



Yvette Vernor Dye, D.D.S.

Dentistry for Children and Young Adults

www.dentonpediatricdentist.com

Patient Information and Health History

Patients Name _____ Nickname _____ Age ____ Date of Birth _____

Date _____ Sex _____ Race _____ School _____ Grade _____

Are there brothers or sisters who are patients? Yes No If yes, names _____

Patients Address _____ City _____ State _____ Zip _____

Name of Child's Physician _____ Date Last Seen _____

Pharmacy _____ Location _____ Pharmacy Phone _____

Referred by Doctor _____ Referred by Family/Friend _____ Referred by Other _____

Person Responsible for this Account _____ Relationship to Child _____

Father / Guardian (Name) _____ Date of Birth _____

Driver's License # _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Residence Phone _____ Cell Phone _____ E-mail Address _____

Employer _____ How Long Employed _____ Work Phone _____

Work Address _____ City _____ State _____ Zip _____

Mother / Guardian (Name) _____ Date of Birth _____

Driver's License # _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Residence Phone _____ Cell Phone _____ E-mail Address _____

Employer _____ How Long Employed _____ Work Phone _____

Work Address _____ City _____ State _____ Zip _____

Dental Insurance

Insured Parent _____ Group Number _____

Insurance Company _____ Insurance Company Phone _____

Consent for Dental Treatment

I request and authorize Dr. Dye to examine, clean, and provide dental treatment for my child. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Dye to diagnose and /or treat my child's dental needs. Photographs may be taken of my child for diagnostic and educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them understand the treatment in terms appropriate to their age. Dr. Dye will provide an environment likely to help children learn to cooperate during treatment using a variety of techniques including, praise, explanation and demonstration of procedures and instruments, and variable voice tone.

I will be responsible for any charges incurred on this child for dental services regardless of insurance payment and coverage.

Signature _____ Date _____

Relationship to Patient _____

Patient's Name _____ Date of Birth _____

- | | Yes | No | |
|---|--------------------------|--------------------------|------------|
| 1. Is your child allergic to anything? (medicine, food) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 2. Is your child taking any medicines at this time? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 3. Has your child ever been diagnosed and/or treated for his/her Heart? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 4. Has your child ever had Rheumatic Fever? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 5. Is your child being teated by a physician at this time? | <input type="checkbox"/> | <input type="checkbox"/> | When _____ |
| 6. Has your child ever been a patient in a hospital? | <input type="checkbox"/> | <input type="checkbox"/> | When _____ |
| 7. Has your child ever received general anesthesia? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 8. When was your child's last dental visit? | | | _____ |
| 9. Does your child suck fingers or thumbs? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 10. Are your child's teeth brushed once daily? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 11. What type of toothpaste does your child use? | | | _____ |
| 12. At what age did your child stop bottle /breast feeding? | | | _____ |

Organs and Systems

Has this child ever been treated for any of the following? Please check yes or no:

- | Yes | No | | Yes | No | | Yes | No | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|----------------------------|--------------------------|--------------------------|--------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Blood Circulatory | <input type="checkbox"/> | <input type="checkbox"/> | Speech / Hearing | <input type="checkbox"/> | <input type="checkbox"/> | Muscles |
| <input type="checkbox"/> | <input type="checkbox"/> | Bones | <input type="checkbox"/> | <input type="checkbox"/> | Gastrointestinal (Stomach) | <input type="checkbox"/> | <input type="checkbox"/> | Nervous Systems |
| <input type="checkbox"/> | <input type="checkbox"/> | Endocrine Glands | <input type="checkbox"/> | <input type="checkbox"/> | Kidney—Bladder | <input type="checkbox"/> | <input type="checkbox"/> | Skin |
| <input type="checkbox"/> | <input type="checkbox"/> | Eyes, Ears, Nose, Throat | <input type="checkbox"/> | <input type="checkbox"/> | Liver | <input type="checkbox"/> | <input type="checkbox"/> | Tonsils / Adenoids |

Illness

Has this child ever been diagnose as having any of the following conditions? Please check yes or no:

- | Yes | No | | Yes | No | | Yes | No | |
|--------------------------|--------------------------|------------------------|--------------------------|--------------------------|----------------------------|--------------------------|--------------------------|------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | AIDS / HIV Positive | <input type="checkbox"/> | <input type="checkbox"/> | Emotional Disturbance | <input type="checkbox"/> | <input type="checkbox"/> | Nutritional Deficiency |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> | Orthopedic Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergy | <input type="checkbox"/> | <input type="checkbox"/> | Eye Problems | <input type="checkbox"/> | <input type="checkbox"/> | Pneumonia |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Excessive Bleeding Problem | <input type="checkbox"/> | <input type="checkbox"/> | Polio |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Fainting | <input type="checkbox"/> | <input type="checkbox"/> | Scarlet Fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Autism | <input type="checkbox"/> | <input type="checkbox"/> | Hearing Loss | <input type="checkbox"/> | <input type="checkbox"/> | Scoliosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Brain Injury | <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | Sickle Cell Anemia |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia | <input type="checkbox"/> | <input type="checkbox"/> | Spina Bifida |
| <input type="checkbox"/> | <input type="checkbox"/> | Cerebral Palsy | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis—Type _____ | <input type="checkbox"/> | <input type="checkbox"/> | Syndrome |
| <input type="checkbox"/> | <input type="checkbox"/> | Chicken Pox | <input type="checkbox"/> | <input type="checkbox"/> | Jaundice | <input type="checkbox"/> | <input type="checkbox"/> | Tetanus |
| <input type="checkbox"/> | <input type="checkbox"/> | Cleft Lip / Palate | <input type="checkbox"/> | <input type="checkbox"/> | Leukemia | <input type="checkbox"/> | <input type="checkbox"/> | Whooping Cough |
| <input type="checkbox"/> | <input type="checkbox"/> | Convulsions / Seizures | <input type="checkbox"/> | <input type="checkbox"/> | Measles | <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Mental Retardation | | | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Diphtheria | <input type="checkbox"/> | <input type="checkbox"/> | Mumps | | | _____ |

Reason for bringing child to the Dentist _____

Is there anything else that you think we should know about your child? _____

Signature _____ Relationship to Patient? _____ Date _____

Reviewer _____	Date _____	Comments _____
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Financial Policy

What About Finances?

Payment for professional services is due at the time dental treatment is provided. Every effort will be made to provide a treatment plan which fits your timetable and budget, and gives your child the best possible care. We accept cash, personal checks, debit cards and most major credit cards.

Our Office Policy Regarding Dental Insurance

If we have received all of your insurance information on the day of the appointment, we will be happy to file your claim for you. You must be familiar with your insurance benefits, as we will collect from you the estimated amount insurance is not expected to pay. **YOU ARE RESPONSIBLE FOR ANY BALANCE ON YOUR ACCOUNT AFTER 30 DAYS, WHETHER INSURANCE HAS PAID OR NOT.** Please understand that we file dental insurance as a courtesy to our patients. **WE DO NOT HAVE A CONTRACT WITH YOUR INSURANCE COMPANY, ONLY YOU DO.** We are not responsible for how your insurance company handles its claims or for what benefits they pay on a claim. We can only assist you in estimating your portion of the cost of treatment, **WE AT NO TIME GUARANTEE WHAT YOUR INSURANCE WILL OR WILL NOT DO WITH EACH CLAIM.** We also cannot be responsible for any errors in filing your insurance; once again we file claims as a courtesy to you.

Fact 1 - NO INSURANCE PAYS 100% OF ALL PROCEDURES

Dental insurance is meant to be an aid in receiving dental care. Many patients think that their insurance pays 90%-100% of all dental fees. This is not true! Most plans only pay between 50%-80% of the average total fee. Some pay more, some pay less. The percentage paid is usually determined by how much you or your employer has paid for coverage or the type of contract your employer has set up with the insurance company.

Fact 2 - BENEFITS ARE NOT DETERMINED BY OUR OFFICE

You may have noticed that sometimes your dental insurer reimburses you or the dentist at a lower rate than the dentist's actual fee. Frequently, insurance companies state that the reimbursement was reduced because your dentist's fee has exceeded the usual, customary, or reasonable fee ("UCR") used by the company. A statement such as this gives the impression that any fee greater than the amount paid by the insurance company is unreasonable or well above what most dentists in the area charge for a certain service. This can be very misleading and simply is not accurate. Insurance companies set their own schedules and each company uses a different set of fees they consider allowable. These allowable fees may vary widely because each company collects fee information from claims it processes. The insurance company then takes this data and arbitrarily chooses a level they call the "allowable" UCR Fee. Frequently this data can be three to five years old and these "allowable" fees are set by the insurance company so they can make a net 20%-30% profit. Unfortunately, insurance companies imply that your dentist is "overcharging" rather than say that they are "underpaying" or that their benefits are low. In general, the less expensive insurance policy will use a lower usual, customary, or reasonable (UCR) figure.

MOST IMPORTANTLY, please keep us informed of any insurance changes such as policy name, insurance company address, or a change of employment.

AUTHORIZATION

I authorize Dr. Yvette V. Dye and staff to release any information concerning my case to my insurance company. I have read and accept the above Financial Policy, I understand it and agree to the terms set forth regarding payment.

Signature of Responsible Party

Date