



Leslie M. Pitts, DMD
Pediatric Dentistry

Date _____

CHILD'S BIOGRAPHICAL, MEDICAL, AND DENTAL HISTORY (PLEASE PRINT ALL INFORMATION CLEARLY)

Child's full name: (Last) _____ (First) _____ (Middle) _____ (Preferred) _____
Birthdate: _____ Age: _____ Social Security Number: _____ Sex: _____
Mailing Address: _____ (City): _____ (State): _____ (Zip): _____
E-Mail: _____ Home Phone: _____ Grade: _____ School: _____

Father's Name: _____ Birthdate: _____ Social Security Number: _____
Driver's License Number: _____ Marital Status: _____
Address (If different from child): _____ City: _____ State: _____ Zip: _____
E-Mail: _____ Home Phone: _____ Employer: _____ Work Phone: _____

Mother's Name: _____ Birthdate: _____ Social Security Number: _____
Driver's License Number: _____ Marital Status: _____
Address (If different from child): _____ City: _____ State: _____ Zip: _____
E-Mail: _____ Home Phone: _____ Employer: _____ Work Phone: _____

Do both parent's live together? Yes No (If not, with whom does the child live?): _____
Please list any alternative phone numbers (Cell, Beeper, Relative): _____
Whom may we thank for referring you? _____ Phone: _____
Person to contact in case of an emergency: _____ Phone: _____

PARENT/RESPONSIBLE PARTY

Name of Person Responsible for account: _____ Birthdate: _____
Relationship to patient: _____ Social Security Number: _____
Driver's License Number: _____
Address (If different from above): _____ Home Phone: _____

PRIMARY DENTAL INSURANCE INFORMATION

Name of Insured: _____ Birthdate: _____ Social Security Number: _____
Relationship to patient: _____ Employer: _____ Work Phone: _____
Union or local Number: _____ Insurance Company: _____ Group Number: _____
Policy/ID Number: _____

Do you have any additional dental insurance? Yes No



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Check any of the following conditions which your child presently has or previously had.

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Convulsions | <input type="checkbox"/> HIV-positive | <input type="checkbox"/> nose/throat disorder |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hormone disorder | <input type="checkbox"/> Prolonged illness |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Ear Disorders | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Bleeding Tendency | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Skin Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Eye Disorder | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Speech problem |
| <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Stomach problem |
| <input type="checkbox"/> Bone Disorder | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Brain Disorder | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Mental retardation | _____ |

Child's Physician (Name): _____ (Address): _____

No Yes Does your child have any other medical condition?

No Yes Is your child taking any medicine?

If yes, please list. _____

No Yes Is your child allergic to any medicine or food?

No Yes Has your child ever been hospitalized?

No Yes Is this your child's first visit to the dentist?

No Yes Were there any problems with previous dental treatment?

No Yes Is your child using fluoride tablets, drops, or rinses?

No Yes Has your child had a toothache lately?

No Yes Does your child suck a thumb, finger, or have any other oral habit?

No Yes Has your child ever injured his/her teeth or jaws?

No Yes Does your child have a dental condition about which you are especially concerned?

If yes, please explain. _____

How often are your child's teeth brushed? _____ By whom? _____

What is the source of your child's drinking water? Public Water Well Water

I acknowledge that this information is correct and hereby authorize a dental examination for my child including necessary radiographs, photographs and acceptable methods to accomplish these services. As the parent or legal guardian of the previously named patient, I do hereby grant Dr. Pitts and her staff permission to perform any needed treatment(s). I also understand that all necessary treatment will be explained prior to commencement and that I am responsible for payment in full at the time of service, unless prior arrangements have been approved.

Parent/guardian's signature: _____ Date: _____



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Financial Policy

We appreciate you choosing our office for your child's dental care. We value our relationship with your family and would like to offer the following as our payment policy.

- If insurance payment is pending, you will receive an interim statement to let you know that the account has not been paid. A finance charge will be added to your account on any balance not paid in full within six weeks from the date of service.
- Once the treatment plan and estimated insurance benefits are reviewed with you, we require that you pay your portion in full at the time of service.
- For your convenience we accept cash, check, VISA, Discover, MasterCard, American Express and debit cards.
- If an appliance needs to be made for your child, half of the fee is due when the impressions are taken for the appliance and the remaining balance paid in full when the appliance is delivered.
- Please note that parents or guardians bringing the child into the office on the day of the service will be expected to pay for services rendered. Only if payment arrangements have been made will we see the child for treatment.
- A cancelled check fee will be applied in the amount of \$35.00 for any returned checks.
- Any unpaid balances over 30 days will be subject to a finance charge of 18% APR. Any balances left unpaid and sent to collections will be subject to an Account Collection Fee of \$65.00 plus any other collection costs/fees incurred while attempting to collect a debt.

I have read and understand the payment policies for the office:

Patient's Name (Printed): _____

Parent's/Guardian's Name (Printed): _____

Parent's/Guardian's Signature: _____

Date: _____



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Insurance

1. Parents must be aware that dental insurance is a contract between the insured and the insurance company. It is the insured's responsibility to correct any problem of the payment with the insurance company.
2. For the convenience of our patient's parents, our office will accept assignment directly from your insurance company. You must be aware that this payment is not necessarily 100% of the charges. The patient or person responsible for the patient is responsible for the patient's percentage (co-payment) and deductible at the time of the treatment. We will use your insurance company's benefit schedule to determine this amount. If an inaccuracy exists in payment, we will refund any overpayment. If your insurance company underpays, then the responsible person will be responsible for paying to us the account balance.

I authorize release of any information relating to any and all claims. I hereby authorize payment directly to Leslie M. Pitts, DMD, Pediatric Dentistry, for any and all group insurance benefits otherwise payable to me.

Signature of Insured: _____ Date: _____

Appointment Policy

We are happy to schedule your child's appointments at a time that is convenient for your schedule. Missed appointments or short term cancellations (within 48 hours) without proper notification can be costly and unfair to other patients who need appointments. A \$25.00 fee will be charged to your account for any appointment that is canceled or rescheduled without at least 48 hours notice. We do understand that emergencies can happen, so the fee will be applied beginning with the second appointment that is missed or cancelled without proper notification. Patients with repeated broken appointments and short term cancellations may be subject to dismissal from the practice.

Parent/Guardian signature _____

