Today's Date: _____/_____/_____

Patient Information

Full Name _____ Preferred Name _____ ☐ Male ☐ Female

Address _____ Date of Birth _____

City/State/Zip _____ Social Security # _____

Home Phone # _____ School & Grade _____

Mother's Information

Full Name _____ Preferred Name _____ ☐ Single ☐ Married

Address _____ Date of Birth _____ ☐ Guardian

City/State/Zip _____ Social Security # _____ ☐ Step-Mother

Home Phone # _____ Employer _____ ☐ Foster Mother

Mobile Phone # _____ Work Phone # _____

E-mail _____

Father's Information

Full Name _____ Preferred Name _____ ☐ Single ☐ Married

Address _____ Date of Birth _____ ☐ Guardian

City/State/Zip _____ Social Security # _____ ☐ Step-Father

Home Phone # _____ Employer _____ ☐ Foster Father

Mobile Phone # _____ Work Phone # _____

E-mail Address_____

Person(s) authorized to bring child to visits: _____

Names & Ages of Patient's Siblings: _____

Do we see any of the patient's siblings? ☐ Yes ☐ No

Person Responsible for Account

Name _____ Relationship to Patient _____

Billing Address _____ Home Phone # _____

City/State/Zip _____ Mobile Phone # _____

E-mail Address _____ Work Phone # _____

Dental Insurance Information (Insurance card must be shown at time of visit.)

Primary Insurance Co. _____ Secondary Insurance Co. _____

Insured's Name _____ Insured's Name _____

Relationship to Patient _____ Relationship to Patient _____

Date of Birth _____ Date of Birth _____

Social Security # _____ Social Security # _____

Employer _____ Employer _____

I would like to receive appointment reminders via: ☐ Email ☐ Text Message

Patient Name _____ How did you hear about us? _____

Favorite things (toys, activities, pets, etc.) that might help us make your child feel more at home:

_____

Medical History

Child's Physician: Name _____ Phone Number _____

Are your child's immunizations current? ☐ Yes ☐ No ☐ We choose not to immunize

Please indicate if your child has a history of any of the following and elaborate if so. Check all that apply.

☐ AIDS
☐ ADD/ADHD
☐ Allergies
- ○ Seasonal
- ○ Latex
- ○ Medicine _____
- ○ Other _____

☐ Anemia
☐ Anxiety
☐ Asthma
☐ Autism
☐ Behavioral Disorder
☐ Blood Disease/Disorder
☐ Cancer/Chemo
☐ Cerebral Palsy
☐ Diabetes
☐ Developmental Disorder
Functions at age _____
☐ Down Syndrome
☐ Emotional Disorder
☐ Epilepsy
☐ Hearing Problems
☐ Heart Condition
☐ Hepatitis
☐ Hospitalization _____
☐ HIV
☐ Kidney Disease/Problems
☐ Learning Disability
☐ Liver Disease
☐ Mental Disorder
☐ Mumps/Measles
☐ Nervous Disorder
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Sensory Integration
☐ Sinus Problems
☐ Speech Disorder
☐ Stroke
☐ Thyroid Disorder
☐ Vision Problems

Other/Comments:
_____
_____
_____

Current Medications:
_____
_____

Dental History

Why did you make this appointment? _____

Is this your child's first visit to a dentist? ☐ Yes ☐ No If no, approximate date of last dental visit: _____

Child's previous Dentist _____ Approximate date of last dental "x-rays" _____

Does your child currently have any dental problems or has your child ever had any major dental problems in the past? ☐ Yes ☐ No

If yes, please explain: _____

Family Dental History

Do any dental problems run in your family? ☐ Yes ☐ No If yes, please explain: _____

Please rank the following family members' decay history, based on past or present cavities:

Mother	Many	Average	Few	None
Father	Many	Average	Few	None
Brothers/Sisters	Many	Average	Few	None

Cavity Prevention History

Does your child receive fluoride daily?

☐ Yes, we have it in our water ☐ Yes, our child swallows a fluoride supplement daily ☐ No, we do not have fluoride in our water and we do not give supplements

Does your child:

Use a toothpaste containing fluoride? ☐ Yes ☐ No Use other fluoride products (gels or rinses)? ☐ Yes ☐ No

How often are your child's teeth brushed daily? 1 2 3+ How often are your child's teeth flossed? Daily Occasionally Never

Who brushes your child's teeth? Child Parent We take turns Other _____

Does your child have any oral habits (sucking thumb, finger, pacifier, etc.)? ☐ Yes ☐ No Explain: _____

Parent Guidelines

Dear Parents,

You may choose whether or not you accompany your child to the exam chair. Although we sense that some children do better without parents present, we are open to having you with your child. If you choose to be present, please follow these guidelines to improve the chance of a positive experience:

1. **Allow us to prepare your child.** We will use "Tell-Show-Do" to explain each step of the procedure.

WE WILL:
TELL your child about the procedure.
SHOW your child what we will do.
DO what we have explained.

2. **Please be supportive of our practice's terminology.** We are selective in our use of words. Our team members try to avoid words that may scare your child. Please be supportive by NOT USING negative words. Our intention is not to "fool" your child, but rather it is to create a positive experience.

Instead of . . .	**Please Use . . .**
Needle or Shot	Sleepy Juice
Drill	Tooth Washer
Pull or Yank Tooth	Wiggle a Tooth Out
Decay, Cavity	Sugar Bug, Dirty Spot
Drill on Tooth	Wash a Tooth
Examination	Count the Teeth
Tooth Cleaning	Tickle the Teeth
Explorer	Tooth Counter
Rubber Dam	Rain Coat

3. **Please be a silent observer.** We ask that you sit quietly so we can maintain communication with your child. Children will normally listen to their parents instead of us and may not hear our guidance. Only one parent will be allowed back to the treatment area due to space constraints and the privacy of our other patients. Plan ahead to bring another adult with you if you will be leaving other children in the reception area.

4. **<u>It may be beneficial for you to observe from outside the treatment room.</u>** If a child is "acting out" in an effort to have their parent remove them from the dental setting, we will ask for you to watch the appointment through the window in the treatment room door.

These are very important ways that you can actively help in the success of your child's visit. We are confident that these guidelines will help us together make your child's dental visit a positive experience.

Parent's Pledge

I have read and fully understand the parent guidelines for sunflower Smiles Pediatric Dentistry. I have been given an opportunity to ask any/all questions and discuss any concerns. I agree to follow these guidelines so my child will have a positive dental experience.

Child's Name _____

Parent's Name _____ Today's Date _____

Financial Policy & Consents

Payment Payment in full is required for each appointment as services are rendered. Payment options are:

- Cash
- Check
- Credit Card (MasterCard, Visa, Discover)
- Care Credit (Special financing with approved credit. No interest plans available.)

Dental Insurance Insurance is a contract between you and your insurance company. There is no direct relationship between our office and your insurance company. Your insurance benefits are determined by the type and design of plan chosen by you and/or your employer and we are not a party to this contract. We have no control over the terms of your contract, the method of reimbursement, or the determination of you benefits. Some and perhaps all of the services can be defined by your insurance company as "not covered", "denied", or "over UCR". We will file your dental insurance claims as a courtesy to you. We do not guarantee payment and are not responsible for providing you with the plan limitations, exclusions and provisions determined by your insurance company. You agree to pay any portion of the charges not covered by your insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. We will file a pre-determination for recommended treatment when it is requested by you. Any insurance claims not paid within 30 days of filing will become your responsibility. You may seek direct reimbursement from your insurance company.

Missed Appointment Fee Our office requests 48 hours notification if you are unable to keep your scheduled appointment. If **less than 24 hours'** notice is given, a $50 fee will be charged to your account. Patients with two missed appointments may be asked to transfer their records to another doctor.

Finance Charge A finance charge will be added to your account for any balance over $50.00 that is unpaid within thirty (30) days of the date of service. The Finance Charge will be computed at the rate of 1% per month.

Returned Checks There is a fee ($40.00) for any checks returned by the bank.

Monthly Statement If you have a balance on your account, we will send you a monthly statement. It will show the previous balance, any new charges to the account, any finance charge, and any payments or credits applied to your account during the month. Professional fees are the responsibility of the parent or guardian authorizing treatment. We cannot send statements to other persons.

Past Due Accounts If your account becomes 60 days past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collections costs incurred.

Divorce/Separation In case of divorce or separation, the responsible party prior to the divorce or separation remains responsible for the account. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Effective Date Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect. This is an agreement between Michael P. Browning, D.D.S. (dba Sunflower Smiles Pediatric Dentistry), and the patient/debtor named on this form. In this agreement, the words "you", "your", and "yours" means the Patient/Debtor. The word "account" means the account that has been established in your name for your child to which charges are made and payments are credited. The words "we", "us", and "our" refer to Michael P. Browning, D.D.S. ***By signing this agreement, you are agreeing to pay for all services that are received.***

Playground Area Children are welcome to play in the playground area under your supervision. We are not responsible for any accidents that may occur.

I hereby authorize, for the patient named below, examination and treatment by Michael P. Browning, D.D.S and any members of his team (assistants or designees) as deemed necessary by Dr. Browning. I am aware that the practice of dentistry and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations. In this office. I authorize the release of information concerning my child's office visit to and/or from the primary care physician, family physician, referring physician or dentist. I hereby authorize payment of third-party benefits, otherwise payable to me directly, to Michael Browning, D.D.S., not to exceed the doctor's regular charges. I understand that I am financially responsible to the hospital and/or doctor and I agree to pay Michael Browning, D.D.S. all amounts incurred by the below named patient which are not covered by a third-party payer, due by me at the time of service. I have fully read and understand the information about scheduling my child's appointments as well as my financial responsibilities regarding the charges incurred during my child's dental visit. I have been offered or I have fully read and understand the information about HIPAA and my privacy rights.

_____	_____	_____
Patient Name	Parent/Legal Guardian/Responsible Party	Date