Child Health Questionnaire

In order to provide a complete dental exam for your child, please answer all of the following questions as completely as possible.

Date _____/_____/_____ Child's Name ______________________________

Birth Date _____/_____/_____ Age _______ Sex _____

Child's Physician ______________________________

Address ______________________________ Physician Phone Number ____________________

Date of last physical examination ______________________________

How is your child's general health? ______________________________

Has your child had any serious illness? Yes ____ No ____

If yes, please describe ______________________________

Has your child ever been hospitalized? Yes ____ No ____ ***If yes when and for what reason?*** ____________________

Is your child receiving any medication, vitamins, and/or natural remedies at this time? Yes ____ No ____

If yes, please describe ______________________________

Has your child ever had an allergic reaction to the following?

Dental Anesthetics ____ Antibiotics ____ Food ____ Drugs ____ Latex ____ Other _____

If yes, please describe ______________________________

Has your child ever received a blow or injury to his/her head or teeth? Yes ____ No ____

If yes, please describe ______________________________

Has your child ever been treated with X-ray or radiation therapy? Yes ____ No ____

Has your child ever had any of the following conditions? ***Please Check:***

	Yes	No	Age		Yes	No	Age		Yes	No	Age
ADD/ADHD				Diabetes				Mentally Challenged			
AIDS/HIV				Hearing Problems				Physically Challenged			
Asthma				Heart Murmur				Pregnancy			
Autism				Heart Problems				Scarlet Fever			
Behavioral Disturbance				Hepatitis				Seizures			
Blood/Bleeding Disorders				Kidney Problems				Stomach Problems			
Cancer				Learning Disability				Tuberculosis			
Cerebral Palsy				Lung Disease							
Other											

If yes to any of the above, please describe ______________________________

Does your child have any habits we should be aware of, such as?

Poor eating habits ____ Thumb Sucking ____ Pacifier ____ Bottles ____ Other ____________________

Does your child receive fluoride in: Drinking water at home Yes ____ No ____ By prescription Yes ____ No ____

Has your child had any unpleasant dental experiences? Yes ____ No ____

If yes, when? ______________________________

How can we help? ______________________________

Date of last dental examination _____/_____/_____

Has your child ever had orthodontic treatment? Yes ____ No ____

What is the nature of today's visit? Regular Exam ____ Emergency ____ State Problem ____________________

Signature of Parent or Guardian ______________________________

Signature of Doctor/Staff ______________________________

Welcome to our practice, and thank you for letting us care for your child's smile!

Chart # ___________

Child and Family History

Patient Information

Patient's Name ______________________ Nickname ______________________ Date ______________

Date of Birth ______________ Sex ________

Is Patient Adopted? Yes _____ No _____ If yes, Legal Guardian Name ______________________________

Name of School ______________________________ Grade Level __________

Name and Ages of Siblings ____

Are Any of These Children Currently Patients in This Office? ______________________________________

Child's Address ____

City ______________________________________ State __________ Zip ________________

Home Phone # (____)________________________

Favorite Pet or Toy ______________________________ Pet's Name ______________________________

Who May We Thank for Referring You? ____

Yellow Pages _____ Website _____ Newspaper _____ Insurance Company _____ Other _____

Responsible Party Information

Father's Name ________________________________ Date of Birth ____________ Marital Status ________

Social Security # ________________________ Email Address ________________________________

Address ____

City ________________________________ State ______________________ Zipcode ____________

Home Phone # __________________________ Work # ______________________ Cell # ____________

Place of Employment ________________________Occupation________________________________

Mother's Name ________________________________ Date of Birth ____________ Marital Status ________

Social Security # ________________________ Email Address ________________________________

Address ____

City ________________________________ State ______________________ Zipcode ____________

Home Phone # __________________________ Work # ______________________ Cell # ____________

Place of Employment ________________________Occupation________________________________

Dental Insurance Information

Primary Insurance

Name of Insured ____

Insured's Date of Birth ____________________ ID # ______________________ Group # ______________

Insured's Employer Name ______________________________ Address ______________________________

Insurance Plan Name ____

Insurance Address ____ Phone # ____________________

Secondary Insurance

Name of Insured ____

Insured's Date of Birth ____________________ ID # ______________________ Group # ______________

Insured's Employer Name ______________________________ Address ______________________________

Insurance Plan Name ____

Insurance Address ____ Phone # ____________________

Winning Smiles Financial Policy

Our office is committed to providing you with the highest quality dental care using only the best materials and technology available. Our clinical and business teams work closely together to provide a positive environment for visits to our office and assistance with financial requirements. ***Payment for professional services is expected at the time dental treatment is provided.*** *A member of our Business Team will be delighted to discuss our options with you!*

We are happy to file dental claims for our families who have dental insurance. In general, we will file claims to any company that will pay us directly and does not restrict coverage to a list of participating providers. Filing to your insurance carrier is not a guarantee of payment. Please understand that the patient or parent/guardian has the final responsibility for payment of any services rendered. Our doctors recommend treatment based on our patients' needs, not on what insurance will pay.

a. **Payment options**: For your convenience, we accept cash, personal checks, debit cards, Visa, MasterCard, Discover, Flexible Spending Accounts, Health Saving Accounts and CareCredit.

b. Financial responsibility: Self-pay patients are expected to pay for services received in full at the time of service. Any alternative financial arrangements must be made before you see the dentist. The parent or guardian bringing the child to our office and authorizing treatment is legally responsible for payment of all charges. We cannot send statements to other persons.

c. Divorce/separation: The party responsible for the account prior to the divorce or separation remains responsible for the account. After the divorce/separation, the parent or guardian bringing the child and authorizing treatment will be the person responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent. We will provide you additional copies of receipts if needed.

d. Required payments: At treatment visits, we collect a percentage of the total cost of treatment, determined by ESTIMATION of what your insurance will cover, plus any deductible required by your insurance. In the event of underpayment, we will send you a statement in the mail. In the event of overpayment on your part, you will receive a credit on your account, or you may request reimbursement by mailed check.

e. Authorization: If your insurance plan requires an authorization we will need to receive the authorization before you or your child sees the dentist. If we have not received the authorization prior to your appointment, we will need to reschedule the appointment until it is received.

f. Deposit: Certain procedures may require a deposit, including deductibles, co-payments and coinsurance. Payment of these amounts is required before the procedure is performed.

g. Uncovered services: In the event your insurance company determines a service to be "not covered," or reimburses Winning Smiles lower than the anticipated amount, you will be responsible for payment. We try to inform patients when services may not be covered; however, it is the patient's responsibility to understand their dental insurance limitations. Most benefits will be verified before your insurance company can be billed. In the event that your insurance has not paid within 60 days, the balance may be transferred to your account.

h. Returned check fee: A $35.00 service charge will be applied to your account for any returned check. If a check is returned, we will only accept cash or a credit card as payment on your account.

i. Canceling/rescheduling: Scheduled appointments that are missed, changed, or canceled with less than 48 hours of notice will be charged a fee of $50 (hygiene appointments) or $75 (treatment appointments).

j. Past due accounts: Unless prior arrangements have been approved in writing by our office, the balance on your statement is due and payable when the statement is issued. If your account becomes past due over 90 days, a collections process may be used to collect funds. All reasonable expenses incurred during the collection process will be the account holder's responsibility.

Effective date: Once you have signed this policy, you agree to all the terms and conditions contained herein and the agreement will be in full force and effect.

I have read the above policies and understand my obligations with Winning Smiles for my or my child's dental care. I acknowledge that I am responsible for payment of any services not covered by my insurance plan.

Print name of person signing______________________________ _____ Relation to patient:_______________

Signature: ____ Date: _______________________