Welcome!
Thank you for choosing Wabash Valley Children's Dentistry. It is our goal to provide your child with the best possible dental care. To help us meet all of your possible dental health needs, please fill out this form. If you have any questions, please ask any of our staff.

PATIENT INFORMATION

CHILD/MINOR INFORMATION (CONFIDENTIAL)

Name of Minor/Child: _____ **Date:** _____

Gender: Male____ Female____ **Birth Date:** _____ **Social Security #:** _____

Minor/Child Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Name of School: _____ **School Phone:** (____) _____

Full Names and Ages of Patient's Siblings: _____

GUARDIAN INFORMATION

Father/Guardian's Name: _____ **Email:** _____

Birth Date: _____ **Social Security #:** _____ **Home Phone:** (____) _____**Cell Phone:** (____) _____

Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Employer:_____ **Work Phone:** (____) _____

Mother/Guardian's Name: _____ **Email:** _____

Birth Date: _____ **Social Security #:** _____ **Home Phone:** (____) _____**Cell Phone:** (____) _____

Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Employer:_____ **Work Phone:** (____) _____

INSURANCE INFORMATION

Person Financially Responsible For Minor/Child: _____

Relationship to Minor/Child: _____ **Do you have dental insurance coverage for Minor/Child?:** Yes ____ No _____

Insurance Company Name: _____

Address: _____ **City:** _____ **State:** ____ **Zip:** _____ **Phone:** (____) _____

Plan Name: _____**Group #:** _____ **Policy #:** _____

MEDICAID/HOOSIERHEATHWISE INFORMATION

Is the minor/child covered by Medicaid/HoosierHeathWise?: Yes ____ No _____

Medicaid/HoosierHeathWise Number: _____

MEDICAL HISTORY

Minor/Child's Physician: _____

Physician's Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Physician's Phone: (____ _)_____

Date of Last Physical: _____ **Results of Physical:**_____

Is the Minor/Child on any medications?: Yes ____ No ____

List Medications:_____

Has the Minor/Child ever been hospitalized?: Yes ____ No ____ **If so any surgeries?:** Yes ____ No ____

Please list any allergies: _____

Does Minor/Child bleed excessively when cut?: Yes ____ No ____

Has Minor/Child had any history or difficulty with any of the following? If yes, please check.

_____AIDS/ HIV	____Epilepsy	____Rheumatic Fever	____Anemia	____Fainting
_____Sinus Problems	____Asthma	____Hearing Problems	____Thyroid Disease	____Bladder Problems
_____Heart Problems	____Tuberculosis	____Cancer	____Hepatitis	____Other
_____Cerebral Palsy	____Kidney Disease	____Chicken Pox	____Liver Disease	____Convulsions
_____Measles	____Diabetes	____Mononucleosis	____Drug/Alcohol Abuse	____Mumps

Please list any other medical conditions: _____

_____

DENTAL INFORMATION

Reasons for today's visit?: _____

Reason for leaving your previous dental office: _____

Has Minor/Child complained of any dental problems?: Yes ____ No ____

If yes, please explain: _____

Does Minor/Child brush daily?: Yes ____ No ____ **Floss Daily?:** Yes ____ No ____ **Using fluoride?:** Yes ____ No ____

Has Minor/Child had any unpleasant dental experiences?: Yes ____ No ____

If yes, please explain: _____

Does Minor/Child have any injuries to the head, mouth or teeth?: Yes ____ No ____

Does Minor/Child have any mouth habits (thumb sucking, nail biting, pacifier, sleeping with bottle...)?: Yes ____ No ____

If yes, please explain: _____

EMERGENCY CONTACT INFORMATION

In the case of an emergency, whom should we contact?

#1 • Name:_____ **Relationship:** _____ **Phone:** (_____) _____

#2 • Name:_____ **Relationship:** _____ **Phone:** (_____) _____

INSURANCE POLICY

Due to the tremendous increase in dental insurance coverage and the varied types of insurance programs, our office will adhere to the following, concerning your insurance program.

1. Your program and insurance is between you and your insurance company. We will file and assist you in recovering the maximum benefits from your program. Extraordinary time spent and special requests from your company may incur administrative charges in handling your policy.

2. We will wait 30 days from the date of service for payment. After 30 days, your account will be charged 2% per month on the unpaid balance and will be due in full.

3. A schedule of your financial responsibility will be given to you. You will know your financial part of each appointment, including deductibles, co-payment and services not covered by your program. These must be paid at each appointment.

4. All insurance payments must be assigned to our office if we agree to wait on payment. Checks sent to you by your insurance company must be endorsed and sent to our office immediately. Failure to comply with this policy will result in a "Fee-for-Service" policy. You will be responsible for 100% of the cost of the appointment and your insurance company can then reimburse you for the services rendered.

5. You are responsible for all appointments scheduled for your minor/child. If you fail to show for your minor/child's appointment or are late, you may be charged a $50.00 fee. We appreciate your cooperation and understanding with this policy. If you have any questions please ask the office manager.

FINANCIAL POLICIES

Please read the following carefully before signing.

1. Payment is due in full at the time services are rendered. As a courtesy, we will gladly file your insurance for you.

2. We accept Personal Checks, MasterCard, Visa, Discover, American Express and Cash. A $50.00 fee plus any bank charges may be charged to your account for any check returned for non-sufficient funds.

3. A monthly service fee plus interest will be charged on all accounts with an outstanding balance after 30 days.

4. Cancellation policy: Our office requires 24 hours notice of cancellation. For any appointment that is not canceled 24 hours in advance, a fee of $50.00 may be charged to your account. As we usually have patients on a waiting list, we appreciate your call if you will need to reschedule your appointment.

5. The responsible party is the parent that brings the child in for the dental visit, independent of what a divorce decree may state. Reimbursement must be made between the divorced parties. We will not intervene.

6. Down payments may be requested and required on special treatment cases requiring sedation, pre-medication, hospitalization or excessive time allotments

7. Alternative financing can be discussed with you by the office manager if extensive treatment is required.

8. A $50.00 charge plus any bank charges may be assessed for all return checks. We appreciate your cooperation and understanding with this policy. If you have any questions, please ask and discuss it with the office manager.

9. Default Policy: If you fail to meet the financial obligations of Wabash Valley Children's Dentistry you agree to be responsible for collection fees of 40%, attorneys fees and court cost.

PATIENTS COVERED BY MEDICAID and HOOSIERHEATHWISE

This is to inform you of our current office policy concerning our patients with this type of coverage.

Due to an increase in Medicaid patients, our office is accepting new Medicaid patients at this time on a priority basis.

In order to treat patients in a quality manner, we must ask that you cooperate with our office staff in several areas.

1. You must present your current Medicaid card at each appointment. Without your Medicaid card, at each appointment Medicaid will not allow us to treat your minor/child. We will be unable to see your minor/child for that appointment.

2. You must cooperate with scheduling all appointments. We will do our best to schedule your child as soon as possible. If you have a home phone or cell phone where you can be reached, we will place your minor/child's appointment on a short call list to see your minor/child at the earliest appointment.

3. You are responsible for all appointments scheduled for your minor/child:

- You must cooperate with the scheduling of your minor/child's appointment.
- If you fail to show for my minor/child's appointment or you are late, you may be charged a $50.00 fee or you may not be able to schedule a future appointment. We appreciate your cooperation and understanding with this policy. If you have any questions, please contact our office. I understand, agree to, and accept the above Medicaid policy. I will also furnish any other information for any of the other agencies named.

OFFICE PRACTICES

We request that all parents/guardians remain in the reception area during the minor/child's treatment, unless special circumstances or parent/guardian assistance is necessary. If we feel that your minor/child has special needs or circumstances develop, we may request your assistance.

There are several reasons for this request. The primary reason is sterility and hygiene. Federal and State laws require us to maintain as sterile a work area as possible. That is why we wear sterile scrubs, masks, and gloves. Secondly, it allows us to work efficiently and effectively without distractions and interference. The doctor-patient relationship will be established and hopefully the necessary treatment can be completed. If at anytime we need parental assistance, the dental assistant will summon the parent for consultation and assistance.

AUTHORIZATION

Minor/Child Consent

I am the parent, guardian, or personal representative of the Minor/Child, listed on page 1, and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

Insurance Assignment and Release

I certify that the minor/child, listed on page1, has coverage with the Insurance Company, listed on page 1, and assign directly to the Doctors of Wabash Valley Children's Dentistry all insurance benefits, if any, otherwise payable to us for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Wabash Valley Children's Dentistry may use your minor/child's health care information and may disclose such information to the above-named heath care providers, insurance companies and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform the doctor if my minor/child ever has a change in health.

Date: _____

Parent/Guardian Name (Print): _____ Relationship to Patient: _____

Parent/Guardian Signature: _____

WVCD AUTHORIZATION FOR FAMILY COMMUNICATION

I authorize Wabash Valley Children's Dentistry, L.L.C. to release the following information about my minor/child's health care (please initial all that apply):

____ Any and all information

____ Information necessary to schedule, confirm, cancel or reschedule an appointment

____ Information about test results

____ Information about prescriptions

____ Information about my bills or account

____ I grant permission to this individual to bring my child to his/her appointment

____ Other information (please describe): _____

This authorization applies to the following individual(s):

Name:	Relationship to Patient/Guardian:
_____	_____
_____	_____
_____	_____
_____	_____

I choose not to authorize any individuals at this time: (Initial) _____

I understand that this authorization is valid until revoked by the patient, or the patient's parent/guardian.

Date: _____

Printed Name: _____

Signature: _____

HIPAA/OCA
3/03

WABASH VALLEY
CHILDREN'S DENTISTRY

Patient Update Sheet

PATIENT'S NAME: _____

By signing below I am confirming that my minor/child's Patient Information, Medical Needs and Insurance Information **has not** changed since I updated the patient's paperwork on _____. If there have been changes, I have informed the front desk personnel and updated the proper paperwork.

1. Parent/Guardian's Signature : _____ **Date:**_____

2. Parent/Guardian's Signature : _____ **Date:**_____

3. Parent/Guardian's Signature : _____ **Date:**_____

4. Parent/Guardian's Signature : _____ **Date:**_____

5. Parent/Guardian's Signature : _____ **Date:**_____

6. Parent/Guardian's Signature : _____ **Date:**_____

7. Parent/Guardian's Signature : _____ **Date:**_____

8. Parent/Guardian's Signature : _____ **Date:**_____

9. Parent/Guardian's Signature : _____ **Date:**_____

10. Parent/Guardian's Signature : _____ **Date:**_____

DENTAL X-RAYS

Dear Parents,

Frequently parents ask about dental x-rays. Why are these necessary? How much do these cost? What does the doctor see on x-rays that he cannot see with his eyes? All of these questions will be answered for you. Please ask if you have questions. In our office we take only those x-rays that are necessary and needed by the doctor to properly treat your child. Secondly the state of Indiana requires that these x-rays stay in our office for 7 years. There are no charges for copying or transferring of your dental x-rays. Below is the state regulation that requires the doctor to retain these records for your safety and benefit. Thanks for you understanding in this manner.

Respectfully,

Wabash Valley Children's Dentistry, L.L.C.

Date: _____

Parent/Guardian's Signature: _____

Witnessed: _____

H.B. 1055 Health Care Providers X-ray Maintenance
This bill started to be limited to mammograms; however, along the way it was amended to include x-rays taken by all health care providers. All providers participating in the Indiana Medicaid program shall maintain, for a period of seven (7) years from the date Medicaid services are provided, such medical or other records, or both, including x-rays, as are necessary to fully disclose and document the extent of the services provided to individuals receiving assistance under the provisions of the Indiana Medicaid program. At the time the x-ray film is taken, the dentist must either advise the patient or post in the x-ray examination area that all the x-ray films will be kept on file for at least seven (7) years and upon request during that time the patient may have a copy.

Anyone who violates this law is subject to disciplinary action by the licensing board.
Effective July 1 , 1988.