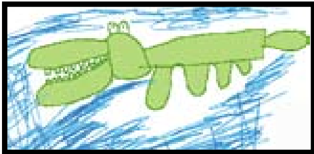

auburn
pediatric
dentistry, p.c.

caroline w. derrow, d.d.s. • pediatric dentist
1005 nicholas street • auburn, in 46706
phone: (260) 927-0707 • fax: (260) 927-0808

Patient Information, Office and Privacy Policies, and Medical/Dental History Questionnaire

To provide the safest and most comprehensive dental care for your child, we ask for your cooperation in completing our detailed questionnaire.

Date:________________________ Child's Name:____

Nickname/Preferred Name:_____________________________ Birthdate: Mo____ Day____ Year____

Age:______ SSN:______________________ Gender: M F Home Phone:______________________

Address:____Apt. #:______________

City:____State:_______ Zip:_____________

Child primarily lives with:_______________________________Primary language spoken:_____________

Who can we thank for referring you to our office?____

Is your child presently under the care of a physician for any reason? ☐ Yes ☐ No

Explain: ______________________________________ __________________________________

Physician's Name:___________________________ ________ Physician's Phone:___________________

Are you child's immunizations up-to-date? ☐ Yes ☐ No

Is your child taking any medications? ☐ Yes ☐ No

List: ____

Has your child ever been hospitalized, sedated, or had surgery? ☐ Yes ☐ No

Explain: ____

Does your child have any allergies to medicines, latex, foods, or metals? ☐ Yes ☐ No

Explain: ____

Are antibiotics necessary for dental work because of a heart murmur, defect, prosthesis, shunt, organ transplant or other medical reason? ☐ Yes ☐ No

Explain: ____

Has any member of the family, including your child, had a problem with sedation or general anesthesia?

☐ Yes ☐ No

Explain: ____

Medical History

If your child has or ever had any of the following conditions, please check "Yes" below.
Please explain any conditions to the doctor.

YES	NO	Condition
☐	☐	ADD/ADHD - Attention Deficit Disorder/ Attention Hyperactivity Disorder
☐	☐	AIDS/HIV
☐	☐	Asthma
☐	☐	Autism
☐	☐	Behavioral Problems
☐	☐	Birth Defects
☐	☐	Bleeding Gums
☐	☐	Blood Transfusions
☐	☐	Bone or Joint Problems
☐	☐	Brain Injury
☐	☐	Cerebral Palsy
☐	☐	Cancer/Tumor
☐	☐	Chemical Dependency
☐	☐	Chemotherapy/Radiation
☐	☐	Chicken Pox
☐	☐	Child Abuse
☐	☐	Cleft Palate/Lip
☐	☐	Cold Sores/Canker Sores
☐	☐	Developmentally Delayed (Age Level:____)
☐	☐	Diabetes
☐	☐	Earaches/Ear Infections
☐	☐	Epilepsy/Seizure Disorder
☐	☐	Eye Conditions
☐	☐	Females: Are you pregnant?
☐	☐	Females: Are you taking birth control medication?

YES	NO	Condition
☐	☐	Hearing Impairment
☐	☐	Heart Disease
☐	☐	Heart Murmur
☐	☐	Hemophilia
☐	☐	Hepatitis/Liver Disease
☐	☐	High Blood Pressure
☐	☐	Injury To Front Teeth
☐	☐	Kidney Disease
☐	☐	Mentally Handicapped
☐	☐	Metallic Implant, Shunts, Pins/Rods
☐	☐	Premature Birth
☐	☐	Prolonged Bleeding When Cut
☐	☐	Psychiatric Care
☐	☐	Rheumatic Fever
☐	☐	Sickle Cell Disease
☐	☐	Sore Throats
☐	☐	Speech Impairment
☐	☐	Thyroid Disease
☐	☐	Tonsillitis
☐	☐	Transplants, Organ (specify) ______________________________
☐	☐	Tuberculosis
☐	☐	Other (specify) ______________________________ ______________________________

Is there any other health information that should be known? ☐ Yes ☐ No

Explain: ____

____

Dental History

Is this your child's first dental visit? ☐ Yes ☐ No

List:____

Previous Dentist:________________________ Date of last visit:________________

Date of last x-rays:________________________

Has your child experienced any unfavorable reaction from previous dental or medical care? ☐ Yes ☐ No

Explain: ____

How often does your child brush? ____________________

Is Fluoride Toothpaste used? ☐ Yes ☐ No Is dental floss used? ☐ Yes ☐ No

Is teeth brushing supervised? ☐ Yes ☐ No Does a parent do the brushing? ☐ Yes ☐ No

Does any member of the family have decay or fillings? ☐ Yes ☐ No

Explain: ____

Does your child receive (check all that apply):

☐ Tap water ☐ Well water ☐ Bottled water ☐ Fluoride rinse ☐ Fluoride tablets/drops

Has there been any injuries to your child's teeth or jaws? ☐ Yes ☐ No

Explain: ____

History of (check all that apply): Circle those that are ongoing currently.

☐ Breast feeding ☐ Thumb sucking ☐ Bottle habits ☐ Pacifier ☐ Sippy cup ☐ Teeth grinding/clinching

Has your child had recent dental pain? ☐ Yes ☐ No

Explain: ____

Does your child have a specific dental problem that needs attention? ☐ Yes ☐ No

Explain: ____

What does your child like to drink?

Explain: ____

What does your child eat for snacks?

Explain: ____

Primary Responsible Party Information

Resident Parent's Name:____________________ (LAST) ____________________ (FIRST) ______ (MI) Gender: M F

Marital Status:__________ SS#__________________ Birthdate:______________

Address:____ Apt. #:__________

City:______________________________ State:________ Zip Code:__________

Cell Phone:________________________ Email:________________________

Home Phone:____________________ Work Phone:____________________Ext.______

Employer:____

Relationship to patient: ____

Secondary Responsible Party Information

Name:____________________ (LAST) ____________________ (FIRST) ______ (MI) Gender: M F

Marital Status:__________ SS#__________________ Birthdate:______________

Address:____ Apt. #:__________

City:______________________________ State:________ Zip Code:__________

Cell Phone:________________________ Email:________________________

Home Phone:____________________ Work Phone:____________________Ext.______

Employer:____

Relationship to patient: ____

Primary Dental Insurance

Insured's Name:____

Employer:____

Insurance Company Group Plan Name:____

Insurance Company Address:____

City:______________________________ State:________ Zip Code:__________

Insurance Phone:______________________________

I.D. #:__________________________ Group #:__________________________

Secondary Dental Insurance

Insured's Name:____

Employer:____

Insurance Company Group Plan Name:____

Insurance Company Address:____

City:______________________________ State:________ Zip Code:__________

Insurance Phone:______________________________

I.D. #:__________________________ Group #:__________________________

auburn pediatric dentistry, p.c.

Financial Policy

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time.

If you have insurance, we will do all we can to maximize your benefit. Dental Insurance is a contract between you, your employer, and your insurance carrier. Your dental insurance is not a contact between your insurance carrier and your doctor, unless your doctor is a provider for your insurance carrier and has contracted to a specific fee schedule with your carrier. The estimated payment for the primary policy will be due at the time of service.

The reimbursement levels will vary from one insurance carrier to another, for example, one carrier may say they pay 80% of our services, when what they actually pay is 80% of the carrier's fee schedule, which is usually below the actual fees for our geographic area. Insurance companies determine benefit packages and payment rates ("usual and customary" or UCR) by the plan type that is purchased by the employer/insured party - not by the level of care provided by our office. All charges, including interest, accrued from the date of services rendered, are your responsibility regardless of insurance benefits, arbitrary determination of UCR payment, or lack thereof. Factors such as deductibles, annual limits, and maximum allowable amounts per procedure may also cause differences in reimbursement.

On treatment visits, we are usually able to accept your insurance if you obtain prior approval from or office. If we accept your insurance, we will have you pay your estimated portion not covered by insurance (we will determine for you). If your insurance pays more than your account balance, we will send you a refund immediately.

No procedure performed on the human body can be guaranteed, as such payment is due and fees are non-refundable regardless of treatment outcome.

As a courtesy our office will file, at no cost to you, your insurance claim with your carrier at the time of service. You must provide us with accurate and complete information to properly obtain the maximum reimbursement. We will provide your carrier copies of x-rays and/or written narration on your claim should your carrier require this level of documentation. We are willing to wait up to 60 days from the date of service for payment from your carrier. After ninety (90) days, unpaid accounts will go to collections. It is therefore very important that you take an active role in following your claim with your insurance carrier.

Should your insurance company (specifically, Delta Dental) send payment on your behalf directly to you after service, we will require 100% of the fees payable for the services rendered that day.

NON-INSURED PATIENTS: All fees are payable on the day service are rendered.

We value your busy schedule and strive to see patients at their scheduled appointment times: we ask you to extend the same courtesy.Whenever possible please provide a minimum of 24 hours advance notice when requesting a scheduling change so that we can arrange care for our other patients experiencing urgent dental needs. Failure to give adequate notice will result in a $75 office fee charge to your account that must be paid prior to rescheduling.

Please check your method of payment: Check Cash Visa MasterCard Discover Care Credit

Financial Agreement: I have read , understand, and agree to the financial policy set forth by Auburn Pediatric Dentistry. I understand that this office has not contracted with any insurance company and will file my insurance as a courtesy. I understand that insurance benefits given at the time of service are only estimates and that I am responsible for the payment of this account. I understand that as soon as my insurance carrier issues a payment, or after 60 days, any unpaid portion of my claim will be due. I authorize my insurance carrier to issue benefits directly to this office and also the release of any information necessary to process the dental insurance. If the use of a third party becomes necessary to secure payment, I agree to be responsible for any and all collection charges incurred, which includes 35% of my outstanding balance and cost of collections, which include court costs and attorney fees.

Patient (guardian) ______________________________ **Date** ____________________

auburn pediatric dentistry, p.c.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I, ________________________________, have received or been offered a copy of this office's Notice of Privacy Practices.

____
PLEASE PRINT NAME

____
SIGNATURE

____
DATE

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign.
- ☐ Communication barriers prohibited obtaining the acknowledgement.
- ☐ An emergency situation prevented us from obtaining acknowledgement.
- ☐ Other (please specify)

____

____

____

Emergency Contact Information - other than parent

Name:____

Relationship To Child:____

Address:____

Phone:____________________________ Cell Phone:__________________________

Work Phone:____

Treatment Consent

The permission of a parent or legal guardian is necessary for dental treatment of a minor. As a minor child, it is necessary that a signed permission be obtained from a parent or legal guardian before any dental care can begin. As a parent or legal guardian of the above patient, I acknowledge that the above information is correct and grant "auburn pediatric dentistry, p.c." permission to provide my child's dental and related medical/surgical treatment as deemed necessary, including digital radiographs (x-rays), diagnostic, restorative, oral surgery, and patient management techniques that are reasonable, necessary and advisable. Protective restraints are used when a child might harm themselves or when certain procedures may jeopardize their health and welfare without such restraints. I also authorize the administration of anesthetics or analgesics that are advisable by Dr. Derrow, such as nitrous oxide (laughing gas).

I have given an accurate report of this patient's physical and mental health history. I have also reported any prior allergic or unusual reactions to medications, latex, foods, or metals, and any other disease or condition, including pregnancy.

I agree to inform Dr. Derrow and the staff of "auburn pediatric dentistry, p.c." of any changes in the medical history. This authorization is valid until revoked by me in writing.

____

SIGNATURE RELATIONSHIP TO CHILD DATE

Office Policies

NO-SHOW POLICY

Missed appointments without 24-hour notification are considered "NO SHOW" appointments and will result in a $75.00 fee. This fee must be paid before being scheduled again.

MISSED APPOINTMENTS

After two "NO SHOW" appointments (missed appointments without 24-hour prior notification) you will need to seek dental care elsewhere as we will dismiss you from our practice.

LATE ARRIVALS

Late arrivals for a scheduled appointment leads to inadequate time to accommodate the remaining patients on the schedule. As such, late arrivals of greater than 10 minutes may not be seen depending on the time available. In addition, those patients who are on the schedule and here at the assigned time will be seen first. We will try to accommodate late appointments if time permits.

____

SIGNATURE RELATIONSHIP TO CHILD DATE

Authorization for Verbal Communication

I ______________________________ am giving consent to disclose any plan of care and/or changes in treatment/procedures, and financial information for my child/children that were provided or diagnosed by Auburn Pediatric Dentistry:

Name:____________________________ Relationship_____________________

Name:____________________________ Relationship_____________________

Name:____________________________ Relationship_____________________

Name:____________________________ Relationship_____________________

Name:____________________________ Relationship_____________________

Name:____________________________ Relationship_____________________

Name:____________________________ Relationship_____________________

Name:____________________________ Relationship_____________________

____ ______________

Signature of Parent or Authorized Representative Date

____ ______________

Signature of APD Representative Date

Auburn Pediatric Dentistry
1005 Nicholas Street
Auburn, IN 46706