JOANNE C. LEWIS
Pediatric Dentistry

PATIENT INFORMATION

CHILD'S NAME: _____ AGE: _____ DATE OF BIRTH: _____/_____/_____

HOME ADDRESS: _____ CITY: _____ STATE: _____

ZIP CODE: _____ E-MAIL ADDRESS: _____ @ _____

How would you like to receive statements? ☐ E-mail statement ☐ Paper Statement (Subject to $1.50 Billing fee per statement)

HOME PHONE: (_____) _____ - _____ CELL PHONE: (_____) _____ - _____

Would you like to enroll in automated appointment reminders? ☐ Yes ☐ No

CHILD'S SCHOOL: _____ GRADE: _____

CHILD'S HOBBIES: _____

MOTHER'S NAME: _____ PHONE: (_____ - _____ SS#: _____ - _____ - _____

FATHER'S NAME: _____ PHONE: (_____) _____ - _____ SS#: _____ - _____- _____

WHO WILL BE RESPONSIBLE FOR THE ACCOUNT? _____ RESPONSIBLE PARTY'S DOB: ____/_____/_____

WHO IS ACCOMPANYING THE CHILD TO THEIR APPOINTMENT TODAY? _____ RELATIONSHIP TO CHILD: _____

Primary Insurance

PRIMARY INSURANCE COMPANY: _____

SUBSCRIBER/MEMBER ID #: _____ GROUP #: _____

SUBSCRIBER NAME: _____ SUBSCRIBER DATE OF BIRTH: _____/_____/_____ SSN: _____

SUBSCRIBER RELATIONSHIP TO PATIENT: _____ INSURANCE COMPANY PHONE #: _____

Secondary Insurance (If applicable)

SECONDARY INSURANCE COMPANY: _____

SUBSCRIBER/MEMBER ID #: _____ GROUP #: _____

SUBSCRIBER NAME: _____ SUBSCRIBER DATE OF BIRTH: _____/_____/_____ SSN: _____

SUBSCRIBER RELATIONSHIP TO PATIENT: _____ INSURANCE COMPANY PHONE #: _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

DATE OF LAST DENTAL VISIT: _____ REASON FOR VISIT TODAY: _____

HAS YOUR CHILD EXPERIENCED ANY PREVIOUS UNHAPPY MEDICAL OR DENTAL VISITS? ☐ YES ☐ NO

HAS YOUR CHILD COMPLAINED ABOUT ANY DENTAL PROBLEMS (TOOTH PAIN, BROKEN TEETH, JAW PAIN, ETC.)? ☐ YES ☐ NO

HAS YOUR CHILD SUSTAINED ANY INJURIES TO THEIR MOUTH, TEETH, OR HEAD? ☐ YES ☐ NO

DOES YOUR CHILD BRUSH THEIR TEETH DAILY? ☐ YES ☐ NO

DO YOU ASSIST YOUR CHILD WITH BRUSHING? ☐ YES ☐ NO

DOES YOUR CHILD USE DENTAL FLOSS? ☐ YES ☐ NO

HOW DOES YOUR CHILD RECEIVE FLUORIDE? ☐ WATER SUPPLY ☐ TOOTHPASTE ☐ SUPPLEMENTS (DROPS, TABLETS, ETC.)

WHAT IS YOUR CHILD'S ATTITUDE ABOUT TODAY'S DENTAL VISIT? _____

ANY OTHER CONCERNS TODAY? _____

MEDICAL HISTORY

ALL OF THE QUESTIONS ASKED ON THE DENTAL AND MEDICAL HISTORY FORM ARE ESSENTIAL IN ARRIVING AT A DIAGNOSIS AND PROPER TREATMENT PLAN. ALL QUESTIONS MUST BE ANSWERED. IF ANY QUESTION IS NOT UNDERSTOOD, IT SHOULD BE DISCUSSED FURTHER WITH THE DOCTOR. IF A MEDICAL CONDITION EXISTS AND IS NOT RELATED TO ANY QUESTION ON THIS FORM, IT MUST BE REPORTED TO THE DOCTOR. THIS INFORMATION IS REQUESTED TO ENABLE OUR PRACTITIONERS TO PROVIDE YOUR CHILD WITH THE BEST DENTAL CARE POSSIBLE. ALL OF THE INFORMATION REQUESTED IS, OF COURSE, KEPT CONFIDENTIAL. THANK YOU!

CHILD'S PHYSICIAN: _____ PHONE: (_____) _____ - _____

DATE OF LAST COMPLETE PHYSICAL EXAMINATION: _____ / _____ / _____ RESULTS: _____

IS YOUR CHILD IN GOOD HEALTH? ☐ YES ☐ NO HEIGHT: _____ WEIGHT: _____

IS YOUR CHILD PRESENTLY UNDER THE CARE OF A MEDICAL SPECIALIST? ☐ YES ☐ NO

IS YOUR CHILD RECEIVING ANY MEDICATIONS OR DRUGS? ☐ YES ☐ NO

IF YES, PLEASE LIST MEDICATION AND DOSAGE: _____

DOES YOUR CHILD HAVE ANY ALLERGIES? ☐ YES ☐ NO

IF YES, PLEASE LIST:

_____

DOES YOUR CHILD REQUIRE AN ANTIBIOTIC PRIOR TO ANY DENTAL TREATMENT? ☐ YES ☐ NO

HAS YOUR CHILD EVER BEEN HOSPITALIZED? ☐ YES ☐ NO FOR WHAT REASON? _____

HAS YOUR CHILD EVER HAD SURGERY? ☐ YES ☐ NO FOR WHAT REASON? _____

HAS YOUR CHILD EVER HAD ANY BLOOD TRANSFUSIONS? ☐ YES ☐ NO

ARE THERE ANY PSYCHOLOGICAL OR EMOTIONAL PROBLEMS YOU WOULD LIKE TO BRING TO OUR ATTENTION? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN: _____

DOES YOUR CHILD HAVE OR EVER HAD ANY OF THE FOLLOWING HEALTH PROBLEMS?

ADHD / ADD	☐ YES ☐ NO	GERD / ACID REFLUX	☐ YES ☐ NO
ANEMIA AND/OR BLOOD DISORDERS	☐ YES ☐ NO	GLANDULAR OR HORMONAL PROBLEMS	☐ YES ☐ NO
ANXIETY, DEPRESSION OR MENTAL DISORDER	☐ YES ☐ NO	HAY FEVER / SEASONAL ALLERGIES	☐ YES ☐ NO
ARTHRITIS / RHEUMATISM	☐ YES ☐ NO	HIGH OR LOW BLOOD PRESSURE	☐ YES ☐ NO
ASTHMA / RESPIRATORY PROBLEMS	☐ YES ☐ NO	KIDNEY AND/OR BLADDER PROBLEMS	☐ YES ☐ NO
AUTISM / AUTISM SPECTRUM DISORDER	☐ YES ☐ NO	LIVER PROBLEMS, JAUNDICE OR HEPATITIS	☐ YES ☐ NO
CONGENITAL HEART DISEASE / HEART MURMUR	☐ YES ☐ NO	RHEUMATIC FEVER / RHEUMATIC HEART DISEASE	☐ YES ☐ NO
CONVULSION, SEIZURES, FAINTING OR EPILEPSY	☐ YES ☐ NO	SPEECH, LEARNING OR HEARING DISORDERS	☐ YES ☐ NO
DIABETES OR BLOOD SUGAR PROBLEMS	☐ YES ☐ NO	SPECIAL NEEDS	☐ YES ☐ NO
ECZEMA, PSORIASIS, OR SKIN CONDITIONS	☐ YES ☐ NO	TUBERCULOSIS OR PNEUMONIA	☐ YES ☐ NO

DOES YOUR CHILD HAVE ANY OTHER HEALTH CONCERNS? IF SO, PLEASE EXPLAIN:

_____

OFFICE POLICIES

PLEASE BE SURE TO READ EACH POLICY THOROUGHLY. YOUR SIGNATURE IS REQUIRED AT EACH AREA INDICATED BY THIS SYMBOL: X

1) OFFICE ACCEPTANCE AND CONSENT: "I understand that the information provided on this form is essential to determine my child's dental needs and the provisions of dental treatment. I understand that if **ANY CHANGE** occurs in my child's health, I am to report it to the dental office. I have read and understand each question and I have answered all of them truthfully, and to the best of my ability. I authorize the doctor to perform diagnostic procedures including: Dental radiographs, examination, dental prophylaxis, topical fluoride application and/or any treatment as be necessary for my child's proper dental care."

X_____

PARENT/LEGAL GUARDIAN SIGNATURE

2) INSURANCE AUTHORIZATION AND PAYMENT/FINANCIAL POLICIES: "I authorize my insurance company to pay Joanne C. Lewis Pediatric Dentistry, LLC directly, and I understand that my dental care insurance carrier may pay less than the actual bill for services. It is the insurance holder's responsibility to know their coverage and benefits. I understand that I am financially responsible for payments in full on accounts."

IF YOU HAVE DENTAL INSURANCE, YOUR DENTAL CLAIMS WILL BE PROCESSED AS FOLLOWS**:**

● **IN NETWORK** – If the dentist is a participating provider with your insurance you will be billed pursuant to the terms of your dentist's agreement with your insurer.

● **OUT OF NETWORK** – If the dentist is not a participating provider with your insurance plan, we will submit dental claims to your insurer, as a courtesy. If your insurance carrier will not accept assignment of benefits to your dentist, YOU ARE RESPONSIBLE for any and all costs incurred, not covered and paid by your insurance company."

We are ONLY "In Network/Participating" providers with:

Delta Dental Premiere Plans, the United Healthcare Rite Smiles Network, Blue Cross Blue Shield Rhode Island

If you have any questions related to your insurance coverage, we encourage you to contact your insurance company directly. It is your responsibility to notify the office **IMMEDIATELY** if there are any changes to your insurance plan or any lapse in coverage.

Unpaid balances will be turned over to a collection's agency after **6 MONTHS** past due, you are responsible for the balance in full on your account regardless of if the insurance company has paid. Accounts sent to collections will be accessed a **$50 collection fee** and all scheduled appointments will be cancelled. Patients who have been submitted to collections will be placed on a scheduling hold until the account is paid in full. If for any reason your account is turned over to a collection agency or collection attorney, the responsible party agrees to pay **ALL FEES CHARGED** by the agency or attorney, in addition to the fees for services provided by the office.

X_____

PARENT/LEGAL GUARDIAN SIGNATURE

3) MISSED APPOINMENT POLICY: "I understand the office requires **24 HOURS NOTICE** for all appointment cancellations**.** If I am unable to provide 24 hours' notice, I will be billed a **$30.00 charge** for my scheduled appointment time. Patients will be subject to dismissal from the practice if missed or less than 24 hours' notice is given for cancelled appointments (2) or more times at the doctor's discretion.

X_____

PARENT/LEGAL GUARDIAN SIGNATURE

4) LATE ARRIVAL POLICY: When a patient arrives late, the time spent with the patient is minimized and does not allow for a full assessment. It also disrupts the schedules of our providers and other patients. Our providers to their best to keep appointments on schedule. Out of respect for patients who have arrived on time for their appointment you may be asked to reschedule your appointment if you arrive later than your scheduled appointment time. We will make every effort to honor your appointment as a "work in" as the schedule allows, but there may be times when this will not be possible, and you will have to reschedule.

Patients who arrive more than **15 minutes late (Exceeding 50%) of** their scheduled appointment time, **will be asked to reschedule**.

X_____

PARENT/LEGAL GUARDIAN SIGNATURE

5) HIPAA ACKNOWLEDGEMENT AND CONSENT: "I have been provided with a copy of the HIPAA policy and notice of privacy practices. I have read and understand its contents. I do hereby consent and acknowledge my agreement to the terms set forth in the office's notice of privacy practices and any subsequent changes in office policy. I understand that this consent shall remain in effect from this time forward."

X_____

PARENT/LEGAL GUARDIAN SIGNATURE

6) CAREGIVER'S AUTHORIZATION AFFIDAVIT: The purpose of this affidavit is to provide your **LEGAL AUTHORIZATION** for another adult to bring your child to routine dental appointments and make decisions on your behalf, in the event that you are unable to bring your child. Should you withdraw of amend this authorization you must do so in person and in writing at our dental office. We prefer that, as the parent/legal guardian, you accompany your child to all dental visits and we reserve the right to decline treatment of your child in any situation where the office feels your presence is essential.

PLEASE NOTE: IF YOU ARE A COURT APPOINTED LEGAL GUARDIAN, COPIES OF COURT DOCUMENTS STATING THAT YOU ARE THE LEGAL GUARDIAN OF THE CHILD ARE NECESSARY FOR OUR RECORDS PRIOR TO ANY TREATMENT.

YOUR SIGNATURE BELOW INDICATES THAT**:**

- You are authorizing our dental office to discuss treatment of your child with any adult accompanying your child to his/her appointment(s).
- You will be responsible for relaying office policies and procedures to any adult accompanying your child and assuring that they comply.
- You understand and agree to allow the adult accompanying your child to make decisions on your behalf, as outlined in this affidavit.
- You are responsible for making payment arrangements **ON THE DATE OF TREATMENT**
- You will notify the dental office IN PERSON and IN WRITING should you wish to amend or withdraw this authorization.
    - Any adult accompanying your child must be at least 18 years of age and is expected to remain in the office with your child while treatment is rendered.
    - The accompanying adult will be able to provide consent on your behalf for any changes in treatment plan. (You will be responsible for any additional fees incurred, consent to behavior management techniques (inhaled nitrous oxide, restraint, etc.) Receiving post-operative instructions and relaying them clearly and correctly to you, communicating to your expectations and/or any information relative to your child's present or future dental needs.

X_____

PARENT/LEGAL GUARDIAN SIGNATURE