Cancellation/Late Arrival/Failed Appointment Policy

We are aware that your time is valuable. In an effort to be respectful of everyone's time with the schedule we are initiating the following policy:

We reserve time in our schedule especially for your child, and in consideration of others we request at least 24 hours notice prior to cancellation of appointments. We do understand that there are circumstances that may prevent you from keeping your child's appointment, however with providing us as much notice as possible we may be able to contact another family who would like that appointment time. You will receive one warning letter after the second missed appointment, and a dismissal letter after the third missed appointment. Patients that are running late are asked to call the office as soon as possible to check with the staff if they will still be able to keep their appointment. If you need to cancel over the weekend, please leave us a message on our voicemail to cancel. If you fail to leave a message, it will be considered a broken appointment.

- ***Cancellations:***
  - We **require a 24 hour notice for cancellation**, please be aware that there is an average of an 8 week lead time to reschedule for the doctor.
- ***Late Arrival:***
  - ***Doctor appointments***: If you are more than 15 minutes late for your scheduled appointment with the doctor, you will be rescheduled. This will be considered a missed appointment. If you repeatedly arrive late you may be dismissed from the practice.
  - ***Hygiene appointments***: If you are more than 5 minutes late for your appointment you will be rescheduled. This will be considered a missed appointment.
- ***Failed appointments***:
  - **Fail 3 appointments** (with either the doctor or hygienist, or both) **you will be dismissed from the practice. This policy is per family, not per patient.**

X_____
Child's Name

X_____
Parent/Legal Guardian Signature Print Name Date

X_____
Witness Signature Print Name Date

Worcester Kids' Dentist
41 Lancaster Street, Worcester, MA 01609
508-754-9825
Child Health History

Name of Child_____ DOB_____

1) Were there any difficulties during the pregnancy, delivery or first year of life? ❑Yes ❑No
Explain_____

2) Is a physician treating your child now for a specific illness? ❑Yes ❑No
Explain_____

3) Is your child taking any medications at this time?

DRUG	FREQUENCY	DOSE	REASON

4) Has your child taken any medication in the past? ❑Yes ❑No
Explain_____

5) Does your child have any allergies or unusual reactions to the following?
A) Medications ❑Yes ❑No Foods ❑Yes ❑No Latex ❑Yes ❑No
B) Other ❑Yes ❑No
Explain_____

6) Has your child ever been hospitalized? ❑Yes ❑No
Explain_____

7) Has your child ever had an operation? ❑Yes ❑No
Explain_____
a) Was general anesthesia used? ❑Yes ❑No
b) Any complications? ❑Yes ❑No
Explain_____

8) Are your child's immunizations up-to-date? ❑Yes ❑No

9) Please check if your child has or had any of the following:

❑ ADD
❑ ADHD
❑ Anemia
❑ Asthma
❑ Autism
❑ Blood Transfusions
❑ Birth Defects
❑ Bone or joint problems
❑ Brain Injury
❑ Bruising Easily
❑ Cancer or malignancies
❑ Cerebral Palsy
❑ Child Abuse
❑ Chronic Adenoid/tonsil issues
❑ Chronic Headaches
❑ Chronic Ear Infections
❑ Cleft lip/palate
❑ Convulsions/Seizure
❑ Developmental Delay
❑ Diabetes
❑ Eye Problems
❑ Excessive Bleeding Problems
❑ Excessive Gagging
❑ Fainting or Dizziness
❑ HIV
❑ Hearing/Speech Issues
❑ Heart Murmur
❑ Hemophilia
❑ Hepatitis or liver disease
❑ Hyperactivity
❑ Growth/Dev. Problems
❑ Mental Health Issues
❑ Oral Ulcers
❑ Premature Birth
❑ Tuberculosis
❑ Other

_____
Signature Legal Guardian Print Name Date

_____
Doctor Signature/Date

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DENTAL HEALTH:

1) Why did you bring your child to the dentist today? _____

2) How long has it been since your child's last dental exam? _____ last tooth cleaning?_____
First visit ever? _____

3) For most drinking & cooking do you use: ❑town water ❑well-water ❑bottled water
If well of bottled, has the water been tested for fluoride? ❑No ❑Yes
Results? _____

4) Does your child take fluoride supplements? ❑Yes ❑ No
Dose_____Frequency_____

5) Have there been any injuries to the face, mouth, or teeth? ❑Yes ❑ No
Please give dates and descriptions_____

6) Has your child ever sucked a thumb or fingers? ❑Yes ❑ No
Pacifier? ❑Yes ❑ No
Any other habits? _____ For thumb, pacifier or other habits until what age? _____

7) Does your child have:

Y N	Y N	Y N
❑❑ Snoring	❑❑Tooth Grinding	❑❑History Of Sleep Apnea
❑❑ Daytime mouth breathing	❑❑Bedwetting Now	❑❑Restless Sleep
❑❑ Nighttime mouth breathing	❑❑Hearing Deficiency	❑❑Speech Problems
❑❑ Frequent Middle Ear Infections		❑❑Environmental Allergies

8) Have you been informed of any missing or extra permanent teeth? ❑Yes ❑ No

9) Are there any unusual sounds in ear (clicking) during eating? ❑Yes ❑ No

10) Has your child ever had an orthodontic examination or orthodontic treatment? ❑Yes ❑ No

11) Does your child go to sleep with a bottle, with a sippy cup, or while nursing? ❑Yes ❑ No
Until what age? _____

12) Is your child nervous or frightened during dental visits? If yes, please circle
Least Nervous 0 1 2 3 4 5 6 7 8 9 10 Most Nervous

13) It would be helpful if you would indicate below what things you are looking for most in choosing a pediatric dentist.
_____

14) Has your child had any unfavorable medical or dental experience? ❑Yes ❑No
If so, please explain_____

_____
Signature Legal Guardian Print Name Date

_____
Doctor Signature/Date

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Patient Information **Date**_____

_____
Last Name First Name Middle Initial Gender Birthdate

_____
Social Security #: Home Address City/Town, Zip

_____
Cell Phone Home Phone Work Phone/ Mother Work Phone/Father

_____
Email Address Preferred Contact Method

_____
Father's Name Birthdate SSN # Occupation/Employer

_____
Mother's Name Birthdate SSN# Occupation/Employer

_____
Parents' Information ❑Single ❑Separated ❑Married ❑Divorced ❑Widowed

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Custody Information:

1. Shared Custody: State name of each parent or guardian _____ and _____
   ** ***Written authorization by the non-attending parent and/or guardian must be received by Worcester Kids' Dentist <u>prior</u> to commencement of any and all dental treatment***.

2. Sole Custody: State name _____

   State relationship to child: _____
   Copy of the most recent Court Order must be provided to Worcester Kids' Dentist prior to commencement of any and all dental treatment.

_____
Previous or Family Dentist Address: Telephone

_____
Child's Physician Telephone Urgent medical conditions/alerts

_____
How did you hear about us? Website Referral/by whom

_____
Date of Last Cleaning: Last date of most recent x-rays

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FINANCIAL POLICY

In effort to avoid any misunderstanding, we would like to review our Financial Policy before you or your child begins dental treatment in our office.

Initial Below:

√ _____Please be aware that federal law makes the parent who brings a child and authorizes the medical/dental treatment responsible for payment of fees, regardless of other contracts or agreements.

✔ _____ Payment is expected for treatment rendered at the time of service. We accept MC/Visa/Discover/Debit, checks and cash. For extensive services, we offer payment plans.

✔ _____ If you are in need of an extended finance option, we also work with Care Credit, which offers 3,6,12 or 18 month "same as cash" or longer terms, with an interest bearing revolving charge designed to meet your treatment plan needs, on approved credit. Please see our billing manager regarding Care Credit.

✔ _____ A return check fee of $40 will be charged for all returned checks.

✔ _____ A specific amount of time is reserved especially for you or your child, and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least 24 hour notice.

✔ _____ If you "no call / no show" to an appointment, there will be a broken appointment fee of $75.

✔ _____ I agree to pay a finance charge if my account is overdue.

✔ _____ The parent/legal guardian bringing the child to the office is deemed financially responsible for the account.

✔ _____ We will send a pre-estimate to your insurance company, if requested.

FINANCIAL POLICY FOR PATIENTS WITH DENTAL INSURANCE

You will need to supply us with the subscriber information (name, date of birth, SSN#, employer, ID# and/or group #), as well as the name and address of your insurance company. Any specific questions you may have relative to your insurance coverage should be made, by you, directly to your insurance company. It is your responsibility to confirm that Worcester Kids' Dentist is listed as a provider on your specific plan.

As a courtesy, we will gladly submit an insurance claim to your insurance company. We will collect your estimated co-payment and deductible from you at the time of service, and your insurance company will pay our office directly. We make every effort to determine benefits when you or your child receive treatment, but consider your co-payment to be an **estimate** until we receive the actual payment from your insurance company.

Please bear in mind that any information that we provide relative to your insurance benefits is just our best **estimate,** and is not a guarantee of the payment that will be received.

Name: _____Signed:_____

Date: _____

We always welcome comments from you, whether they are positive or negative in nature. Without your critique, we have no way of knowing how to improve our practice. We want to be responsive to your needs and your feedback is essential to our understanding those needs!

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Insurance Information

Primary Dental Insurance Company

Name_____

Name of Insured_____

SS# _____

Subscriber DOB_____

City, State _____

Employer of Insured_____

Secondary Dental Insurance Company

Name_____

Name of Insured _____

SS# _____

Subscriber DOB_____

City, State _____

Employer of Insured_____

_____
Person Responsible for the Account

_____
Billing Address

I authorize my insurance company (ies) to pay benefits directly to Worcester Kids' Dentist. I understand that all policies are different and I am responsible for knowing my plan provisions. I understand that I will be responsible for all copayment, deductible and rejected charges.

_____
Signature Date

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Consent for Dental Treatment

_____I request and authorize the doctors and staff to examine, clean and provide my child with routine dental treatment which may include x-rays, fillings, crowns, extractions and local anesthesia. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Worcester Kids' Dentist will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone. I understand that I will be responsible for any charges incurred on this child for dental treatment.

PHOTOGRAPHY CONSENT FORM/RELEASE FOR MINOR CHILDREN (Under 18)

I hereby grant permission to Worcester Pediatric Dental Group, Inc. (hereafter referred to as "WKD") staff, to take and use: photographs of my child for use in news releases, social media and/or educational materials as follows: printed publications or materials, electronic publications, or web sites. I agree that my child's first name: may be revealed in descriptive text or commentary in connection with the image(s). I authorize the use of these images without compensation to me, without expiration. All images and reproductions and shall be the property of WKD.

Yes_____ or No_____

_____I have the right to request a copy of this office's Notice of Privacy Practices

_____

Signature Legal Guardian **Print Name** **Date**

……

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Our practice sees many children from many different walks of life. We ask you to certify that you have legal authority to make healthcare decisions for your child, and to update us if that authority changes through adoption, divorce or other circumstances. From time to time, you will be asked to re-execute this form, along with other important documents in your child's medical/dental record.

I have the legal authority to consent to treatment for the below listed child. If authority is related to a legal ruling or court order, I am attaching a copy of the relevant paperwork. I agree to update this form if my legal authority changes.

Patient Name: _____

Date of Birth: _____

Please note: **Only a legal guardian or parent with custody can consent to procedures such as treatment using nitrous oxide (laughing gas) and extractions. Please consider that when your child is coming in for a procedure that requires written consent.**

_____

Signature Legal Guardian **Print Name** **Date**