



MONADNOCK PEDIATRIC DENTISTRY, LLC

56 Peterborough Street
Jaffrey, NH 03452

Welcome to our office! Please fill out the form in black ink.

Child's name _____ Birthdate _____ Sex: F M

Last /First /MI

Child's Social Security # _____ Name child goes by _____

Hobbies/Pets _____

Child's Home Address _____

City _____ State _____ Zip _____ Phone # _____

School _____ Grade _____

Name and ages of other children in family _____

Do parents live together? Yes No If not, with whom does the child live? _____

Parent or Guardian Information Mother Stepmother Guardian

Name _____ DOB _____ Occupation _____

Last/ First/ MI

Employer _____ Work Phone # _____

SS# _____ Pager# _____ Cell# _____

Marital Status _____ Email Address _____

Parent or Guardian Information Father Stepfather Guardian

Name _____ DOB _____ Occupation _____

Last/ First/ MI

Employer _____ Work Phone # _____

SS# _____ Pager# _____ Cell# _____

Marital Status _____ Email Address _____

Where did you hear about our office? Website Yellow Pages Drove by Other

Who may we thank for referring your child? Name: _____

Address: _____ Phone #: _____

Financial Policy

Our office, as a courtesy to you, will obtain your insurance benefits for proposed treatment plans. At your first visit, we request that fees for dental services rendered are due on the date of treatment. All account balances which have not been paid within 30 days become the responsibility of the parent/guardian.

Method of Payment

Check or cash at time of treatment Bank Card MasterCard Visa

Insurance - Plus co-payment at time of treatment

Healthy Kids Gold # _____

Primary Dental Insurance

Insured's name _____ Relationship _____

Birthdate _____ Social Security # _____

Employer _____

Insurance Co. _____ Group # _____

Insurance Co Phone # _____

Secondary Dental Insurance

Insured's name _____ Relationship _____

Birthdate _____ Social Security # _____

Employer _____

Insurance Co. _____ Group # _____

Insurance Co Phone # _____

Child's Medical History

Name of Child's Physician/Pediatrician: _____ Date of last Medical Exam: _____

Physician's Address: _____ Phone #: _____

Is your child taking any medications? Yes No / If yes, please explain: _____

Does your child have any food allergies? Yes No / If yes, please explain: _____

Does your child have any allergies to medications including antibiotics? Yes No

If yes, please explain: _____

Has your child ever been hospitalized? Yes No

If yes, which hospital(s)? _____ When: _____

Reason for hospitalization: _____

How was your child delivered: C-Section Vaginal Delivery (Circle one)

Were there any complications at birth? Yes No / If yes, please explain: _____

Was your child frequently ill during the first year? Yes No / If yes, please explain: _____

Do any of the following apply to your child? Please mark the appropriate column.

	Yes	No		Yes	No
Anemia	___	___	Abnormal Bleeding	___	___
Asthma	___	___	Hepatitis	___	___
Diabetes	___	___	Handicap/Disabilities	___	___
Tuberculosis	___	___	Skin Disorders	___	___
Rheumatic Fever	___	___	Heart Conditions/Murmur	___	___
Premedication needed	___	___	Nose/throat disorders	___	___
Lung disorders	___	___	Hemophilia	___	___
HIV/AIDS	___	___	Cancer/Tumors	___	___
Stomach/kidney problems	___	___	Liver problems	___	___
Convulsions/epilepsy	___	___	Ear problems	___	___
Tubes in ears	___	___	Speech/vision problems	___	___
Hyperactivity/ADD/ADHD	___	___	Mental/emotional disorders	___	___
Latex allergy	___	___	Premature at birth	___	___
Complications during pregnancy	___	___	Blood transfusions	___	___
Sickle Cell Disease	___	___	Eating disorders	___	___
Thyroid/Gland disorders	___	___	Rapid weight loss/gain	___	___
Pregnancy	___	___	Genito-urinary problems	___	___
Headaches	___	___	Bone problems	___	___

Please explain any medical conditions/issues about which you would like us to know:

Child's Dental History

Has your child ever seen a dentist? Yes No

If yes, please indicate the following about the previous dentist:

Name: _____ Address/City/St: _____

Phone #: _____ Date of last appointment: _____

Does your child have an immediate dental problem? Yes No

If yes, please explain: _____

Has your child ever suffered any injury to the mouth and/or teeth? Yes No

If so, please explain: _____

Child's age (in months) when first tooth erupted: _____

Does your child have any problems with opening/closing the mouth? Yes No

If yes, please explain: _____

Has your child had an unfavorable dental experience? Yes No

If yes, please explain: _____

Diet & Nutrition:

Is/Was your child breastfed? Yes No

Does your child sleep with a bottle? Yes No / If yes, what is in the bottle? _____

Does your child drink from a cup? Yes No / Does your child use a sippy cup? Yes No

Is your child on a special diet? Yes No

If yes, please explain: _____

Does your child tend to snack often or graze? Yes No / If so, please list snacks: _____

Does your child drink any of the follow? (Please circle all that apply) Fruit Juice / Soda / Flavored water / Iced tea / Sports drinks

Fluoride:

Do you know the fluoride level of your water? ___ Yes ___ No / If yes, what is it? _____

Do you have well water? ___ Yes ___ No

If yes, has the well water been tested for fluoride? ___ Yes ___ No

Does your child drink bottled water? ___ Yes ___ No

Do you use a water conditioner or filtration system? ___ Yes ___ No

Does your child take fluoride supplements? ___ Yes ___ No

Does your child use toothpaste with fluoride? ___ Yes ___ No

Oral Habits:

Does your child use a pacifier: ___ Yes ___ No

Does your child suck a thumb or finger(s)? ___ Yes ___ No

Does your child grind his/her teeth during the day and/or night? ___ Yes ___ No

Oral Hygiene:

How often does your child brush in a day? _____

How often does your child floss in a day? _____

Does your child get assistance with brush and flossing? ___ Yes ___ No

In case we need to contact you and cannot do so with the provided information, please provide the following information for an alternative contact person in an emergency situation:

Name: _____ Relationship to your child: _____

Address: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

Authorization & Release:

I have answered the questions on this form as accurately as possible and to the best of my knowledge. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform this dental office of any changes to my child's health status. I authorize the dental staff to perform the necessary dental services my child needs. I authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or health practitioners. I authorize the use of radiograph and photographs for the purpose of teaching and scientific publications. I request that my insurance company pay the dentist directly. I understand that my insurance carrier may pay less than the actual bill of services. Therefore, I agree to be responsible for the payment of all services rendered on my child's behalf.

Signature of Parent/Guardian: _____ Date: _____

Monadnock Pediatric Dentistry, L.L.C.

FINANCIAL AGREEMENT

I agree to pay for services at the time of each appointment. As a service to you, we will submit the treatment plan to your primary insurance company. Upon written receipt of pre-approval, we will contact you to inform you of how much your insurance will cover and the balance for which you will be responsible.

I agree to pay interest at the rate of 1.75% per month that will be added to any of my accounts past 30 days due.

In the event, your account is turned over to our collection agency for non-payment, there will be a 30% increase added to your balance to defray the costs the collection agency charges us. A 50% balance will be added if the case goes to court. In addition, you will be responsible for all incurred legal and /or all court fees.

I agree that I am responsible for payment to this office for care provided for my child/children.

Parent/Guardian: _____ Date: _____

ASSIGNMENT OF INSURANCE BENEFITS

I authorize direct payment to Monadnock Pediatric Dentistry, L.L.C. of any insurance benefits for treatment rendered for my child/children.

However, if assignment is directly to the Insured, I agree to pay the provider the full payment prior to rendered services.

Parent/Guardian: _____ Date: _____

HIPAA INFORMATION

The first-ever federal privacy standards to protect patients' medical records and other health information provided to health plans, doctors, hospitals and other health care providers took effect on April 14, 2003. Developed by the Department of Health and Human Services (HHS), these new standards provide patients with access to their medical records and more control over how their personal health information is used and disclosed. They represent a uniform, federal floor of privacy protections for consumers across the country. State laws providing additional protections to consumers are not affected by this new rule.

A copy of the HIPAA policy can be provided by this office at the front desk for your review. Please check one of the boxes listed below.

Yes, I have requested and received a copy of the HIPAA policy from the front desk.

No, I do not wish to receive a copy of the HIPAA policy.

Parent/Guardian Signature: _____

Date: _____

MONADNOCK PEDIATRIC DENTISTRY

CANCELLATION & FAILURE TO ARRIVE

If you need to cancel an appointment, we request that you call at least one day before your scheduled appointment time. The 24-hour notice gives us an opportunity to alter our daily schedule accordingly. Please note that **two or more cancellations with less than 24-hour notice or failures to arrive will result in a \$35 fee.** Insurance companies will not pay for the missed appointment fee, and we will schedule a new appointment only when this fee is paid. Additional failed appointments and cancellations with less than 24-hour notice may warrant dismissal from the practice.

I understand the office policy for canceled and missed appointments.

Parent/Guardian: _____ Date: _____

Monadnock Pediatric Dentistry, L.L.C.

Caregiver's Authorization Affidavit

To the parent: The purpose of this form is to give 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 the child yourself. Should you withdraw or amend this authorization, you must do this in person at our dental office. ***We prefer that you, as the parent or legal guardian, accompany your child to all dental visits – We reserve the right to decline treatment of your child in situations where it is essential that you be present.***

Patient's name: _____ Date of Birth ____/____/____

Parent/ Legal Guardian

Note: if you are a court appointed legal guardian, a copy of court documents stating that you are the legal guardian of this child are necessary for our records prior to any treatment.

Your name: _____ Date of Birth ____/____/____
(Must be over 18 years of age)

Relationship to the patient:

Parent ____ court-appointed legal guardian ____ other: _____

Address: _____ City _____ State ____ Zip _____

Phone #: home(____)____-____ work:(____)____-____ cell:(____)____-____

Your NH drivers license # _____

Any adult accompanying your child to their scheduled appointment must be at least 18 years of age and will be expected to stay in the clinic while your child is receiving treatment, and may be required to make decisions on your and your child's behalf and/or accept responsibility for situations such as, but not limited to:

- Consent for any required changes in planned treatment for the day- you will be responsible for altered or additional fees for any such treatment.
- Consent for behavior management techniques, such as inhalation Nitrous-Oxide, restraint, etc.
- Receiving on your behalf, post operative instructions for the day's procedures.
- Communicating to you information relative to your child's visit and any post-operative instructions.
- Communicating to you expectations for your child's future visits.

Please be aware that there are situations for which you must be present for your child to receive treatment. In the event that you cannot accompany your child in these situations, we reserve the right to decline treatment for your child until you can be present in the clinic. Your presence is absolutely necessary for the child's first visit in our office.

Please read and sign the back of this form

Your signature below indicates that:

1. You are authorizing our dental office to discuss treatment of your child with any adult accompanying your child to his or her appointment.
2. You will be responsible for relating clinic policies to the adult accompanying your child assuring that they comply.
3. You understand and agree to allow the adult accompanying your child to make decisions on your behalf, as outlined above.
4. You are responsible for making arrangements for payment at time of treatment.
5. You will notify the dental office in person should you wish to amend or withdraw this authorization.

Signature: _____ Date Signed: ____/____/_____
(Parent or legal guardian only)

Decline Caregiver's Authorization Affidavit

Please be aware if you decline to sign the above section, we will only be able to see your child for his or her scheduled appointment if a parent or legal guardian is accompanying him or her to our office.

Should you wish to amend your decision to decline, you must do so in person before your child may be accompanied by another adult to their appointment.

Signature: _____ Date Signed: ____/____/_____
(Parent or legal guardian only)