fidel Dental Group

4400 Jenifer Street • Suite 335 • Washington DC • 20015 • 202-362-7413
5500 Columbia Pike • Suite B • Arlington, VA • 22204 • 703-575-9899
www.fideldentalgroup.com

Date _____/_____/_____

Patient Information

Name of Minor/Child_____
(First) (Middle) (Last)

Nickname_____ Age_____ Date of Birth _____/_____/_____ Gender M / F

Address_____
(Street) (City) (State) (Zip Code)

Home Phone (_____)_____ Hobbies _____

School Name_____ School Phone (_____)_____

Whom may we thank for referring you? _____

As a courtesy, how would you like to be contacted regarding upcoming appointments? Phone / Text message / Email

Family Information

Have any family members been patients of our office in the past? If so, please list: _____

_____

Mother's / Guardian's Name_____ Date of Birth_____/_____/_____

Work (_____)_____ Cell (_____)_____ Email_____@_____._____

Occupation_____ Employer_____ Marital Status M / S / D / Other

Father's / Guardian's Name_____ Date of Birth_____/_____/_____

Work (_____)_____ Cell (_____)_____ Email_____@_____._____

Occupation_____ Employer_____ Marital Status M / S / D / Other

Dental Insurance Information

Primary Plan _____ Plan Phone # (_____)_____

Subscriber's Name _____ Relationship to Patient _____

Subscriber Soc.Sec.#_____-_____-_____ Subscriber Date of Birth _____/_____/_____

Policy ID # _____ Group # _____

Employer _____

Secondary Plan _____ Plan Phone # (_____)_____

Subscriber's Name _____ Relationship to Patient _____

Subscriber Soc.Sec.#_____-_____-_____ Subscriber Date of Birth _____/_____/_____

Policy ID # _____ Group # _____

Employer _____

Dental History

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Is this your child's first visit to a dentist? Y / N

If no, please provide previous Dentist information and reason for the visit_____

_____

Does your child any recent complaints about dental problems? Y / N. If yes, please explain_____

_____

Does your child take fluoride in any form? Y/ N - rinse / gel / bottled of water / toothpaste / others_____

Does your child had or have a history of any of the following? Please check all that apply

- ☐ Thumb or Finger Sucking
- ☐ Nail biting
- ☐ Gridding or Clenching
- ☐ Bleeding or Sore Gums
- ☐ Breastfeeding
- ☐ Abscess
- ☐ Sippy cup
- ☐ Bad Breath
- ☐ Pacifier
- ☐ Speech Problems
- ☐ Snoring
- ☐ Mouth Breathing
- ☐ Behavioral Issues
- ☐ Other:_____

Medical History

Child's Physician _____

(Name) (Address) (Phone)

Date of the last examination _____/_____/_____ Is your child currently under care of a physician Y / N

Does your child take any medications or drugs? Y / N If yes, please list _____

_____

Has your child ever been hospitalized? Y / N If yes please explain when and why _____

_____

Has your child ever had a surgery? Y / N If yes please explain

_____

Allergies

☐ Penicillin ☐ Amoxicillin ☐ Latex ☐ Sulfa Other_____

Has your child had any history of or difficulty with any of the following? If yes, please check all that apply.

- ☐ Aids / HIV
- ☐ Measles
- ☐ Anemia
- ☐ Asthma
- ☐ ADHD/ADD
- ☐ Autism
- ☐ Bleeding Disorder
- ☐ Bone Disorder
- ☐ Cerebral Palsy
- ☐ Convulsions/Epilepsy
- ☐ Bladder Problems
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Ear Infection
- ☐ Eczema
- ☐ Hearing Disability
- ☐ Heart Murmur
- ☐ Heart Condition
- ☐ Hepatitis
- ☐ Jaundice
- ☐ High Blood Pressure
- ☐ Head Injury
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mononucleosis
- ☐ Mumps
- ☐ Respiratory Issues
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sinus Problems
- ☐ Tuberculosis
- ☐ Tumor
- ☐ Thyroid Disease
- ☐ Vision Disability
- ☐ Other_____

Is patient currently taking birth control pills? Y / N Is Patient currently Pregnant? Y / N

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Practice Terminology and Parent Guidelines

Dear Parents

In Order to improve the chances of your child having a positive experience in our office, we are selective in our use of words. We try to avoid words that scare the child due to previous experiences. Please support us by NOT USING negative words that are often used for dental care. These include:

DON'T USE	OUR EQUIVALENT
Needle or shot	Sleepy juice
Drill	Whistle
Drill on a tooth	Clean a tooth
Pull or yank a tooth	Wiggle a tooth out
Decay, cavity	Sugar bug
Examination	Count teeth
Tooth cleaning	Tickle teeth
Explorer	Toothpick
Rubber dam	Raincoat
Gas	Magic air

This will help you to understand your child's description of the dental experience. Our intention is not to "FOOL" your child – it is to create an experience that is positive. We appreciate your cooperation in helping us build a good attitude toward proper dental care and hygiene for your child.

Agreement

You may choose whether or not to remain in the waiting room during your child's filling appointment.
Although we sense that some children do better without parents present, we are open to having **one of you** with your child. If you choose to be present, we have the following guidelines to improve chances of positive outcome.

1) Allow us to prepare your child
2) Be supportive of the Practice's terminology
3) Please be a silent observer – support your child with touches, not words
    a) This allows us to maintain communication with your child
    b) Children will normally listen to their parents instead of us and may not hear our guidance
    c) You might give incorrect or misleading information
4) If asked to leave, be ready to immediately walk away
    a) Many children try to control the situation
    b) "Acting out" is normal, but unacceptable during fillings
    c) This is intended to "short circuit" the control attempt
    d) We will continue to support your child at all times.

These are very important ways that you can actively help in the success of your child's visit. We are confident that all will go well and hope these guidelines help prepare you with confidence for your child's upcoming appointment.

_____ _____/_____/_____
Signature of Parent, Guardian or Personal Representative Date

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Authorization and Consent for care

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

I am the Parent / Guardian or Representative of _____
Please print patient's name

And there are no court orders now in effect that prohibit me from signing this consent.

I hereby authorize Fidel Dental Group to perform necessary dental services for the child named above.

I understand that an authorized parent or guardian named in the Family Information Form above must be present when treatment is rendered. I may also fill out a consent form authorizing another individual to accompany my child for treatment.

I authorize and consent Fidel Dental Group to use the health care information of the child named above and disclose information to insurance companies and their agents for the purpose of obtaining payment for services and determining insurance benefits.

_____ _____/_____/_____
Please print name of Parent, Guardian or Personal Representative Date

_____ _____/_____/_____
Signature of Parent, Guardian or Personal Representative Date

Emergency Contact

In the event of an emergency whom should we contact?

_____ (_____) _____
(Name) (Relationship) (Phone)

_____ (_____) _____
(Name) (Relationship) (Phone)

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Office Policies & Financial Agreement

We thank you for choosing our office for your dental care. In order to build a trustworthy relationship for years to come we ask you to take a minute to familiarize yourself with our appointment and payment policies.

1. Appointment times are reserved exclusively for you. We make every effort to see patients on time and request that you extend the same courtesy to us by arriving on time for your appointment.

2. Please inform us of any changes to your appointment time at least two business days in advance or we will consider the appointment broken and charge your account $50.00 per broken appointment. If you find that you are running late please call our office to tell us so. Otherwise we may not be able to see. We reserve the right to decline scheduling any future appointments if there is a history of late or broken appointments.

3. A parent must accompany each minor to a visit to our office. Contact our office if you wish to assign another adult to accompany your child. You may choose whether or not to remain in the waiting area during your child's dental appointment. Children almost do better in treatment without parents present but we are open to having one parent accompany your child.

4. Payment for professional services is due at the time dental treatment is provided so please come prepared to pay your deductible, co-payment, and any fees not covered by your insurance on the day of the appointment. A fee of $25.00 will be charged for returned checks.

5. We will file a claim and bill your insurance for you if we are a participating provider. We will provide you with an estimate in writing of your out-of-pocket responsibility. We always try to maximize your benefits but we highly recommend that you contact your insurance company to review your benefits.

6. For patients covered by insurance plans with which we do not participate (*out-of-network provider)*, we will provide you with a claim for filing so that you may be reimbursed by your insurer. Payment for services will be charged in full on the day service is rendered.

7. If your insurance plan does not cover any portion of the services rendered, the remaining balance becomes your responsibility and is due upon receipt of the explanation of benefit document. If your insurance company does not pay our claim with 45 days of filing a claim then the account balance becomes your responsibility. After your insurance pays its portion of the treatment we send a statement to your address on record. We ask that you pay the bill within ten (10) days of the statement date or a fee of $5.00 will be assessed to your account. An additional $5.00 late fee will be charged to your account for every 30 days your account is past due.. An account which is 60 days past due will be transferred to a collection agency and assessed a charge of $50.00 in addition to any legal and court fees.

8. After completion of dental treatment you may be entitled to a refund. You may choose to keep the credit balance with us for use towards future dental care or have the amount refunded to you. Refund checks are issued in the name of the signer of this document and mailed to the address on record.

Please keep us informed of any insurance changes such as policy name, insurance company address, or a change of employment, phone numbers and change of personal address.

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Privacy Policy

Effective April 14, 2003, the federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA's requirements, a copy of our Notice of Privacy Practices is posted for your review and a copy is available at your request. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices. From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Authorization and Consent to Treat Patient and adhere to Office Policies

To the best of my knowledge all the information above is complete and accurate. I understand that it is my responsibility to inform Fidel Dental Group should I have a change in health.

I hereby authorize Fidel Dental Group to perform necessary dental services and to disclose patient information to insurance companies and their agents for the purpose of obtaining payment for services and determining insurance benefits.

I agree to pay all related professional charges. Fees not covered by my dental insurance will be promptly paid upon notification from the office according to the financial policy above. I have read and understood this document in its entirety including the office and financial policies and agree to abide by them in full.

I acknowledge that I have reviewed a copy of the Notice of Privacy Practices.

_____ _____

Please print name Parent or Guardian Date

_____ _____

Signature of Parent or Guardian Date

Other Contacts

Whom should we contact if we are unable to contact you ?

Name _____ Relationship _____ Phone ( ) _____

Name _____Relationship_____ Phone ( ) _____

Staff Initials_____