ASHBURN
PEDIATRIC DENTAL CENTER

Welcome to Ashburn Pediatric Dental Center!

Today's Date _____

Patient's Full Name _____
LAST FIRST M.I.

Patient's Nickname _____Date of Birth_____□ M □ F

Child's School _____ Grade _____

Child's Home Phone _____

Child's Home Address _____
Street City State Zip

How did you hear about our office? _____

What is the reason for today's visit? □ Exam □ Emergency □ Consultation

What is the name of the child's previous dentist? _____

Date of last dental exam___/___ /___ Date of last dental X-rays____/____/_____

Is the child in pain? _____ How long has he or she been in pain? _____

Are there any other dental concerns? _____

Does your child have or has he/she ever had any of the following medical conditions?

Y N Heart Murmur	**Y N** Tonsillitis	**Y N** High/Low Blood Pressure
Y N Rheumatic Fever	**Y N** Respiratory Problems	**Y N** Hepatitis
Y N Artificial Heart Valves	**Y N** Asthma	**Y N** Artificial Bones/Joints
Y N Congenital Heart Defect	**Y N** Blood Transfusion	**Y N** Organ Problems
Y N Scarlet Fever	**Y N** Leukemia/Anemia	**Y N** HIV/AIDS/ARC
Y N Surgeries/Operations	**Y N** Diabetes/Hypoglycemia	**Y N** Tuberculosis (TB)
Y N Cancer/Tumors	**Y N** Hemophilia	**Y N** Psychiatric Problems/Autism
Y N Chemotherapy	**Y N** Abnormal Bleeding	**Y N** Hyperactive ADD
Y N Jaw Problem TMJ/TMD	**Y N** Cleft Lip/Palate	**Y N** Fainting/Seizures/Epilepsy
Y N Hearing problem	**Y N** Birth Defects	**Y N** Cerebral Palsy

ALLERGIES

Does the child have an allergy to any of the items listed below?

□ Latex □ Penicillin/Amoxicillin □ Tetracycline □ Lidocaine □ Aspirin □ Foods

Please list any other allergies:_____

MEDICAL CONDITIONS

Please list any other medical conditions not mentioned above.

_____

Does the child require pre-medication for dental procedures? □ Yes □ No □ Unsure

MEDICATIONS

Is the child currently taking any of the following medications?

□ Ritalin □ Stimulants □ Blood Thinners □ Tranquilizers □ Insulin □ Muscle Relaxers

□ Painkillers (including aspirin). **Is the child taking any other medications?**

_____

Who is accompanying this child today?

_____ _____
Full Name Relationship to Child

Do have legal Custody of this child? □ Yes □ No

Please include at least two phones numbers when completing the information below.

Mother's Name_____

Mother's Home Address (if different than child's) _____
Street City State Zip

Home Phone _____Work Phone_____ Cell Phone_____
Email Address_____
Mother's Social Security Number_____ Date of Birth _____
Mother's Employer _____

Father's Name_____

Father's Home Address (if different than child's) _____
Street City State Zip

Home Phone _____Work Phone_____ Cell Phone_____
Email Address _____
Father's Social Security Number _____ Date of Birth_____
Father's Employer _____

Primary Dental Insurance

Policy Holder's Full Name_____
Policy Holder's Social Security Number _____
Insurance Card Identification Number_____
Date of Birth_____/_____/_____
Name of Employer_____
Group Number_____
Relationship to Patient_____
Name and Address of Insurance Company_____

_____
Street City State Zip

Insurance Company's Telephone Number: (_____) _____-_____

Secondary Dental Insurance

Policy Holder's Full Name_____
Policy Holder's Social Security Number _____
Insurance Card Identification Number _____
Date of Birth_____/_____/_____
Name of Employer_____
Group Number _____
Relationship to Patient_____
Name and Address of Insurance Company_____

_____
Street City State Zip

Insurance Company's Telephone Number: (_____) _____-_____

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Financial Policy

- For patients without dental insurance, we require payment in full at the time services are rendered. We accept cash, checks, and all major credit cards. Please be advised that our returned check fee is $25.00.

- For patients with insurance, we require the patient's estimated portion at the time of service. We will then submit the claim and obtain the remaining balance from the insurance company. Payment of any outstanding balance is expected within 30 days of the billing statement. If payment is not received within 30 days, there will be a $15.00 billing fee for each additional 30-day period that the balance remains unpaid.

- Responsible parties with a balance remaining unpaid for 60 days will receive a final notice letter before the account is sent to collections.

- In the event that the account is sent to collections, the individual ultimately responsible for the account will be required to pay legal fees at the rate of 33.3%, interest charges at the rate of 21%, collection agency fees, and any other expenses incurred in the collection of the debt. In addition, the account will be inactivated; moreover, no further services will be rendered.

- **We reserve the right to charge $40.00 for appointments that are canceled or broken without an advance notice of 24 hours.**

This following section must be completed and signed by the person financially responsible for the patient's account at Ashburn Pediatric Dental Center.

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I authorize the staff of Ashburn Pediatric Dental Center to perform any necessary services needed during diagnosis and treatment. In addition, I acknowledge that I am solely responsible for any balance not paid by my insurance company.

I understand the above information, and I am aware that it is my responsibility to inform this office of any changes to the information I have provided. I have read and agree to abide by Ashburn Pediatric Dental Center's financial policy as outlined.

Name (please print)_____

Signature_____

Date_____

Thank you for choosing Ashburn Pediatric Dental Center as your child's health care provider.

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Cancelled or Missed Appointments

We reserve the right to charge a fee for any appointment missed or cancelled within 24 hours of the scheduled time. Our broken appointment fee for an exam/cleaning appointment is $40. Our broken appointment fee for an operatory (dental work) appointment is $50. We do hold this time slot for you, and cancellations prevent us from scheduling other patients during that time. We also prepare the operatory for your appointment, which wastes supplies and the time of our staff by doing so. As a courtesy, we do try to confirm 1-2 days prior to your appointment; however, patients are responsible for keeping the appointments they make. We do understand that emergencies do occur, but please remember to call ahead if you will not be able to make it. We reserve the right to change our fees and policies at any time without notice.

I have read and agree to abide by this financial policy.

Date: _____

Signature: _____

As always, thank you for choosing Ashburn Pediatric Dental Center.

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Acknowledgement:
Notice of Privacy Practices

For your convenience, attached to this clipboard is a copy of Ashburn Pediatric Dental Center's privacy practices. Please take a few moments to review the information before signing this acknowledgement. If you would like a copy of the policy for your records, please ask the front desk; they will be more than happy to provide you with one.

_____
Parent's name (please print)

Below, please print the name of each child who will be treated at this office.

_____

_____

_____

_____

_____

IN OFFICE USE ONLY
____ The individual refused to sign.

____ A communication barrier prevented the obtainment of an acknowledgement.

____ An emergency situation prevented obtainment of the acknowledgement.

_____
Signature of parent /or legal guardian

_____
Date