

PATIENT HISTORY

PATIENT NAME _____

ACCOUNT # _____

IS THIS YOUR CHILD'S FIRST VISIT TO A DENTIST? YES NO

IF NOT, WAS PREVIOUS EXPERIENCE ___ GOOD ___ BAD ___ OTHER

PLEASE EXPLAIN _____

DID YOU FIND US ON: INTERNET ___ PHONEBOOK ___ Ad ___ FRIEND ___ OTHER _____

PLEASE TELL US THE MAIN REASON FOR TODAY'S VISIT: _____

HAS YOUR CHILD BEEN EXPERIENCING DENTAL PAIN? YES NO

HAS YOUR CHILD BEEN AWAKE AT NIGHT DUE TO DENTAL PAIN? YES NO

DO YOU HAVE ANY CONCERNS ABOUT YOUR CHILD'S DENTAL HEALTH? _____

HAS YOUR CHILD EVER BEEN HOSPITALIZED? YES NO IF YES, PLEASE GIVE DATE(S) AND REASON: _____

IS YOUR CHILD ALLERGIC TO ANY MEDICATIONS? YES NO PLEASE IDENTIFY: _____

IS YOUR CHILD CURRENTLY TAKING ANY MEDICATIONS? YES NO PLEASE IDENTIFY: _____

REASON FOR THIS MEDICATION _____ PEDIATRICIAN NAME & PHONE _____

HAS YOUR CHILD HAD: DPT IMMUNIZATION YES NO POLIO VACCINE YES NO MEASLES, MUMPS & GERMAN MEASLES YES NO

IS THERE ANYTHING YOU CAN TELL US ABOUT YOUR CHILD THAT MIGHT HELP US TAKE THE BEST POSSIBLE CARE OF YOUR CHILD: _____

DOES YOUR CHILD NOW HAVE OR HAS SHE OR HE EVER HAD IN THE PAST:

SPEECH PROBLEMS <input type="checkbox"/> YES <input type="checkbox"/> NO	ANEMIA/SICKLE CELL DISEASE <input type="checkbox"/> YES <input type="checkbox"/> NO	CEREBRAL PALSY <input type="checkbox"/> YES <input type="checkbox"/> NO
HEARING PROBLEMS <input type="checkbox"/> YES <input type="checkbox"/> NO	BRUISES EASILY <input type="checkbox"/> YES <input type="checkbox"/> NO	SEIZURES <input type="checkbox"/> YES <input type="checkbox"/> NO
ASTHMA <input type="checkbox"/> YES <input type="checkbox"/> NO	BLOOD TRANSFUSION <input type="checkbox"/> YES <input type="checkbox"/> NO	KIDNEY/BLADDER PROBLEMS <input type="checkbox"/> YES <input type="checkbox"/> NO
SKIN PROBLEMS <input type="checkbox"/> YES <input type="checkbox"/> NO	HEPATITIS/JAUNDICE <input type="checkbox"/> YES <input type="checkbox"/> NO	DIABETES <input type="checkbox"/> YES <input type="checkbox"/> NO
ALLERGIES (OTHER) <input type="checkbox"/> YES <input type="checkbox"/> NO	CYSTIC FIBROSIS <input type="checkbox"/> YES <input type="checkbox"/> NO	PREGNANT (PATIENT) <input type="checkbox"/> YES <input type="checkbox"/> NO

PLEASE IDENTIFY ALLERGIES: _____

HEART DISEASE OR MURMUR YES NO PLEASE DESCRIBE _____

IS PRE-MEDICATION REQUIRED FOR DENTAL TREATMENT YES NO DRUG PREFERRED _____ CHILD'S WEIGHT _____

PLEASE CIRCLE ILLNESSES YOUR CHILD HAS HAD: CHICKENPOX EARACHES MEASLES GERMAN MEASLES MUMPS MONONUCLEOSIS
HIV/AIDS SCARLET FEVER TUBERCULOSIS VENEREAL DISEASE TONSILLITIS

LEARNING/BEHAVIOR DISORDER(S) YES NO PLEASE DESCRIBE: _____

HAS YOUR CHILD HAD ANY SURGERIES YES NO IS YOUR CHILD SCHEDULED FOR SURGERY? YES NO IF YES, DATE: _____

PLEASE DESCRIBE _____

IS THERE ANYTHING ELSE WE SHOULD KNOW ABOUT YOUR CHILD?

PARENT(S)/GUARDIAN PLEASE SIGN: _____ DATE _____

PEDIATRIC DENTISTRY OF NORTHERN NEW MEXICO, p.c.

Dentistry for Kids

James A. Evans, DDS, MS, FICD

Financial Policy

Your child's dental care is our primary objective. Our professional relationship depends on your clear understanding of our financial policy as well as of your own insurance plan if applicable.

Payment is due at time of service. If you have dental insurance, as a courtesy to you, we will submit your claims. Since our patients represent over 350 insurance companies, we cannot be knowledgeable about every policy. Even within one company, such as Delta Dental, there are several different plans. It is your responsibility to become familiar with your own policy. We have contracts with most Deltal Dental plans and United Concordia. For other insurance companies, we ask you to pay 25% of the day's services, plus the gross receipts taxes, at time of service. This is an estimate. If the insurance company pays more than estimated, we will reimburse you. If it pays less, we will send you a statement.

We do not normally send monthly statements. Insurance companies are required by law to make a determination within 45 days. You will be notified of any balance due, and we expect payment within 30 days. Your dental insurance is a contract between you and your insurance company, not this office. We will not become involved in disputes between you and your insurance company, other than to provide factual information as needed.

Also, we will not become involved in marital or family disputes. The person designated as the responsible party – that is, the person making appointments and bringing the patient to appointments – will be sent any relevant communication. That person will receive our phone calls and notices of payment due, regardless of court settlements or other personal arrangements. If someone other than a parent brings the child to the appointment, we need to have a signed parental consent before the child is seen.

OTHER SERVICE CHARGES:

*18% Annual (1 ½ % monthly) interest is charged to accounts with outstanding balances 60 days from date of service.

*Returned checks are subject to a \$25 service charge.

I have read this policy statement and hereby agree to the conditions herein.

(Signed)-----(Date)-----