	Inherited dental conditions	☐	☐	Jaw joint problems (popping, clicking, pain, etc)
☐	☐	Mouth sores or fever blisters	☐	☐	History of excessive gagging or vomiting
☐	☐	Bad breath	☐	☐	Does your child brush their own teeth
☐	☐	Bleeding gums	☐	☐	Are your child's teeth brushed more than once a day
☐	☐	Cavities, cracks or holes in teeth	☐	☐	Is your child's brushing less than once a day or irregular
☐	☐	Toothache	☐	☐	Does your child floss or attempt to floss their own teeth
☐	☐	Injury to teeth, mouth or jaw	☐	☐	Does someone help your child floss
☐	☐	Does your child use fluoridated toothpaste	☐	☐	Does your child receive fluoride treatment at school or at their doctor's office
☐	☐	Clenching or grinding concern	☐	☐	Does your child take prescribed fluoride supplements
☐	☐	Is your drinking water from city or tap	☐	☐	Does your child mainly drink bottled or filtered water
☐	☐	Do you have a well for drinking water source	☐	☐	Any current sucking habits (pacifier, finger or objects like a blanket)
☐	☐	Is your child a grazer or a picky eater			
☐	☐	Does your child eat a lot of sweets /drink a lot of juice			

☐ ☐ Any tobacco use if so, what kind and how much _____
☐ ☐ Any unusual reaction to dental injections if so, what kind _____

☐ ☐ Is this your child's first visit to the dentist, if no complete below *

*Name/location of previous dental office_____

Appointments

******If a legal guardian/parent will not accompany the patient for an appointment, contact our office for the required authorization form******

● Cancellations

If you find that you must change your appointment, we require a minimum of 48 hours' notice so that we may make every effort to accommodate other patients. If proper notice is not received, a fee may be charged for every appointment canceled. Once an appointment is made, please remember this time is reserved for the patient. Families who miss two or more appointments without proper notification, at least 48 business hours, may be dismissed from the practice.

●Late Arrival

Your appointment was scheduled to allow for enough time to provide the best service for you. Patients who arrive for their appointments more than 10 minutes late may have to be rescheduled. If you need to be rescheduled, you may be charged a fee.

Financial

●Payment

The parent or guardian who accompanies the child is responsible for payment.

Payment is expected at time of service. If you have insurance, you may be expected to make an estimated payment for services not covered by your insurance plan. For your convenience, we offer several payment options:

*Cash *Personal Check * MasterCard, Visa, Discover, and American Express

●Insurance

Dental insurance is intended to cover some, but not all of the cost of your dental care. Most plans include coinsurance provisions, a deductible, and certain other expenses which must be paid by the patient at the time of services. Reimbursement amounts are not, and never have been, a guideline for quality care. As a courtesy to our patients, we can file most insurance claims. If you would like us to file for you, please be sure to bring all insurance plan information with you on your first visit. Our goal is to ensure that you receive the maximum benefits to which you are entitled. Insurance PPO's and HMO's and office participation are constantly changing and updated. Children's Dental of Winona's current participation should be verified by you. This can be done by contacting your insurance plan directly.

Treatment plans and fees for return appointments will be reviewed and dental procedures discussed. If you have any questions about your insurance plan, what information is required for us to file for you, please call our office at 507-452-1543.

● Billing/ Fees

Our fees are based on the time and cost required to provide our services to you and your family. We strive to use the most updated materials and technology available. We encourage you to openly discuss your questions or concerns regarding the treatment with our doctor or staff. Payment of fees are due at the time service is rendered. For multiple appointments or complex treatment, a financial agreement with monthly payments can be discussed with our financial coordinator. Our billing statements are mailed on a monthly basis and payment is expected within 30 days. Any accounts over 30 days are subject to a finance charge. Accounts will be charged a fee of $25.00 for checks returned NSF (non sufficient funds). Contact our office if you have any concerns about your account.

I certify that I have read and understand the above information and I have answered all questions accurately and my questions have been answered to my satisfaction. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependents to third party payers and/ or health practitioners in connection with our healthcare operations. I authorize my insurance company to pay any benefits directly to the dentist, that are otherwise payable to me.

X Signature_____Date:_____

I acknowledge I have received (if requested) or reviewed, a copy of the office's Notice of Privacy Practices, located on our website. I understand that I can refuse to sign and that by refusing to sign, I agree to file my own insurance and pay for services on the day of treatment.

X Signature_____ Date:_____

EMAIL COMPLETED FORM TO: CDOWSECURE@GMAIL.COM