Colmar Dentistry for Kids, LLC.

CHILD'S NAME_____

*****OFFICE POLICIES*****

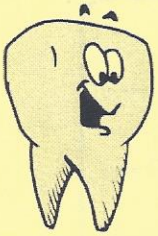
1. For all CHECK UP APPOINTMENTS...FLUORIDE TREATMENTS will always be given unless you tell us otherwise. Bitewing x-rays will be taken once a year. Other x-rays may be taken if deemed necessary by the Doctor. Please check with your insurance company to see if they cover these services. Some insurances will NOT cover these procedures and **you will be responsible**.
2. FOR CHILDREN WHO NEED WORK: Predeterminations will be sent to your Insurance Company to see what is covered or not covered. A copy of this predetermination will be sent to you, from the insurance company, as well as to us. It will state any copays or deductibles that you will be responsible for at the time of your visit.
3. Please do not leave the office during your child's visit...The doctor may need to talk to you.

Thank you for all your help in trying to make our office more efficient. If you have any questions or concerns, please let us know. Thank You.

SIGNATURE OF PARENT
OR
GUARDIAN:_____

??? How did you hear about us ???

_____



Colmar Dentistry for Kids, LLC

Deanna S. Dudenbostel, DMD

2621 North Broad Street
Colmar, PA 18915
Phone: (215) 822-6777

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive dental care. We strive to teach good oral health care that will enable your child to have a beautiful smile that lasts a lifetime.

1 Tell Us About Your Child

Todays Date: _____

Child's Name: _____

Nickname: _____ ☐ Male ☐ Female

Child's Birthdate: ____/____/____ Child's Age: _____

Last Dental Visit Date: _____ X-ray: _____

School: _____ Grade: _____

Name/Age of Child's Siblings: _____

Child's Hobbies/Pets: _____

Child's Home Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell # _____

E-mail: _____

2 NOTES:

3 Mother's Information: (☐ Stepmother ☐ Guardian)

Name: _____ Birthdate: _____

Wk #: _____ Ext: _____ Hm #: _____ Cell #: _____

Employer: _____ Occupation: _____

Business Address: _____

City: _____ State: _____ Zip: _____

SS #: _____ DL #: _____

Mother's Home Address If Different Than Father's: _____

4 Father's Information: (☐ Stepfather ☐ Guardian)

Name: _____ Birthdate: _____

Wk #: _____ Ext: _____ Hm #: _____ Cell #: _____

Employer: _____ Occupation: _____

Business Address: _____

City: _____ State: _____ Zip: _____

SS #: _____ DL #: _____

Father's Home Address If Different Than Mother's: _____

5 Dental Insurance Information

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co Phone #: _____

Group # (Plan, Local or Policy#) _____

Insured's Name: _____ SS#: _____

Secondary Ins. if any: Y N Name: _____

Insurance Co. Phone: _____ Group # _____

Insurance Co. Address: _____

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6 Why did you bring your child to the Dentist today? _____

_____

Has your child ever had a serious/difficult problem associated with previous dental work? ☐ Yes ☐ No

Name of previous Dentist _____

Is your child's water fluoridated? ☐ Yes ☐ No

Is your child taking fluoridated supplements? ☐ Yes ☐ No

Has your child ever had any pain in their teeth? ☐ Yes ☐ No

Does your child brush their teeth daily? ☐ Yes ☐ No

Who helps your child brush/floss their teeth daily? _____

7 Does your child have any of the following habits?

Y N Thumb / Finger Sucking
Y N Lip Sucking / Biting
Y N Nail Biting
Y N Nursing Bottle Habits / Pacifier
Y N Other _____

Our office is committed to meeting or exceeding the standards of infection control and sterilization mandated by OSHA, the CDC and the ADA. We are also HHPAA Compliant.

8 Medical

Child's Physician: _____ Medical #: _____

Phone #: _____ Date of last visit: _____

Is your child currently under the care of a physician? ☐ Yes ☐ No

Please describe your child's current physical health: ☐ Good ☐ Fair ☐ Poor

Has your child been immunized? ☐ Yes ☐ No

Has your child ever had any of the following medical problems?

Y	N	Heart Murmur	Y	N	Tuberculosis
Y	N	Congenital Heart Defect	Y	N	Convulsions / Epilepsy
Y	N	Rheumatic Fever	Y	N	Kidney / Liver Problems
Y	N	Hepititis	Y	N	HIV+ / AIDS
Y	N	Blood Transfusion	Y	N	Cancer
Y	N	Abnormal Bleeding	Y	N	Allergies to any drugs / latex
Y	N	Hemophilia	Y	N	Any stays in a hospital
Y	N	Diabetes	Y	N	Any Operations
Y	N	Asthma	Y	N	Handicaps / Disabilities

Please discuss all medical problems that your child has had:

_____

_____

_____

Please list all drugs that your child is currently taking: _____

_____

_____

Please list all drugs / latex that your child is allergic to: _____

_____

_____

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I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need.

I understand that I must give 48 business hours notice if I need to change my child's appointment to avoid a possible cancellation fee.

Treatment plans and financial arrangements are based on the information provided by my insurance company.

I understand that Dr. Dudenbostel's office cannot guarantee what my insurance will cover and that I am financially responsible for all services rendered.

I understand that payment is due when services are rendered. If collection is required, I agree to pay attorney fees and costs and to pay any account within these terms.

_____

Signature of parent or guardian Date

OFFICE USE ONLY OFFICE USE ONLY **OFFICE USE ONLY** OFFICE USE ONLY **OFFICE USE ONLY**

MEDICAL HISTORY UPDATE

1. Date: _____ Signature: _____

Comments: _____

_____

2. Date: _____ Signature: _____

Comments: _____

_____

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