Just For Kids
Pediatric Dentistry, P.A.

PATIENT HISTORY

Stephen C. Mills, D.D.S.
Diplomate - American Board of Pediatric Dentistry
Michael J.McCoy, D.M.D.
Diplomate - American Board of Pediatric Dentistry
Kristin M. Lawson, D.D.S.
Diplomate - American Board of Pediatric Dentistry

Patient's Full Name: _____ **DOB:** _____/_____/_____ **Age:** _____ **Sex:** Male/Female

Nickname: _____ **Interest/Hobbies:** _____ **Pets:** _____

DENTAL HISTORY

What's the reason for your child's dental visit? _____

_____

Is this your child's first visit to the dentist? YES/NO

If not, last dentist office? _____

Date Seen: _____**Last x-rays:**_____

Has your child ever had any major dental problems in the past? YES/NO

If so, please explain: _____

Has your child ever had any unpleasant dental experience? YES/NO

Have you ever been advised that your child has a "bite problem"? YES/NO

Does your child have any oral habits? (Circle all that apply)

thumb/finger sucking, n**ail biting, lip sucking, other**: _____

CAVITY PREVENTION

Does your child receive fluoride daily?

We have fluoride in our water supply. **Yes / No /Unsure**

Child swallows a fluoride supplement. **Yes / No**

Child uses a toothpaste containing fluoride. **Yes / No**

Child uses a fluoride mouthwash at home. **Yes / No**

Has your child received fluoride varnish from a school, dental clinic, or pediatrician in the last 12 months? **Yes(date_____)/No**

Is your child familiar with dental floss? (Circle one below)

YES (use it on teeth regularly) YES (use it on occasion)

NO (do not use dental floss on child's teeth)

MEDICAL HISTORY

Name of child's physician: _____

Address: _____

Physician's phone number: _____

Does your child have regular medical exams? YES/NO

Is your child currently under a physician's care?

YES/NO If so, please explain: _____

Has your child had any surgery, serious illness, or accident in the past or scheduled in the future? YES/NO

If yes, please explain: _____

Is your child currently taking any medications? YES/NO

If yes, please explain: _____

Does your child have any mental, emotional or physical handicap?

YES/NO If yes, please explain: _____

Is your child allergic to any medications or drugs? YES/NO

If yes, please explain: _____

Please list any other allergies. _____

_____

Has your child had any history of: (Check all that apply) □ Bleeding trouble □ Nervous system disorder □ Heart trouble □ Asthma □ Rheumatic fever □ Diabetes □ Kidney disease □ Liver disease □ Speech problem □ Epilepsy □ Tuberculosis □ Lung problems □ ADD □ ADHD □ Autism spectrum disorder □ Other:_____

Permission is hereby granted to the doctor to perform any necessary dental treatments for this child after doctor's consultation with the parent/guardian.

Parent/Guardian Print Name:_____

Parent/Guardian Signature: _____ **Date:** _____

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RESPONSIBLE PARTY INFORMATION

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Patient's Full Name: _____

Parent/Guardian: _____Relationship to child: _____

Address: _____ City, State, Zip: _____

Cell Phone: _____ Alternative Phone: _____

DOB: _____/_____/_____ SS # _____ -_____-_____ Email: _____

Marital Status: □ Married □ Single □ Divorced □ Separated □ Widowed (please √ one)

Other Parent/Guardian: _____ Relationship to child: _____

Address: _____ City, State, Zip: _____

Cell Phone: _____ Alternative Phone: _____

DOB: _____/_____/_____ SS # _____ -_____-_____ Email: _____

Alternate Emergency Contact: Name/Phone Number: _____

PRIMARY DENTAL INSURANCE INFORMATION

Policy Holder: _____ DOB: ____/_____/_____SS # _____ -_____-_____

Insurance Company: _____Employer: _____

Insurance Address: _____

Insurance Phone #: _____

Group Number: _____ ID/Subscriber #: _____

SECONDARY DENTAL INSURANCE INFORMATION

Policy Holder: _____ DOB: ____/_____/_____SS # _____ -_____-_____

Insurance Company: _____Employer: _____

Insurance Address: _____

Insurance Phone #: _____

Group Number: _____ ID/Subscriber #: _____

MaineCare Status: Is (are) your child (children) currently a MaineCare member/s or have you applied for MaineCare coverage? Please circle YES or NO If yes, provide copy of current card. If no card, please provide ID#_____

HIPAA POLICY ACKNOWLEDGEMENT

I have reviewed/received a copy of Just For Kids Pediatric Dentistry's HIPAA Notice of Privacy Practices.

Parent/Guardian Print Name:_____

Parent/Guardian Signature: _____ **Date:** _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

□ Communications barriers prohibited obtaining the acknowledgement □ Individual refused to sign

□ An emergency situation prevented us from obtaining acknowledgement □ Other (Please specify) _____

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FINANCIAL POLICY

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1. **No Dental Insurance:**
   We accept Visa/MC, cash, personal checks and CareCredit. **Payment is due in full at the time of service.**

2. **Dental Insurance:**
   A. Please realize that your insurance policy is a contract between you, your employer and your insurance company. We have no control over the terms of your contract, the method of reimbursement or the determination of your insurance benefits. All insurance policies are different and you are responsible for knowing your plan provisions.
   B. This policy grants permission to submit charges to your dental insurance and allow payment to be made directly to our office. You are responsible for all non-covered charges i.e. co-payments, deductibles and rejected charges. If payment is not received from the insurance company within 60 days, or if an account balance remains after an insurance payment has been applied, it will be your responsibility to make payment in full within 10 days of the billing date.
   C. It is your responsibility to provide any changes with your dental insurance prior to treatment. Failure to present this information will result in your acceptance of all incurred charges.
   D. Payment is due at the time of service for those plans that pay subscriber only, i.e. Federal Blue Cross Blue Shield. We will submit your insurance claim.
   E. For services other than routine cleanings, we will endeavor to provide estimates for co-pays and out of pocket expenses. **Payment for estimated co-pays are due at appointment time.**

3. **MaineCare:**
   A. For those patients covered by MaineCare you must be eligible for benefits on the date of service, otherwise the account is considered a cash account and payment will be due at the time of service. If MaineCare does not make a payment for services rendered, you will be responsible for paying the balance on the account in full within 10 days of the billing date.
   B. If the patient is covered by a primary insurance company that pays only the subscriber (ie: Federal Blue Cross Blue Shield), payment will be due at the time of service based on the plans reimbursement rate.
   C. For those services not covered by MaineCare payment is due at the time of service.

4. **Returned Check Fee:** A charge of $25.00 will be accessed for any returned checks.

5. **Cancellation Policy:**
   We require a 24-hour prior notice for cancellation of any scheduled appointment. Without this proper notice, we reserve the right to appoint family members separately or to no longer reappoint and also a $50.00 fee may be charged to your account. We offer appointment reminders by text, email and phone calls by our automated system. It is your responsibility to provide updates for any changes as needed.

6. **Acceptance of Financial Policy:**
   Signature is required prior to patient treatment, this indicates acceptance of the above terms and responsibilities for the account.

Parent/Guardian Print Name:_____

Parent/Guardian Signature: _____ **Date:** _____