Apple Tree Pediatric Dentistry

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Dr. Jeni Kong, DMD
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Child's name:_____ Nickname:_____ Age:_____ Sex: (M) (F)

Purpose of visit:_____ Concerns:_____ Birthdate:_____

Name and age of brothers/sisters: _____Is your child adopted? Y N

Child's Interests: _____Name of Pet(s):_____

Does your child have any special needs? _____ Any phobias? _____

Child's school: _____Who may we thank for referring you to us? _____

Health History

Child's Pediatrician: _____ Phone Number : (_____)_____ Last Physical: _____

Is your child under a physician's care now? Y N If yes, reason: _____ Immunization up to date? Y N

Is your child taking any medications currently (including Bisphosphonates and over the counter)? Y N

If yes, list:_____

Is your child allergic to any medication? Y N If yes, please list: _____

Any history of hospitalization or surgery: (if yes, when) _____

Does your child have allergic reaction to: (if yes: please check all that applies)

__Peanuts/Tree nuts	__Soy	__Latex/Rubber	__Pollen/Dust/Environmental	__Anesthetics
__Eggs	__Metals	__Animals	__Berries	__Acrylic
__Milk	__Wheat/Gluten	__Dyes/Coloring	__Others: _____	

Has your child had a history or difficulty with any of the following?

ADHD/ADD	Y N	Cardiac Disease/Heart	Y N	Hepatitis	Y N
Anemia	Y N	Cerebral Palsy	Y N	Immune Disorder	Y N
Allergies	Y N	Chemo/Radiation Therapy	Y N	Kidney	Y N
Arthritis/Joint Disorder	Y N	Cystic Fibrosis	Y N	Liver	Y N
Asthma	Y N	Delayed Development	Y N	Murmur	Y N
Allergies to Meds	Y N	Depression/Anxiety	Y N	Muscular Disorder	Y N
Autism	Y N	Diabetes	Y N	Premature Birth	Y N
Bladder	Y N	Down's Syndrome	Y N	Rheumatic Fever/Heart	Y N
Bleeding Disorder	Y N	Earaches/Infections	Y N	Speech Disorder	Y N
Bone Disorder	Y N	Eating Disorder	Y N	Sinusitis	Y N
Brain Injury	Y N	Emotional/School Problems	Y N	TMJ Problems	Y N
Bruising	Y N	Epilepsy/Seizure	Y N	Tuberculosis	Y N
Cancer/Malignancy	Y N	Hearing Impaired	Y N	Visual Impaired	Y N

OTHER: _____

I HAVE REVIEWED MY CHILD'S MEDICAL HISTORY.

SIGNED_____ **DATE** _____

Dental History

Is this your child's first dental visit? Y N If no, previous dentist: _____

Phone number: (____)_____ Date of last visit: _____ Were any x-rays taken? Y N

How was his/her experience? _____

Child's attitude towards the dentist or dental care:

_____

Has your child had any injuries to teeth, mouth, or head? Y N If yes, please describe: _____

Has your child done any of the following (past or present)? Please circle:

thumb/finger-sucking	pacifier	nail biting	lip sucking	mouth-breathing
snoring	teeth grinding	nursing	bottle-feeding	

Is your water fluoridated? Y N Does your child take fluoride supplements? Y N

Does your child use fluoridated toothpaste? Y N How often does your child brush his/her teeth? _____

With adult supervision? Y N How often does your child floss? _____

How may we help to make this visit a positive experience for your child?

_____

General Information

Father (full name)_____ SSN:_____ Birthdate:_____

Mother (full name)_____ SSN:_____ Birthdate:_____

Parent(s) are: Married___ Divorced___ Single___ Widowed___ Partners___ Child lives with: both parents/mother/father/other

Home Address: _____ Home Phone: _(____)_____

Father's Employer: _____ Cellular Phone: (____)_____

Business Address:_____ Work Phone: __(____)_____

Mother's Employer: _____ Cellular Phone: (____)_____

Business Address:_____ Work Phone: __(____)_____

E-mail Address:_____

Emergency Contact:_____ Phone: (_____)_____

How would you like us to contact you? Home Work Cell E-mail

The permission of parent or guardian is necessary for dental treatment of a minor. I give the permission to use such measures as deemed necessary in his/her professional judgment to render the best dental treatment for my child. I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform the office of any changes in my child's health status.

SIGNATURE:_____Relationship:_____Date:_____

Insurance Information

Do you have dental insurance coverage for your child? Y N

Father's Insurance Company:_____ Group Number:_____

Address of Father's Insurance Company:_____

Mother's Insurance Company_____ Group Number_____

Address of Mother's Insurance Company:_____

Financial Policies

Billing Policy

Our office will be happy to file your charges for services rendered to your insurance company. If you are a participating member of a managed care plan, we will expect you to pay your co-pay and/or any other fees that are not covered at the time of your visit. If your Insurance is one that we DO NOT participate with, you will be asked to pay in full for your visit upon checkout. IF your insurance pays us directly, we will reimburse you promptly for any overpayment that has been made.

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We accept many different dental Insurance plans and it is difficult to always be 100% accurate with the changes that Insurance companies make. We attempt to keep up with the most recent changes and updates as best we can but we strongly feel that it is ultimately the patient's responsibility to be aware of how their Insurance plan works. Any patient who is seen and fails to notify our office of any changes in their Insurance that in tum deems your services as non-covered will be billed directly for their charges.

Check Policy

We are happy to accept your personal check for payment towards your account balance. However if funds are not available in your account and your check is returned to us for any reason, such as NSF, you will be assessed $25 service fee plus the cost of the original check. If you present two checks that are insufficient, then we will no longer accept payment by check on your account. All funds must then be paid by cash or credit card.

No Show Policy

Any time that you miss an appointment to see a provider without giving 24 hour notice, you will be assessed a $25 no-show fee. This will be your responsibility to pay and will not be billed to your insurance company. This fee must be paid prior to your next visit. Extenuating circumstances should be discussed with our business office.

I HAVE READ AND UNDERSTAND THE BILLING, CHECK AND NO SHOW POLICIES

SIGNED_____ **DATE**_____

Parent or Legal Guardian

Payment Information

- PAYMENT IS EXPECTED AT TIME OF TREATMENT
- ALL EMERGENCY PATIENTS (BEING SEEN FOR THE FIRST TIME) ARE REQUESTED TO PAY IN FULL AT THE TIME OF TREATMENT
- PATIENTS WITH INSURANCE MAY PAY ONLY THEIR PORTION, INCLUDING DEDUCTIBLE, PROVIDED A COMPLETED, SIGNED INSURANCE FORM IS PRESENTED AT EACH VISIT FOR EACH CHILD. WE WILL GLADLY FILL OUT THESE FORMS FOR YOU. HOWEVER, IT IS THE PARENTS'S RESPONSIBILITY TO SEE THAT INSURANCE COMPANY MAKEES PROMPT PAYMENT. ANY INSURANCE BALANCE OVER 60 DAYS IS DUE AND PAYABLE BY THE PARENT.

I HEARBY AUTHORIZE PAYMENT DIRECTLY TO APPLE TREE PEDIATRIC DENTISTRY, LLC, THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME AND AUTHORIZE RELEASE OF INFORMATION REGARDING TREATMENT TO THE INSURANCE COMPANY

SIGNED _____
Insured Person

I GIVE CONSENT TO NEEDED DENTAL SERVICES, LOCAL ANESTHETIC, NITROUS OXIDE ANALGESIA (LAUGHING GAS) AND USE OF PROPER AND ACCEPTABEL METHODS TO COMPLETE SAME AND ACCEPT RESPONSIBILITY FOR PAYMENT OF SERVICES RENDERD FOR

_____ (Print Child's Name)

IN ADDITION, I AGREE THAT IF MY ACCOUNT FOR ANY REASON BECOMES OVERDUE AND UNCOLLECTIBLE BY GOOD FAITH EFFORTS BY YOUR OFFICE AND HAS TO BE TURNED OVER TO AN OUTSIDE COLLECTION AGENCY, I WILL ALSO BE HELD RESPONSIBLE FOR ANY AND ALL ADDITIONAL FEES REQUIRED TO COLLECT THIS ACCOUNT.

SIGNED_____ **DATE**_____
Parent or Legal Guardian