Des Moines Children's Dentistry

5950 Village View Drive Suite 200 ▪ West Des Moines, IA 50266
515.225.1677 ▪ www.dsmcd.com

Tell us about your child:

Child's Name: _____

Preferred Name: _____

Birthday:_____ Male | Female

Patient's School: _____ Grade: _____

Parent 1 Information *(check all that apply)*:

Check one: Mother ◯ Father ◯ Step-Parent ◯ Guardian ◯

Check one: Married ◯ Single ◯ Divorced ◯ Widowed ◯

Does this person have custody of this child? **YES NO**

Name: _____

DOB: ____/____/_____ SS#: _____

Home #:_____ Cell # :_____

Address:_____

_____

E-mail: _____

Parent 2 Information *(check all that apply)*:

Check one: Mother ◯ Father ◯ Step-Parent ◯ Guardian ◯

Check one: Married ◯ Single ◯ Divorced ◯ Widowed ◯

Does this person have custody of this child? **YES NO**

Name: _____

DOB: ____/____/_____ SS#: _____

Home #:_____ Cell # :_____

Address:_____

_____

E-mail: _____

Please list anyone else who has custody of this child and/or any other custody arrangements that we should be aware of:

_____

_____

Person Responsible for Account (if not previously listed):

Name: _____ Relation: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

SS#: _____ DL#: _____

Who is accompanying the child today?

Name: _____

Relation: _____

How did you hear about us?

Google |Facebook | TV Ad | WIC | Billboard | iSmile

Referring Dentist:_____

Doctor's Office: _____

Friend: _____

Other: _____

Dental Insurance:

Policy Holder's Name: _____

Employer_____

Subscriber ID#: _____ DOB: _____

Insurance Company: _____

Phone Number:_____

Do you have secondary coverage? **Yes No**

Health History:

Patient's Name: _____ Date of Birth____ /____ / _____

Reason for today's visit: _____

Pediatrician's Name/Pediatric Office Name: _____

Yes | **No** Is your child allergic to anything? If yes, please explain _____

Yes | **No** Has your child ever been hospitalized? Please give reason and dates: _____

Yes | **No** Is your child currently taking any medications? If Yes, please list and give reason: _____

_____

Has your child been diagnosed with or treated for any of the following:

Y | N Abnormal Bleeding	Y | N Cleft Palate/Lip	Y | N Hepatitis – Type _____
Y | N AIDS/HIV	Y | N Diabetes	Y | N High/Low Blood Pressure
Y | N Anemia	Y | N Epilepsy/Seizures	Y | N Hives
Y | N Any Hospital Stays/Surgeries	Y | N Handicaps/Disabilities	Y | N Kidney Problems
Y | N Asthma	Y | N Hearing/Speech	Y | N Liver Problems
Y | N Blood Transfusion	Y | N Heart Disease	Y | N Rheumatic Fever
Y | N Cancer	Y | N Heart Murmur	Y | N Sickle Cell Anemia
Y | N Cerebral Palsy	Y | N Hemophilia – Type _____	Y | N Tuberculosis (TB)

Please elaborate if any were checked: _____

_____

Please list any conditions not listed above: _____

Dental History

Yes | **No** Has your child ever been to the dentist? If yes, please complete below:

Name of Dental Office: _____City: _____ State:_____

Date of last visit: _____ Were x-rays taken at this visit? **Yes** | **No**

Yes | **No** Has your child experienced any unfavorable reactions from previous dental visits? If yes, please elaborate:

_____

Yes | **No** Does your child suck a finger, thumb or pacifier?

Please indicate if your child is having problems with any of the following:

Cavities Toothache Sensitive Teeth Trauma Gum Infections Color of teeth

Consent for Dental Treatment

I request and authorize Dr. Warrington and Dr. Revell to examine, clean and provide dental treatment on my child's teeth. I further request and authorize the taking of dental x-rays considered necessary by Dr. Warrington and Dr. Revell to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or child's teeth for diagnostic, educational and office promotion purposes. 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. Dr. Warrington and Dr. Revell 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 will be responsible for any charges incurred on this child for dental treatment.

Signature: _____ **Date**: _____

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Parental Agreement

Parents are welcome to accompany their child into the treatment area during the initial examination. This gives you the opportunity to see our dental team in action and allows the doctors to discuss dental findings and treatment needs directly with you. We do ask that if you accompany your child, you assume the role of a silent observer to allow our team to build a good relationship with your child and to prevent confusion about who to listen to during the appointment. For treatment appointments we will allow ONE parent to observe outside the treatment room on the parent bench. We also do NOT allow other siblings to be present in the clinical area during treatment appointments. **If you would like to watch your child's treatment appointment, please make arrangements for your other children or you will be asked to remain with them in the waiting room.** The following is a brief explanation of some of the methods we use to guide your child's behavior and provide a positive dental experience. Since each child is unique, no list can be complete and other methods may be explained as needed.

Tell, Show, Do: We tell children in simple, playful terms what is going to be done. For example, a dental exam becomes "looking and counting teeth". Next we will show demonstrate the procedure before performing it on the child. This is the most important tool for teaching your child.

Distraction: Sometimes it is necessary to distract your child from an unpleasant sensation by focusing his/her thoughts on something other than what is being done.

Positive Reinforcement: This is a technique used to reinforce good behavior by praising your child or providing a reward following a desired response in hopes of promoting continued good behavior.

Voice Control: Voice control is a controlled change of voice volume, tone or pace to influence and direct the child's behavior. This technique is used to establish a line of communication between our doctors and your child.

Appointment Policy

Your appointment: Please make every effort to arrive on time for your appointment. We specifically reserve the required amount of time for your child's planned treatment. If you arrive more than 10 minutes late, your child's appointment may be cancelled or all planned treatment may not be able to be completed at that visit.

Our doctors and staff value your time and make every effort to see your child on time for his/her appointment. By keeping us up to date on all of your current contact information, we are able to send you appointment reminders via email, text messaging, and phone calls. Please keep in mind, we reserve specific time and staff for each patient so ***if you are late or do not show up, you are taking time away from other patients***. If this becomes a pattern of behavior, we may limit the times your appointment may be scheduled, the number of children scheduled per day, or dismissal of your family from our practice.

Canceling, Rescheduling, or Failing an Appointment: We request 2 business days' notice for a cancellation or to reschedule your appointment. If we do not receive 2 business days' notice, we may not be able to reschedule.

I agree to the above Parental Agreement and Appointment Policy:

Child's Name/Children's Names: _____

Parent/Guardian's Name: _____

Signature of Parent/Guardian:_____Date: _____

Des Moines Children's Dentistry

Financial Policy

Thank you for choosing our office for your child's dental care. A clear understanding between us will help ensure that our main concern is your child's dental care. For this reason we would like to inform you of the following financial policies:

- **We require payment in full for all services at the time of your child's visit.**

As a courtesy for those with dental insurance, we will file your insurance claim, and you will be responsible for your co-payments and deductibles at the time of service. Please provide our office with a copy of your current insurance identification card and make sure you update us with any changes in the future.

- **It is the responsibility of the person carrying the insurance to understand his or her dental insurance benefit coverage.**

We are preferred (in-network) providers for Delta Dental Premier and PPO plans and also for Wellmark Blue Dental plans. We also accept Iowa Medicaid and Delta Dental of Iowa Hawk-I plan. We can file with most other insurance companies, but are considered out-of-network providers. Our staff will attempt to give you the best estimate for any treatment with the information provided by your insurance company. However, all costs are given on an ESTIMATE ONLY basis since insurance companies will not guarantee the amount of their payment to our office.

- **We are happy to file your dental insurance claims. However, please understand that you always have the final responsibility for payment of any services rendered.**

We are not responsible for any limitations in coverage that may be included in your plan. In the event that your insurance pays less than estimated, or not at all, for treatment rendered by our office, you will be responsible for the difference. All accounts with any balance over 120 days will be sent to an outside collection agency. There is a $50 charge to all accounts that go to collections.

- **Our staff is always available to discuss any questions and assist you.**

Your child's dental health depends upon the success of our partnership. Please feel free to ask questions at any time.

I have read and understand my obligations and I acknowledge that I am fully responsible for payment of any services not covered by my insurance carrier.

_____

Parent or Legal Guardian Signature Date

I hereby authorize payment of the dental benefits, otherwise payable to me, directly to the above named dental entity.

_____

Policyholder Signature/Parent or Legal Guardian Signature

Acknowledgement of receipt of Notice of Privacy Practices and Consent/Limited Authorization & Release Form

You may refuse to sign this acknowledgement, but in refusing we *will not be allowed* to process your insurance claims.

Today's Date: _____

The undersigned acknowledges receipt of a copy of the current effective Notice of Privacy Practices for Des Moines Children's Dentistry. A copy of this signed, dated document shall be as effective as the original. My signature will also serve as a protected health information document release should I request treatment or radiographs be sent to other attending doctors in the future.

_____ _____

Child's Name Guardian's Name

_____ _____

Guardian's Signature Description of authority

Please list any other parties who can have access to your child's dental information. This includes step parents, grandparents and any care takers who can have access to this patient's records.

Name: _____ Relationship to Child: _____

This person can consent to treatment and authorize treatment decisions in my absence on behalf of my child **Y | N**

Name: _____ Relationship to Child:_____

This person can consent to treatment and authorize treatment decisions in my absence on behalf of my child **Y | N**

Name: _____ Relationship to Child: _____

This person can consent to treatment and authorize treatment decisions in my absence on behalf of my child **Y | N**

I authorize contact from this office to confirm my dental appointments, treatment & billing information via:

- ✓ Cell phone confirmation
- ✓ Home phone confirmation
- ✓ Work phone confirmation
- ✓ Text message to my cell phone
- ✓ Email confirmation
- ✓ U.S. mail/postcard

I authorize information about my dental health be conveyed via:

- ✓ Message on cell phone
- ✓ Message on home phone
- ✓ Message on work phone
- ✓ Text message
- ✓ Email Message
- ✓ U.S. mail/postcard

I approve being contacted about special services, events or new dental info via:

- ☐ Phone message
- ☐ Text Message
- ☐ Email
- ☐ U.S. Mail/postcard
- ☐ Any of the about

Office use only

As Privacy Officer, I attempted to obtain the patient's (or representative's) signature on this Acknowledgement but did not because:

It was emergency treatment _____

I could not communicate with the patient _____

The patient refused to sign _____

Other (please describe) _____

Signature of Privacy Officer_____