

TELL US ABOUT YOUR CHILD

Child's Name _____
First Middle Initial Last

Nickname _____ Gender _____

Child's Birthdate ____ / ____ / ____ Child's Age ____

Child's Home Address _____

City, State, Zip _____

How did you choose our office? _____

INDIVIDUALS OTHER THAN LEGAL GUARDIAN AUTHORIZED TO BRING CHILD AND CONSENT FOR TREATMENT Grandparents, etc.

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Signature _____

If treatment involves nitrous oxide, individual must be 18 years or older to bring child.

MOTHER'S INFORMATION

Mother Stepmother Guardian Foster Parent

Name _____

Address _____

City, State, Zip _____

Primary # _____ Secondary # _____

Birthdate _____ SSN _____

Email Address _____

Marital Status Single Married Separated Widowed Divorced

Do you have legal custody of this child? Yes No

EMERGENCY CONTACT OTHER THAN LEGAL GUARDIAN

Name _____

Relationship _____ Phone _____

FATHER'S INFORMATION

Father Stepfather Guardian Foster Parent

Name _____

Address _____

Same as mother's

City, State, Zip _____

Primary # _____ Secondary # _____

Birthdate _____ SSN _____

Email Address _____

Marital Status Single Married Separated Widowed Divorced

Do you have legal custody of this child? Yes No

PRIMARY DENTAL INSURANCE

Insurance Co. Name _____

Insurance Co. Phone _____

Subscriber Member # _____

Group # _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birthdate ____ / ____ / ____ SSN _____

Policy Owner's Employer _____

SECONDARY DENTAL INSURANCE

Insurance Co. Name _____

Insurance Co. Phone _____

Subscriber Member # _____

Group # _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birthdate ____ / ____ / ____ SSN _____

Policy Owner's Employer _____

AUTHORIZATION

I certify the truth of all information given. I also authorize the release of pertinent information to those persons requiring it for the treatment of my child or for the purpose of payment of the account or credit reference. Under certain circumstances, I authorize payment of insurance benefits directly to the doctors at Honeymint Pediatric Dentistry, otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I understand I am financially responsible for payment of services not paid, in whole or in part, by my dental insurance. My part of the expenses will be due today or at the time services are rendered.

Signature of Parent/Guardian _____

Print Name _____

Date _____

Main reason for today's visit: _____

DENTAL HISTORY

- How often are the child's teeth brushed? 1x/day 2x/day Every Other Day Not Regularly
- How often are the child's teeth being flossed? 1x/day 2x/day Every Other Day Not Regularly
- Who does the brushing and flossing? Parent Child Half/Half None
- Fluoride Use? Rx by MD/DMD in H2O Toothpaste Rinse None
- Does your child have any oral habits? Thumb/Finger Binky Mouth Breather Grinding None
- History of Dental Trauma? If yes, please explain: _____
- How would you rate mother's oral health? Excellent Good Fair Poor I don't know
- How would you rate father's oral health? Excellent Good Fair Poor I don't know
- How would you rate your child's sugar consumption? (candy, juice, etc.) Low Average High
- When was your child weaned off nursing/bottle? 6 Months 12 Months 24 Months Still Use I don't know

MEDICAL HISTORY

- Is your child under a physician's care other than his/her PCP? Yes No If yes, explain _____
- Has your child ever been hospitalized or had any surgeries? Yes No If yes, explain (list dates) _____
- Has your child ever had any serious complications from general anesthesia? Yes No If yes, explain _____
- Has your child ever had a serious head injury? Yes No If yes, explain _____

DOES YOUR CHILD HAVE ANY ALLERGIES?

- | | | | |
|--------------------------------------|--------------------------------------|---|------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Penicillin/Amoxicillin | <input type="checkbox"/> Codeine |
| <input type="checkbox"/> Acrylic | <input type="checkbox"/> Augmentin | <input type="checkbox"/> Clindamycin | <input type="checkbox"/> Metal |
| <input type="checkbox"/> Latex | <input type="checkbox"/> Sulfa drugs | <input type="checkbox"/> Local anesthesia | <input type="checkbox"/> Zithromax |
| <input type="checkbox"/> Other _____ | | | |

IS YOUR CHILD TAKING ANY MEDICATIONS?

 Please list all medications your child is currently taking: None

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING?

Yes	No	ADD/ADHD	Yes	No	Chest Pains	Yes	No	Hearing Loss	Yes	No	Lung Disease	Yes	No	Special Diet
<input type="checkbox"/>	<input type="checkbox"/>	ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Special Diet
<input type="checkbox"/>	<input type="checkbox"/>	AIDS/HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	Cold Sores/Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack/Failure	<input type="checkbox"/>	<input type="checkbox"/>	Malignant Hyperthermia	<input type="checkbox"/>	<input type="checkbox"/>	Speech Therapy
<input type="checkbox"/>	<input type="checkbox"/>	Anaphylaxis	<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Spina Bifida
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Drug/Marijuana Use	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble/Disease	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Jaw Joints	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco/Vape Use
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Gout	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Parathyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis Type _____	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatments	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Autism	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	Tumors or Growths
<input type="checkbox"/>	<input type="checkbox"/>	Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells/Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Hives or Rash	<input type="checkbox"/>	<input type="checkbox"/>	Renal Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Food Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Intestinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease
<input type="checkbox"/>	<input type="checkbox"/>	Breathing Problems	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Cough	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Vision Problems
<input type="checkbox"/>	<input type="checkbox"/>	Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	Yellow Jaundice
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Shingles	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>	

Has your child ever had any other serious conditions not listed above? Yes No If yes, _____

If yes to heart murmur, does your child need a pre-medication for dental treatment? Yes No If yes, _____

Does your child have a genetic disorder? Yes No If yes, _____

Does your child have a syndrome/disease? Yes No If yes, _____

 Is your daughter: NA Pregnant/Trying to get pregnant? Due Date _____ Nursing? Taking oral contraceptives?

Child's physician: Name _____ Phone _____ Last appt? _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my child's health. It is my responsibility to inform HoneyMint Pediatric Dentistry of any changes in my child's medical status.

Please initial that you have read and understand each section.

Financial Policy

I have received the Honeymint Pediatric Dentistry Financial and Insurance Policy that outlines my financial responsibility toward care rendered by the doctors at Honeymint Pediatric Dentistry. I understand that the parent or legal guardian who accompanies my child to an appointment will be responsible for payment at the time services are rendered.

Appointment Cancellation or No-Show Policy

I take full responsibility for the cancellation/rescheduling of any needed appointments. A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, WE REQUIRE AT LEAST A 24 HOUR NOTICE PRIOR TO YOUR APPOINTMENT TIME to avoid a \$40 cancellation fee. Many patients are waiting months in advance for appointments, please respect our schedule and our other patients by giving us time to fill your reserved spot with another patient in need of care. Should a patient fail to keep a surgery appointment a \$200 fee will be charged if advance notice is not given so that appointment may be given to another child in need of treatment. Should no advance notice of cancellation be given, Honeymint Pediatric Dentistry reserves the right to dismiss the patient from the practice after 3 missed or late cancelled appointments.

Medical/Dental Release Statements

As the birth/adoptive parent or legal guardian, I give my consent for the doctors of Honeymint Pediatric Dentistry to complete a thorough examination on the patient named above including any needed diagnostic radiographs. To the best of my knowledge the information I have provided is accurate and I understand that it will be held in the strictest of confidence and in accordance to all federal and state HIPAA regulations. Further more, I understand that it is my responsibility to inform Honeymint Pediatric Dentistry of any future changes to my child's medical history status. As a parent or legal guardian of the previously named patient, I also hereby grant the doctors and staff of Honeymint Pediatric Dentistry permission to perform future treatment(s) as deemed appropriate. I understand that all necessary treatment will be explained prior to commencement and that I am responsible for payment in full at the time services are rendered, unless prior arrangements have been approved.

Insurance Claim Release & Financial Responsibility Statement

To precipitate the filing of this and all future dental insurance claims, I do hereby authorize the release of confidential information to my child's dental insurance company. I am aware that Honeymint Pediatric Dentistry will be providing an estimate of the insurance coverage prior to initiating any future treatment and that I am legally responsible for any portions not paid by this policy. I understand that additional out-of-pocket expenses may be accrued should estimates provided by my insurance company be inaccurate or should procedures change during the course of the treatment. Furthermore, I am aware of my financial responsibility should my insurance policy fail to pay, for any reason, within 45 days of receiving such treatment.

Authorization for Direct Payment

I hereby authorize payment of insurance benefits directly to Honeymint Pediatric Dentistry or the dentist that performs treatment on my child. Furthermore, in the event of payment default for services previously rendered, I also agree to pay all reasonable collection and/or legal fees incurred in an attempt to collect on this amount.

Notice of Privacy Practices, Health Insurance Portability & Accountability Act of 1996

I have read the form entitled, "Notice of Privacy Practices," and understand its contents concerning the privacy of my child's confidential healthcare information. I do hereby provide consent for the standard use of such information and understand that these provisions prohibit Honeymint Pediatric Dentistry from selling or transferring this information to any unauthorized locations without my prior approval. I have reviewed this information and all questions have been answered to my satisfaction.

I have read and understand the above policies.

Methods of Payment

For your convenience we accept cash, check, and all major credit cards (Visa, MasterCard, American Express and Discover). We gladly offer and accept payment plans through CareCredit for dental treatment.

As we strive to be one of Albany's leading providers for pediatric dental care, we work to assist parents in taking an active role in their child's dental health. Because we value our relationship with you and believe that the best relationships are based upon understanding, we offer these clarifications on methods of payment & insurance reimbursement.

At each visit, we will request a copy of your dental insurance information to allow us to file your claim. Please remember to bring all dental insurance information/insurance card(s) to each appointment. Please contact Honeymint Pediatric Dentistry immediately after making any changes to your dental coverage, so we can keep our records current and to provide expeditious reimbursement of your benefits.

If any treatment needs are discovered during your child's exam, we will provide you with a cost estimate indicating our total fee, what we anticipate your insurance coverage to be, and your ESTIMATED out-of-pocket portion for the treatment plan. We will discuss all treatment options and costs before beginning any further treatment. We know that dental insurance can be confusing so feel free to contact us with insurance or payment questions.

Dental Insurance

We are dedicated to providing all our patients with the best treatment available and base all our treatment recommendations on what will be best for your child and not what your insurance company does or doesn't pay. Please note the following in regards to your dental insurance coverage:

1. We must emphasize that as a health care provider, our relationship is with you and not your dental insurance company. Your dental insurance is a contract between you, your employer and the insurance company. Most plans routinely pay between 50-75% of the average total fee for a given procedure. This percentage is pre-determined by the plan your employer has purchased.
2. As a courtesy, we will be happy to file for your insurance benefits. Because your dental insurance plan is a contract between you, your employer, and the insurance company, many carriers will not reimburse our office. **In this instance, you will be responsible for the full cost of each visit at the time services are provided and your insurance company will send you the reimbursement check directly.**
3. **Any amount not covered by your insurance company is payable at the time services are rendered.** These fees may include deductibles, co-payments or certain procedures not covered by your insurance policy. Unfortunately, some of the services that we may recommend for your child may not be covered by your specific dental insurance. Our primary goal is to treat your child using the best possible materials, supplies, medications and environment.
4. We allow a maximum of 45 days for your insurance company to clear account balances. **Any unpaid portions will be due in full, by you, after this period.** If you have not paid your balance within 60 days of the date treatment was rendered, a finance charge of 1.5% will be added to your account each month until paid. Should your insurance company submit payment after this time, we will be glad to reimburse you. This is rare but is important that you recognize that your insurance is a legal contract between you and your insurance company. Our office is not, and cannot be part of that legal contract. Ultimately you are responsible for all charges incurred in our office.
5. Our office does not determine your dental benefits. Your employer chooses your particular policy. If you are unhappy with it's coverage, this should be mentioned to your employer's benefits coordinator. Only your employer can adjust benefits.

Prior to completing any treatment, we will provide you with a cost estimate indicating our total fee, what we anticipate your insurance coverage to be, and your estimated out-of-pocket portion (estimated patient portion or EPP). Please remember, this is only an estimate based upon generalized information provided by your dental insurance company. An additional billing or possibly a refund may be subsequently required should information provided be inaccurate.

We will always do our best to maximize the insurance benefits that you are eligible to receive and we appreciate your prompt settlement of any charges that may be incurred during the treatment process. We look forward to years of close association with you, as we work together to maintain your child's oral health!