Brush & Smile with Dr. Weil

WELCOME!

Dr. Jack Weil, D.M.D
402 Maple Avenue W Vienna, VA 22180

1. Tell Us About Your Child

Today's Date: _____ Child likes to be called: _____

Name: _____
First Middle Last

School: _____Grade: _____ Boy or Girl Age: _____ Birthday: mo _____ day _____ yr _____

Special interests, sports, and/or hobbies: _____

Home Address: _____City: _____ State: _____Zip: _____

Home phone: _____ Family email: _____

Who is responsible for making appointments? Name: _____Preferred # for us to call: _____

Names of other siblings who are patients: _____

Who is accompanying the child today? Name: _____Relationship: _____

Do you have legal custody of this child? Yes or No Whom may we thank for referring you? _____

2. Account Responsibility Information

Please check one: ☐ Mother ☐ Stepmother ☐ Grandmother ☐ Guardian ☐ Other

Name: _____Employer: _____

Occupation: _____Work #: _____Cell #: _____

Please check one: ☐ Father ☐ Stepfather ☐ Grandfather ☐ Guardian ☐ Other

Name: _____ Employer: _____

Occupation: _____Work #: _____ Cell #: _____

Who is financially responsible for this account?

Name: _____

Billing Address (if different from child's home address): _____

City: _____ State: _____Zip: _____ Phone #: _____Phone #2: _____

Is there someone we could contact in the event of an emergency?

Name: _____Relationship: _____Phone #: _____ Phone #2: _____

3. Insurance Information

Primary

Dental Insurance Company: _____Policy Number _____

Insured's Name: _____Insured's Birthday: _____/_____/_____Insured's SS#: _____-_____-_____

Insured's Employer: _____Relationship to patient: _____

Secondary

Dental Insurance Company: _____Policy #: _____

Insured's Name: _____Insured's Birthday: _____/_____/_____Insured's SS#: _____-_____-_____

Insured's Employer: _____Relationship to patient: _____

Please continue with other side

4. Purpose for Today's Visit

_____First Check-up _____Regular check-up, x-rays (if necessary) and cleaning

_____Emergency visit, please describe: _____

_____Referral from another dentist or physician, reason: _____

5. Dental History

Date of last dental visit: _____ For what service: _____

Please circle **Explain if necessary**

YES NO Is your child in dental pain now? _____

YES NO Is your child happy to be here today?

YES NO Has your child ever had a serious/difficult problem associated with previous dental work? _____

YES NO Any Injuries to mouth, teeth, or head? _____

YES NO Orthodontic appliances worn now or in the past? _____

YES NO Any pain / tenderness in their jaw joint (TMJ/TMD)? _____

YES NO Brush teeth? How often? _____

YES NO Floss teeth? How often? _____

7. Oral Habits & Fluoride History

Does your child have any of these habits?

Please circle Explain if necessary

YES NO Thumb / finger sucking_____
YES NO Nursing / bottle habits_____
YES NO Lip sucking / biting _____
YES NO Pacifier or other _____
YES NO Mouth breather _____
YES NO nail biter _____
YES NO chews pencils / pens _____

Fluoride History:

What type of water does your child drink the most?
TAP BOTTLED WELL

YES NO Is the water fluoridated?
YES NO Does your child use fluoride toothpaste?
YES NO Taking any fluoride supplements?
Type / amount: _____

6. Health History

Child's physician: _____Doctor's #: _____Date of last physical: _____

Please circle Explain if necessary

YES NO Is your child under care of a physician now? _____

YES NO Is child in good health? _____

YES NO Is your child taking any medications? _____

YES NO Has your child ever been hospitalized / surgery? _____

YES NO Is your child allergic to any medications? _____

YES NO Any other allergies (i.e. latex, food, etc.) _____

YES NO Does your child need to be pre-medicated before dental treatment? _____

Has your child had any history of or difficultly with any of the following:

___Anemia	___Bladder	___Developmental Delay	___Heart Disease	___Rheumatic Fever
___ADD / ADHD	___Bleeding disorder	___Chronic Sinus	___Heart Murmur	___Seizures
___Asthma	___Cerebral Palsy	___Convulsions	___Kidney	___Speech/Hearing
___AIDS/HIV	___Cancer/Tumors	___Diabetes	___Liver Disease	___Social Issues
___Autism	___Congenital Birth Defect	___Epilepsy	___Personality issues	___Other
___Autism Spectrum	___Cleft Lip/Palate	___Fainting	___Physical Delays	

Please elaborate on ANY items marked or any other information we should be aware of:_____

_____

. Signature of Parent or Guardian

I understand that the information that I have given is correct to the best of my knowledge. I also understand that this information 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 any necessary dental services my child may need.

_____
Signature of parent or guardian Date

Office use only

Doctor's Comments: _____

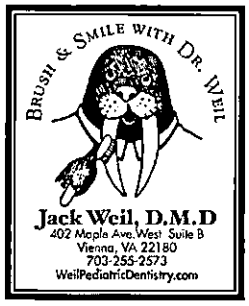
_____

_____

_____

_____

_____



DENTAL AUTHORIZATION & FINANCIAL POLICY

Patient Name: _____

Patient's Date of Birth: _____

The patient identified above authorizes Jack Weil D.M.D. to use or disclose protected health information in accordance with the following:

SPECIFIC AUTHORIZATIONS

I give permission to Jack Weil, D.M.D. to use my address, phone numbers, email address, and clinical records to contact me with appointment reminders, birthday cards, reminder cards, and information about treatment alternatives or health related information.

I give Jack Weil, D.M.D. permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations.

By signing this form you are giving Jack Weil, D.M.D. permission to use and disclose your protected health information in accordance with the directive listed above.

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke the AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of Jack Weil, D.M.D. The written notice must contain the following information:

- Patient name, date of birth, parent/guardian name and SS#
- A clear statement of your intent to revoke the AUTHORIZATION
- The date of your request, and your signature
-

Financial and Insurance Policy

While our office is more than willing to submit insurance claims on your behalf, we are doing so as a courtesy.

WE ARE IN-NETWORK PROVIDERS FOR:
CIGNA PPO, DELTA DENTAL PPO & PREMIER, METLIFE PPO, UNITED CONCORDIA PPO, & AETNA PPO ONLY

For any other insurance company we are considered **out-of-network. We <u>don't</u> accept any DMO Plans.** We will gladly answer questions to the best of our knowledge about your plan, but it is your responsibility to know your benefits and eligibility. All insurance claims and payments are always the responsibility of the Parent or Guardian of the patient whose name and signature appears below regardless if they are the subscriber of the insurance. We are not responsible for failure to file a claim or for improperly filed claims. After insurance claims have been filed and payment received, you are responsible for any remaining balance. Balances are due upon receipt of the statement. All outstanding balances must be paid in full prior to future visits.

In the event that a payment plan is set up, balances must be paid off within 90 days unless other arrangements are discussed. If these payments are not made in a timely manner, you may be charged an APR of 19.99% and/or a late fee of $10 per month the balance remains unaddressed. If an account becomes delinquent and is subsequently sent to a collection agency, you will be responsible for any attorney's fees which are incurred.

We have a 24 hour cancellation policy for appointments. Failure to cancel an appointment 24 hours in advance may result in a charge of $50.00.

I, _____ ____UNDERSTAND AND AGREE TO THE ABOVE STATED INFORMATION AND THAT I AM ULTIMATELY FINANCIALLY RESPONSIBLE FOR SERVICE PERFORMED.

Signature of Parent/Guardian: _____ Date: _____ UD0218