New Pediatric Patient Information

D. Scott Hume, DDS, FAGD - Bloomington, IL

We are committed to excellence in dentistry and appreciate you taking the time to complete this confidential questionnaire. The better we communicate, the better we can care for your child. If you have any questions or need assistance, please ask us - we will be happy to help.

Whom may we thank for referring you? _____

ABOUT YOUR CHILD

Name: _____ Prefers to be called_____ [ ] Male [ ] Female

Birth date: _____/_____/_____ Age: _____ S.S. #: _____

Home Address: _____ City_____State_____Zip_____

School _____ Grade _____

PERSON ACCOMPANYING THE CHILD TODAY

Name: _____ Relation: _____

Do you have legal custody of this child? ( ) Yes ( ) No

Other family members seen by us: _____

_____

Previous Dentist: _____Last visit date: _____

Parent's Marital Status: ( ) Single ( ) Married ( ) Widowed ( ) Divorced ( ) Separated

PARENT INFORMATION

Mother's Information ( ) Stepmother ( ) Guardian

Name:_____

Birthdate: _____/_____/_____

Employer: _____

How long there? _____ Occupation:_____

Home Phone: (_____) _____

Work: (____) _____ Cell Phone: (____)_____

Email:_____

S.S. #_____

Father's Information ( ) Stepfather ( ) Guardian

Name:_____

Birthdate: _____/_____/_____

Employer: _____

How long there? _____ Occupation:_____

Home Phone: (_____) _____

Work: (____) _____CellPhone:(____)_____

Email:_____

S.S. #_____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ Birth date:_____/_____/_____ Relation: _____

Billing Address: _____ City_____State____Zip_____

Home Phone: (_____) _____ Work: (_____) _____ Cell Phone: (____)_____

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S.S. #: _____ DL #_____

Employer: _____ How long there? _____ Occupation:_____

DENTAL INSURANCE INFORMATION

Primary Insurance

Insurance Co. Name: _____

Phone: (____) _____ Group/Policy #: _____

Insured's Name: _____

Insured's Birth date: ____/____/_____ Relation: _____

Insured's Social Security #: _____

Insured's Employer: _____

Secondary Insurance

Insurance Co. Name: _____

Phone: (____) _____ Group/Policy #: _____

Insured's Name: _____

Insured's Birth date: ____/____/_____ Relation: _____

Insured's Social Security #: _____

Insured's Employer: _____

HAS YOUR CHILD EVER HAD THE FOLLOWING MEDICAL PROBLEMS?

Do you have or have ever had any of the following? Please check those that apply:

[ ] Abnormal Bleeding	[ ] Diabetes	[ ] Hepatitis	[ ] Liver Problems
[ ] Allergies/Hay Fever	[ ] Epilepsy or Seizures	[ ] HIV*/AIDS	[ ] Rheumatic Fever
[ ] Asthma	[ ] Heart Disorder(Congenital)	[ ] Hospital Stays	[ ] Operations
[ ] Cancer/Chemotherapy	[ ] Heart Murmur	[ ] Kidney Problems	[ ] Tuberculosis

Please provide information for any medical problems that your child has had:_____

_____

Name of Physician: _____

WHY DID YOU BRING YOUR CHILD TO THE DENTIST TODAY?

_____

Has your child ever had a serious or difficult problem associated with previous dental work? ( ) Yes ( ) No ( ) Unsure

Is your child's water fluoridated? ( ) Yes ( ) No ( ) Unsure

Is your child taking fluoridated supplements? ( ) Yes ( ) No ( ) Unsure

Does your child brush his/her teeth daily? ( ) Yes ( ) No ( ) Unsure

Does your child floss his/her teeth daily? ( ) Yes ( ) No ( ) Unsure

List any drugs that your child is currently taking: _____

_____

List any allergies that your child may have to any drugs or materials: _____

_____

Does your child have any of the following habits?

( ) Lip Sucking/Biting ( ) Nail Biting ( ) Nursing Bottle Habits ( ) Thumb Sucking/Finger Sucking

To the best of my knowledge, all of the preceding answers are correct. If there are any changes in my child's health status or if his/her medications change, I will inform the dentist and the staff at the next appointment without fail**.**

X_____ **Date**_____

Signature of patient, parent or guardian

APPOINTMENTS

We value your time so you can expect us to see you at the appointed time and to keep your time spent in our office as short as possible. In return, when you make an appointment with us please be on time since we have reserved our time just for you. Please make every effort not to change your scheduled appointment. If you must change an appointment, please provide us at least **2 working days advanced notification** so that we may use our time to accommodate other patients. Broken and missed appointments create scheduling problems for other patients and our practice. We value your time, please value ours.

FINANCIAL POLICY

Unless another financial option is pre-arranged, payment in full is due the day of treatment. Should a patient have dental insurance with assignment to Dr. Hume, the estimated patient portion will be the amount due. Insurance payments without assignment will be sent to the insured with payment due in full.

Payment Options

1. For your convenience we accept Cash, Check, Visa, MasterCard, Amex, Discover & Care Credit.
2. We also offer in-house financing options. (Interest-free options may apply)

For Patients with Dental Insurance

Dental insurance plans often pay less than the actual fee for service, therefore the patient or Guarantor is the responsible party for all dental services provided. Dental insurance in most cases is a benefit with limitations and should not be expected to take care of all costs. Our staff would be happy to assist you with maximizing your benefits.

Finance Charge and Fees

Balances in excess of 60 days are subject to a finance charge of 1.5% per month (18% annual).

AUTHORIZATION AND CONSENT

General Consent to Treatment

I agree and consent to a dental examination by Dr. Hume. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to being done. Also, I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatments performed.

Release of Information

I authorize Dr Hume to release any information regarding my dental/medical history, diagnosis or treatment to third part payors and/or other health professionals.

Assignment of Insurance Benefits

I authorize and request my insurance company to pay my benefits directly to Dr. Hume.

Payment for Services Rendered

I understand that I am responsible for all costs of dental treatment. I understand that I am responsible for payment of services rendered and for payment of co-payment, deductible, or any charges that my insurance does not cover.

Acknowledgement of Receipt of Privacy Practice Policy

I hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I understand that I may ask Any questions I might have regarding this notice.

X_____ **Date**_____

Signature of patient, parent or guardian