Bloomfield Children's Dentistry
6405 Telegraph Road
Bloomfield Hills, MI 48301

New Patient Information

Date _____

In order to get to know your family better, and to provide you with the best service, we ask that you provide us with some information. Please fill out this form to the best of your ability. Thank You.

Patient's Name _____ Nickname _____

School _____

Age _____ Date of Birth _____ Ethnicity _____ Sex _____

Whom (or what) may we thank for referring you to our office? _____

What is the reason for your visit? (cleaning, tooth ache, etc.) _____

Family History

Mother's / Guardian's Complete Name _____ Date of Birth _____

Home Address _____ City _____ State _____

Home Phone _____ DL / ID # _____ Zip _____

Cell Phone _____ SS# _____

Email Address _____

Name of Employer _____ Phone _____

Work Address _____ City _____ State _____ Zip _____

Father's / Guardian's Complete Name _____ Date of Birth _____

Home Address _____ City _____ State _____

Home Phone _____ DL / ID # _____ Zip _____

Cell Phone _____ SS# _____

Email Address _____

Name of Employer _____ Phone _____

Work Address _____ City _____ State _____ Zip _____

Patient's Parents are: ☐ Together ☐ Divorced ☐ Separated Other: _____

Emergency Contact

Emergency Contact _____ Phone _____

Address _____ City _____ State _____ Zip _____

Medical Information

Physician _____ Phone _____ Date of Last Exam _____

Does your child have / or had:	YES	NO		YES	NO
Birth Defect	☐	☐	Eye Disorder	☐	☐
Cleft Lip / Palate	☐	☐	Hearing Problems	☐	☐
Difficulty with Speech	☐	☐	Kidney Disease	☐	☐
Asthma	☐	☐	Cystic Fibrosis	☐	☐
Blood Transfusion	☐	☐	Tuberculosis	☐	☐
Emotional Disorder	☐	☐	Developmental Disorder / Delay	☐	☐
Diabetes	☐	☐	Thyroid or Endocrine Disorder	☐	☐
Heart Disease	☐	☐	Heart Murmur	☐	☐
Hepatitis or Liver Disease	☐	☐	Rheumatic Fever	☐	☐
Neurological Disorder	☐	☐	Epilepsy or Seizures	☐	☐
Anemia	☐	☐	Bleeding Disorder	☐	☐
HIV Positive	☐	☐	Cancer	☐	☐
Immunization are up to date	☐	☐	Has the patient ever been advised to take antibiotics prior to a dental visit?	☐	☐

Please list any known allergies (medicines, foods, latex, etc.)

_____

Is the patient currently taking any medications (include over the counter medications)

_____

Please list hospitalizations and surgeries with dates

_____

Patient's Dental History

Date of last visit: _____ What procedure(s) were performed? _____

Previous Dentist _____ Phone _____

How often does the patient brush? _____ How often does the patient floss? _____

The Patient:	YES	NO		YES	NO
Suck Thumb / Finger	☐	☐	Use a Pacifier	☐	☐
Take a Bottle at Night	☐	☐	Breastfeed	☐	☐
Had Unfavorable Dental Visits	☐	☐	Had an Injury to the Mouth	☐	☐

Home Water Supply ☐Well ☐City ☐Bottled

Insurance

Primary Name _____ Relationship to Patient _____

Primary SSN _____ Date of Birth _____ Group Number _____

Insurance Company _____ Insurance Phone _____

Secondary Name _____ Relationship to Patient _____

Secondary SSN _____ Date of Birth _____ Group Number _____

Insurance Company _____ Insurance Phone _____

Please read and sign to have our office file your insurance benefits.
I authorize the release of information and understand that I am responsible for all costs of dental treatment.

_____ _____

Signature of Patient, Parent, or Guardian Date

Responsible Party

We understand there are times a parent or guardian is unable to bring a child in for scheduled appointments or emergencies. You may give permission for others to bring in your child if you list them below. Only parents, legal guardians, or those listed below can consent for treatment for your child.

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

General Consent for Treatment
I hereby authorize and direct the doctor(s) to perform upon my child (or legal ward for whom I am empowered to consent) the following dental procedure(s):

Examinations & radiographs
I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan. I understand the doctor will perform an examination, resulting in her diagnosis and a treatment plan. Radiographs will be taken only when there is a clinical need to do so. There may be a clinical need for radiographs every 6 months and occasionally more often for patients at high risk of decay or with conditions that require frequent monitoring. _____ Initial

Dental Prophylaxis (cleaning)
I understand that this type of cleaning is preventative in nature and intended for patients with healthy gums. It is limited to the removal of plaque, extremely light build-up and stains from tooth structures in the absence of periodontal (gum) disease. This treatment helps to minimize gingivitis. Cleanings may be completed using a toothbrush and polishing paste in young patients that are not yet able to cooperate for the rotary rubber cup polisher. _____ Initial

Application of topical fluoride
Fluoride treatments are typically performed as part of dental cleanings every six months. In certain situations they may be recommended more frequently. Fluoride helps to prevent and slow the process of dental decay and can also improve symptoms of sensitivity by strengthening enamel. _____ Initial

Behavior Management
"Mouth pillows" or "mouth props" can make holding the mouth open more comfortable during dental procedures. I consent to their use during all dental restorative procedures and sealants.

Every effort will be made to ensure your child has a positive experience during each visit. I understand that my child will not be restrained to complete dental treatment unless there is an emergent need to do so.

During the course of the visit, if your child is unable to cooperate for the examination or cleaning, we may ask you to hold and comfort your child so the doctor can perform the examination or cleaning. _____ Initial

Local anesthesia
I understand that local anesthesia will sometimes be used to numb the teeth and tissues if dental fillings/crowns/extractions are necessary. Local anesthetics are very safe medications, but as with any medications there are risks. Common side effects include discomfort at the injection site and chance of injury to oral tissues due to loss of sensation while numb. Uncommon risks include allergic reaction, nerve damage, and infection - which may require medical treatment and hospitalization.
_____ Initial

Changes in treatment plan
I understand that during dental treatment, it may be necessary to change or add procedures. The most common change is the additional need for primary tooth nerve treatment or addition of a crown instead of a filling. I give my permission to the doctor(s) to make changes and additions as necessary and understand that I will be informed of such changes. Said changes may impact my financial responsibility. _____ Initial

Dental insurance benefits
I understand that my dental insurance may not provide coverage for all recommended procedures. I further understand that it is my responsibility to know my insurance plan's limitation and payment provisions, including maximums, deductibles, exclusion, benefit year, etc. The office will verify my dental benefits and file my insurance claims as a courtesy, but understanding that the limitations and covered service under my policy is ultimately my responsibly. Deductibles and co-payments are due at the time of service. I assign all insurance benefits payable to Bloomfield Children's Dentistry. I understand that if the insurance company does not receive payment for services within 45 days of the date of service the balance will be turned over to me. _____ Initial

Text message and email notifications
I authorize the use of the mobile number I provide and or email address, to send me appointment reminders and past due notifications for prophylaxis (cleaning) and exam, and unscheduled treatment. If I do not wish to receive reminders via text or email I may request this in writing to the office to call an alternate number. _____ Initial

Notice of privacy practice
I have received a copy of the offices notice of privacy practices. _____ Initial

Cancellation policy
We are a small office that designates specific time for your child's appointment. We understand that sickness and emergencies may keep you from attending a scheduled appointment and ask that you provide our office with at least **24 hours advance notice or you may be charged a $40 cancellation fee.** We will try to reschedule your child's appointment at a more convenient time. Please understand the best appointment times are difficult to obtain with short notice. _____ Initial

I understand that the information that I have given is correct to the best of my knowledge, that it will held in the strictest of confidence, and that it is my responsibility to inform this office of any changes in my child's medical status and any changes to insurance. In the absence of a legal guardian, the person bringing this patient is hereby authorized to approve. I also authorize the dental staff to perform the necessary dental service that my child may need.

_____ _____
Signature of Patient, Parent, or Guardian Date

Bloomfield Children's Dentistry
6405 Telegraph Road
Bloomfield Hills, MI 48301

Financial Consent

Patient's Name _____ Patient's Date of Birth _____

Financial Agreement

Thank you for choosing us as your child's dental care provider. We are committed to providing the best dental care possible for your child. An important part of providing excellent dental care is making the cost manageable for our patients. The following statement explains our Financial Policy, which we ask that you read and sign.

Payment or Co-Payment is due at the time of service. We accept cash, checks, Visa, MasterCard, Discover, and CareCredit.

Insurance
For patients with dental benefits, we are happy to work with carriers to maximize benefits and directly bill the carrier for reimbursement of treatment. However, if we do not receive payment from the carrier within 45 days of the date of service, you will be responsible for payment of the treatment fees. We will do our best when estimating fees which will be due from the patient for procedures, however, by signing below, the patient acknowledges that they are responsible for any amount due and owing Bloomfield Children's Dentistry which is not covered by benefits, no matter the estimate given at the time of service. _____ Initial

If insurance will not pay all or part of the fees for treatment, or the insurance is discontinued for any reason, the patient is responsible for the unpaid portion of our treatment fees. _____ Initial

Collections
All accounts which become 30 days delinquent are subject to a $25 service charge per month on the past due amount. In the event of non-payment of dental services, we may seek remedy through the legal process. You agree to the reasonableness of such remedies, and agree to bear the burden of such collection costs including but not limited to, collection agency fees, attorney fees, court costs, and filing fees. _____ Initial

Returned Checks
A $35 fee is charged to patients for returned checks. Payment will need to be made by cash, credit card, or cashier's check within 14 days. _____ Initial

Although we will accept assignment for Medicaid patients, the patient, by law, has to be responsible for any portion of the approved amount not covered by Medicaid or a secondary insurance carrier. _____ Initial

The responsibility for payment for services rendered to any dependent children whose parents are divorced rests with the parent who seeks treatment. Any court ordered responsibility judgment must be determined between the individuals involved without the inclusion of our office. _____ Initial

Patient Acknowledgement
I have read and understand the Financial Polices of Bloomfield Children's Dentistry.

_____ _____
Signature of Patient, Parent, or Guardian Date

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have been given a copy of the Notice of Privacy Practices for Bloomfield Children's Dentistry. This notice describes how my or my child's health information will be used and shared. I understand the doctor(s) has the right to change this notice at any times and that I may obtain a current copy upon request.

This information permits Bloomfield Children's Dentistry to use and/or disclose health information relating to my or my child's dental treatment in this office.

I have read and acknowledge the HIPAA notice for:

_____	_____	_____
Patient's Name	Patient's Name	Patient's Name

_____ _____

Patient/Guardian Signature **Date:**

_____

Printed Name