BRIDGER
Children's Dentistry

New Patient Form

Today's Date: _____

How did you hear about our practice? _____

1 TELL US ABOUT YOUR CHILD

Child's Name: _____ Child's Home Address: _____

Nickname: _____ ☐ Male ☐ Female City_____ State_____ Zip_____

Child's Birthdate: __/___/___ Child's Age: _____ Child's Home #:_____

School: _____ Special Interests:_____

Siblings We Treat: _____ Childs 1st Language:_____ Child's 2nd Language:_____

2 DENTAL HISTORY

Is this your child's 1st visit to the dentist? Yes ☐ No ☐

If not, how long since the last visit to the dentist? _____

Date of last X-rays at Previous Dental Visits: _____

Have there been any injuries to the teeth, face or mouth? Yes ☐ No ☐

If yes, pleases explain: _____

Why did you bring your child to the dentist today? _____

_____

_____

Does your child have any current dental issues? Please circle

Cavities Toothache Bleeding Gums Sensitivity to Hot or Cold

Bad Breath Discolored Teeth Teeth Grinding Mouth Trauma

Is your child's water fluoridated? Yes ☐ No ☐

Is your child taking fluoride supplement? Yes ☐ No ☐

Has your child ever had any pain or tenderness in his/her jaw joint (TMJ/TMD)?

Yes ☐ No ☐

Does your child have any of the following habits? Please circle

Lip sucking/ Biting Nail Biting Tongue Thrust Tobacco Us

Nursing/ Bottle Habits Thumb sucking/ Finger Sucking

How often does your child brush his/her teeth? _____

Does your child use fluoridated toothpaste? Yes ☐ No ☐

How often does your child floss? _____

Has your child ever had a serious or difficult problem associated with previous dental work? If yes, please explain:

_____

3 HEALTH HISTORY

Has your child ever had any of the following conditions? Please circle all that apply:

Abnormal Bleeding ADD/ADHD Allergies to Any Drug Allergies to Latex Products Any Hospital Stays Any Surgeries

Asthma Cancer Cardiac (Heart Condition) Autism Spectrum Disorder Congenital Birth Defects Diabetes

Hearing Impairment Hepatitis Developmental Delays/ Disabilities HIV/AIDS Hemophilia/ Blood disorder Pregnancy

Reflux/ GI Problems Seizures Kidney/ Liver Condition Rheumatic/ Scarlet Fever Tuberculosis None of the Above

If you have checked any of the above conditions, or if you would like to discuss any other medical conditions your child has had, do so below:

_____

List all drugs/ supplements your child is currently taking: _____

_____

List all allergies your child currently has: _____

_____

Please describe your child's current physical health:

Good ☐ Fair ☐ Poor ☐

Does your child require antibiotics for dental procedures Yes ☐ No ☐

Child's Physician: _____

Physician Phone #_____

Is your child currently under the care of a physician? Yes ☐ No ☐

Comments:

_____

4 PARENT OR LEGAL GUARDIAN'S INFORMATION/ PERSON RESPONSIBLE FOR ACCOUNT

The information in the section applies to the main legal caregiver of the child /children

Name: _____ Employer: _____

Relationship: _____ Birthdate_____ Work # _____

Marital Status: Single Married Divorced Widowed Cell # _____

Address: _____ SSN: _____ DL#: _____

_____ Email Address: _____

5 SPOUSE OR OTHER LEGAL GUARDIAN'S INFORMATION

(If different form Section #4)

Name: _____ Employer: _____

Relationship: _____ Birthdate_____ Work # _____

Marital Status: Single Married Divorced Widowed Cell # _____

Address: _____ SSN: _____ DL#: _____

_____ Email Address: _____

6 WHO WILL BE ACCOMPANYING THE CHILD/CHILDREN TO THEIR APPOINTMENT?

Important Note: The parent or guardian who accompanies the child is responsible for payment at the time of service

Name: _____ Do you have legal custody of this child? ☐ Yes ☐ No

Relationship: _____

Name: _____ Do you have legal custody of this child? ☐ Yes ☐ No

Relationship:

_____

7 PRIMARY DENTAL INSURANCE

Insurance Name: _____ Policy Owner's Name: _____

Insurance Address: _____ Relationship: _____

_____ Birthdate: _____

Insurance Phone # _____ SSN: _____

Group #: _____ Employer: _____

8 SECONDARY DENTAL INSURANCE

Do you have dual coverage? Yes ☐ No ☐ Insurance Name: _____

9 QUESTIONS/COMMENTS:

_____

_____

Signature

I understand that the information I have given is correct to the best of my knowledge and that it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

Signature of Parent or Guardian _____ **Relationship**_____ **Date:** _____

BELOW FOR OFFICE USE ONLY

I verbally reviewed the medical/ dental information above with the parent/guardian and patient named herein.

Initials_____ **Date:** _____ **Doctor's Comments** _____

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10 FINANCIAL POLICY AND AGREEMENT

Payment

Payment in full is due at time of service. For your convenience, we offer several payment options.

1.) Cash
2.) Check
3.) Visa, MasterCard, Discover and Amex
4.) Care Credit

Insurance Coverage

Our office is committed to helping patients maximize their insurance benefits. We accept many different insurance plans; however, all plans have a unique schedule of covered services depending on what plan you or your employer purchased. Therefore, owing to the complexity of insurance contracts***, we can only estimate in good faith, not guarantee coverage***. It is your responsibility to understand and know what your insurance covers. Your estimated patient portion must be paid at the time of service. As a service to our patients, we will bill your insurance company for service, and allow 90 days for them to render payment. After 90 days, you are responsible for the entire balance and it will be due in full. If you have any questions, our courteous staff is always available to answer them.

I have read and fully understand the above paragraph on Insurance Coverage. _____ Initial

To lessen the financial burden to our patients and their families, we are in network for most insurances, including Medicaid. We are required to bill all insurances uniformly, including procedures such as oral hygiene instruction and nutritional counseling. However, some insurances do not cover these procedures. As a preferred provider we will write off these procedures after payment is received from your insurance company as a courtesy to our families. In many instances you may receive an EOB from your insurance company before our office has had a chance to make the appropriate adjustments. Therefore, please contact our office if you have any questions about any EOB's you receive from your insurance company.

I have read and fully understand the above paragraph. _____ Initial

Missed Appointments

Once an appointment has been made, please remember that this time has been reserved for your child. We reserve the right to charge a fee for all cancelled or missed appointment without a 24-hour notice. We realize unexpected things happen, but we ask for your assistance in this regard.

Returned Checks

We will charge a $35.00 NSF fee for any returned checks.

Collection Fees

Fees incurred to collect payment will be billed to and payable by the patient's account holder.

Financial Consent:

The account holder/responsible party agrees to be fully responsible for total payment of treatment/services performed in this office.

I understand and agree to this Financial Policy and Agreement

_____ _____ _____

Print Name of Responsible Party **Signature** of Responsible Party **Date**

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10 ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. This notice describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of health care operations. This form will be filed in the patient's medical record.

_____	_____	_____
Please **Print** Child's Name	Child's Name	Child's Name
_____	_____	_____
Signature Legal Representative/Guardian	Title	Date

11 PERMISSION TO PHOTOGRAPH

I hereby give permission to Bridger Children's Dentistry, its assigns, and legal representatives the right to use my child's photograph in all forms of media including our website (www.bridgerchildrensdentistry.com), for advertising, for publication or any other lawful purposes. I waive the right to inspect or approve the finished product, which may be created in connection with them.

Child's (Children's) Name (s):

_____

Parent or Guardian Signature: _____ _____

Date: _____

OFFICE USE ONLY

An attempt was made to obtain the patient's or legal guardian's signature on this Acknowledgement but was unable because:

It was emergency treatment _____ Inability to communicate with patient/guardian _____
Patient/Guardian refused to sign_____

Patient/Guardian unable to sign_____ Other: Reason_____

Staff Signature: _____