WELCOME

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

1 Tell Us About Your Child

Today's Date: _____

Child's Name: _____
Last First MI

Child's Birthdate: ___/___/___ Child's Age: _____

Nickname: _____ ☐ Male ☐ Female

School: _____ Grade: _____

Child's Home #: (____)_____ SS #: _____

Child's Home Address: _____
Apt / Condo #

_____
City State Zip

Email Address: _____

2 Who Is Accompanying the Child Today?

Name: _____ Relation: _____

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

Is child adopted? ☐ Yes ☐ No Is child in a foster home? ☐ Yes ☐ No

Whom may we thank for referring you? _____

Other siblings seen by us: _____

Previous / Present Dentist: _____
(Please Circle)

Last Visit Date: _____

Parent's Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Partnered ☐ Separated

3 Parent's Information

☐ Father ☐ Mother ☐ Step Parent ☐ Guardian

Name: _____ Birthdate: ___/___/___

Email Address: _____

Cell #: (____)_____ Hm #: (____)_____

Employer: _____ Wk #: (____)_____

SS #: _____ DL #: _____

☐ Mother ☐ Father ☐ Step Parent ☐ Guardian

Name: _____ Birthdate: ___/___/___

Email Address: _____

Cell #: (____)_____ Hm #: (____)_____

Employer: _____ Wk #: (____)_____

SS #: _____ DL #: _____

4 Person Responsible for Account

Name: _____ Relation: _____

Billing Address: _____

_____
City State Zip

Wk #: (____)_____ Ext: _____ Hm #: (____)_____

Employer: _____

DL #: _____ SS #: _____

Who is responsible for making appointments?

Name: _____

Wk #: (____)_____ Ext: ____ Hm #: (____)_____

5 Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____)_____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ___/___/___ ID #: _____

Policy Owner's Employer: _____

Employer's Address: _____

Orthodontic Coverage? ☐ Yes ☐ No

6 Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____)_____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ___/___/___ ID #: _____

Policy Owner's Employer: _____

Employer's Address: _____

Orthodontic Coverage? ☐ Yes ☐ No

CONTINUED ON BACK

7 Why did you bring the child to the dentist today?

_____

_____

Has the child ever had a serious / difficult problem associated with previous dental work? ☐ Yes ☐ No

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

Is the child taking fluoridated supplements? ☐ Yes ☐ No

Has the child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Does the child brush his / her teeth daily? ☐ Yes ☐ No

Floss his / her teeth daily? ☐ Yes ☐ No

Child's Physician: _____

Phone #: _____ Date of Last Visit: _____

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

Please describe the child's current physical health: ☐ Good ☐ Fair ☐ Poor

Has the child ever taken Fosamax, Actonel, Boniva or any other bisphosphonate? ☐ Yes ☐ No

Please list all drugs that the child is currently taking:

_____

_____

Aside from items listed below, list all drugs/things the child is allergic to:

_____

_____

Latex ☐ Yes ☐ No Metals/Nickel ☐ Yes ☐ No Plastic ☐ Yes ☐ No

8 Has the child ever had any of the following medical problems?

Y	N	Abnormal Bleeding	Y	N	Exposed to HIV, but Neg.
Y	N	ADD / ADHD	Y	N	Handicaps / Disabilities
Y	N	Anemia	Y	N	Hearing Impairment
Y	N	Any Hospital Stays	Y	N	Heart Murmur
Y	N	Any Operations	Y	N	Hemophilia
Y	N	Artificial Bones/Joints/Valves	Y	N	Hepatitis
Y	N	Asperger's Syndrome	Y	N	Hives
Y	N	Asthma	Y	N	HIV^+ / AIDS
Y	N	Autism	Y	N	Kidney / Liver Problems
Y	N	Cancer	Y	N	Measles
Y	N	Chicken Pox	Y	N	Mononucleosis
Y	N	Congenital Heart Defect	Y	N	Rheumatic / Scarlet Fever
Y	N	Convulsions	Y	N	Sickle Cell Disease / Traits
Y	N	Diabetes	Y	N	Skin Rash
Y	N	Epilepsy	Y	N	Tuberculosis (TB)

Are the Child's Immunizations current? ☐ Yes ☐ No

Anything you would like to discuss with the Doctor in private? ☐ Yes ☐ No

Please discuss any serious medical problems that the child has had: _____

_____

Does/did the child experience any of the following?

Y	N	Lip Sucking / Biting	Y	N	Nursing Bottle Habits
Y	N	Nail Biting	Y	N	Thumb / Finger Sucking

Was the child breast fed? ☐ Yes ☐ No

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and 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.

My method of payment will be: _____

_____
Signature of parent or guardian Date

I certify that my child is covered by _____ Insurance Co. and I assign directly to Dr. _____ all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____
Signature of parent or guardian Date

The Parent or Guardian who accompanies the child is responsible for payment at times of service unless prior arrangements have been approved.

OFFICE USE ONLY OFFICE USE ONLY **OFFICE USE ONLY** OFFICE USE ONLY **OFFICE USE ONLY**

I verbally reviewed the medical / dental information above with the parent / guardian & patient named herein. Initials: _____ Date: _____

Doctor's Comments:

_____

_____

_____

_____

Medical History Update

1. Date: _____ **Signature:** _____

Comments: _____

_____

2. Date: _____ **Signature:** _____

Comments: _____

_____

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FINANCIAL POLICY:

FOR YOUR CONVENIENCE, WE OFFER MULTIPLE FORMS OF PAYMENT: CASH, CHECK, VISA, MASTERCARD, AMEX, DISCOVER, CARECREDIT AND LENDING CLUB.

PAYMENT IS DUE AT THE TIME OF SERVICE.

PATIENT IS RESPONSIBLE FOR ALL CHARGES. IF PATIENT'S ACCOUNT BALANCE IS NOT PAID IN FULL WITHIN 90 DAYS, WE RESERVE THE RIGHT TO SEND THE ACCOUNT TO A COLLECTION AGENCY.

FACTS ABOUT INSURANCE:

• Your dental benefit program is a contract between you, your employer and the insurance company. **WE ARE NOT PART OF THAT CONTRACT.** In addition, it is your responsibility to determine if our office is in or out of network with your insurance.

• Dental insurance is not meant to be a PAY-ALL, it is only meant to be an aid.

• Our fees are generally, but not always, covered in full by the maximum allowance determined by your carrier. Many plans tell their insured that they will be covered up to 80% or up to 100% but do not clearly specify the plan's fee scheduled allowance, annual maximum or limitations.

• It has been the experience of many dentists that insurance companies occasionally tell their insurance that "the fees charged were above the usual and customary rate", rather than saying "the insurance benefits are low."
• Many routine dental services are **NOT** covered by insurance carriers.

• YOU ARE RESPONSIBLE TO US FOR ALL FEES FOR SERVICES RENDERED. IF YOUR INSURANCE COMPANY HAS NOT PAID ON YOUR CLAIM WITHIN 30 DAYS, IT IS YOUR RESPONSIBILITY TO SEE WHY THE CLAIM HAS NOT BEEN PAID, AND YOUR BALANCE IS DUE IN FULL. OUR STAFF WILL BE GLAD TO ASSIST YOU IN ANY WAY THEY CAN REGARDING YOUR INSURANCE CLAIM RECOVERY.

Patient's Signature:_____Date:_____
Parent/Guardian's Signature (if patient is a minor): _____

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Robert Baumann, DDS • Ashley Lanman, DDS • Kristie Haller, DDS

Bryce Baumann, DDS • Darrell Guttery, DDS

HIPAA CONSENT

MY SIGNATURE ON THIS FORM INDICATES THAT I CONSENT TO THE USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR MY TREATMENT, PAYMENT AND OPERATIONAL USE. IF I HAVE ANY QUESTIONS, I KNOW I CAN CONTACT THE PRIVACY OFFICER FOR THIS OFFICE. I HAVE BEEN ADVISED THAT A NOTICE OF PRIVACY PROTECTIVE PRACTICES PAMPHLET IS AVAILABLE TO ME UPON REQUEST.

LIST THE NAMES OF ANYONE WE CAN RELEASE INFORMATION TO:

NAME:_____

RELATIONSHIP TO YOU: _____

IS IT OKAY TO LEAVE A MESSAGE ON YOUR VOICEMAIL? _____

IS IT OKAY FOR OUR OFFICE TO SEND YOU AN EMAIL? _____

SIGNATURE: _____DATE: _____

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