



auburn
pediatric
dentistry, p.c.

caroline w. derrow, d.d.s. • pediatric dentist
1005 nicholas street • auburn, in 46706
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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	YES	NO	Condition
<input type="checkbox"/>	<input type="checkbox"/>	ADD/ADHD - Attention Deficit Disorder/ Attention Hyperactivity Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Impairment
<input type="checkbox"/>	<input type="checkbox"/>	AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur
<input type="checkbox"/>	<input type="checkbox"/>	Autism	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia
<input type="checkbox"/>	<input type="checkbox"/>	Behavioral Problems	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Liver Disease
<input type="checkbox"/>	<input type="checkbox"/>	Birth Defects	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Gums	<input type="checkbox"/>	<input type="checkbox"/>	Injury To Front Teeth
<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusions	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease
<input type="checkbox"/>	<input type="checkbox"/>	Bone or Joint Problems	<input type="checkbox"/>	<input type="checkbox"/>	Mentally Handicapped
<input type="checkbox"/>	<input type="checkbox"/>	Brain Injury	<input type="checkbox"/>	<input type="checkbox"/>	Metallic Implant, Shunts, Pins/Rods
<input type="checkbox"/>	<input type="checkbox"/>	Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	Premature Birth
<input type="checkbox"/>	<input type="checkbox"/>	Cancer/Tumor	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged Bleeding When Cut
<input type="checkbox"/>	<input type="checkbox"/>	Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care
<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy/Radiation	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease
<input type="checkbox"/>	<input type="checkbox"/>	Child Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Sore Throats
<input type="checkbox"/>	<input type="checkbox"/>	Cleft Palate/Lip	<input type="checkbox"/>	<input type="checkbox"/>	Speech Impairment
<input type="checkbox"/>	<input type="checkbox"/>	Cold Sores/Canker Sores	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease
<input type="checkbox"/>	<input type="checkbox"/>	Developmentally Delayed (Age Level:____)	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Transplants, Organ (specify)
<input type="checkbox"/>	<input type="checkbox"/>	Earaches/Ear Infections			_____
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Eye Conditions	<input type="checkbox"/>	<input type="checkbox"/>	Other (specify)
<input type="checkbox"/>	<input type="checkbox"/>	Females: Are you pregnant?			_____
<input type="checkbox"/>	<input type="checkbox"/>	Females: Are you taking birth control medication?			_____

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: _____ Gender: M F
Marital Status: _____ LAST SS# _____ FIRST Birthdate: _____ MI
Address: _____ Apt. #: _____
City: _____ State: _____ Zip Code: _____
Cell Phone: _____ Email: _____
Home Phone: _____ Work Phone: _____ Ext. _____
Employer: _____
Relationship to patient: _____

Secondary Responsible Party Information

Name: _____ Gender: M F
Marital Status: _____ LAST SS# _____ FIRST Birthdate: _____ MI
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 #: _____

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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 contract 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 our 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 _____

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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 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 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.

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 15 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.

TEXTING POLICY

auburn pediatric dentistry, p.c. reserves then right to send text communications regarding practice updates, marketing promotions and feedback requests. I understand that by providing a cell phone number, I agree to receive texts from auburn pediatric dentistry, p.c. At any point, you may opt out. Message and data rates may apply.

SIGNATURE

RELATIONSHIP TO CHILD

DATE

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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