WESTMINSTER FAMILY DENTISTRY
115 Airport Drive, Suite 110
Westminster, MD 21157
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e. info@westminster-dentistry.com
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Minor Patient Information

Name _____ Birth Date _____ Age _____ Sex ❑ M ❑ F

I prefer to be called _____

Soc. Sec # _____ Best Phone Number to Confirm Appointments _____

E-mail Address _____ May we contact you via ❑ E-mail ❑ Text Message

Name of Person Responsible for Account _____ Phone (if different from above)_____

Home/Mailing Address _____

Parent/Legal Guardian #1 _____ Relationship _____ Birthdate _____
Cell Phone _____ Work Phone _____ Home Phone _____

Parent/Legal Guardian #2 _____ Relationship _____ Birthdate _____
Cell Phone _____ Work Phone _____ Home Phone _____

Insurance Information

Insured's Name _____ Relation to Patient _____ Birth Date _____

Insurance Company Name _____ Phone _____

Soc. Sec. #_____ Subscriber #_____ Group #_____

Will you be using any secondary insurance? ❑ Yes ❑ No (if yes, please present card at appointment)

Medical History

Child's physician _____ Phone Number_____

Current Medications _____ Reason for Taking _____

Name and location of pharmacy _____

Are you allergic to: ❑ Penicillin ❑ Codeine ❑ Latex ❑ Ibuprofen ❑ Vicodin ❑ Metals
❑ Local Anesthetics (Novocaine) ❑ Seasonal ❑ Sulfa ❑ Other:_____

Women Only: Are you pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Taking Birth Control Pils? ❑ Yes ❑ No

- Circle if your child has any problems with: speech / hearing / vision / sleep
- Is this child your biological child? Yes/No. If no, when did you adopt or obtain legal guardianship of this child? _____
- How does your child tolerate medical or dental treatment? _____
- How do you expect your child to behave today? Circle all that apply: friendly / happy / anxious / timid / afraid / resistant
- Does your child receive fluoride in any form? Yes/No. If so, in what form? _____
- Has your child ever had any surgeries/hospitalizations in his/her lifetime? Yes/No : _____
- Were there any problems at birth? Yes/No. If so, please describe: _____

Check X if your child has or has had any of the following:

- ❑ Chest Pain/Angina
- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Artificial Heart Valves
- ❑ Congenital Heart Disease
- ❑ Infective Endocarditis
- ❑ Birth Defects
- ❑ Arrythmia
- ❑ HIV/AIDS
- ❑ STD's
- ❑ Drug or Alcohol Addiction
- ❑ Eating Disorder
- ❑ Frequent Diarrhea
- ❑ Other Heart Disease
- ❑ HeartMurmur
- ❑ Other Childhood Illness
- ❑ Autoimmune Disease
- ❑ High Fever
- ❑ Cortisone/Steroid Treatments
- ❑ Prolonged Bleeding
- ❑ Blood Disorder
- ❑ Arthritis/Rheumatism
- ❑ Artificial Joints (hip/knee)
- ❑ Back Problems
- ❑ Sinus Problems
- ❑ Other Breathing Problems
- ❑ Asthma
- ❑ Tuberculosis
- ❑ Snoring
- ❑ Sleep Apnea
- ❑ Type I Diabetes (need insulin)
- ❑ Type II Diabetes (oral meds)
- ❑ Migraines/Headaches
- ❑ GERD (heartburn/reflux)
- ❑ Hepatitis B or C
- ❑ Liver Disease
- ❑ Stroke
- ❑ Epilepsy/Seizures
- ❑ Cancer/Tumor/Cysts
- ❑ Transplant
- ❑ Hypothyroid
- ❑ Hyperthyroid
- ❑ Kidney Disease/Dialysis
- ❑ Bladder Problems
- ❑ Special Needs
- ❑ Mental Illness
- ❑ Trauma to Head or Neck
- ❑ Head or Neck Radiation

Signature Of Patient/Legal Guardian _____ Date _____

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Dental History

- Are your teeth sensitive to:
  Heat? ❑Yes ❑No Cold? ❑Yes ❑No Sweets? ❑Yes ❑No Biting Pressure? ❑Yes ❑No
- Does food constantly get stuck between certain teeth in your mouth? ❑Yes ❑No
- Do you get frustrated because you always have something to be treated or repaired when you visit a dentist? ❑Yes ❑No
- Have there been any injuries or trauma to your teeth? ❑Yes ❑No
- Are you dissatisfied with the way your teeth look? For example: color, shape, spaces, etc. ❑Yes ❑No
- Do you have any discolored teeth or fillings? ❑Yes ❑No
- Do you frequently drink sugary beverages (soda,juice,gatorade,sweet tea,energy drinks) ❑Yes ❑No
- Do you currently smoke or chew tobacco? ❑Yes ❑No
- Any history of thumb sucking/pacifier use? ❑Yes ❑No
- Do you clench or grind your teeth? ❑Yes ❑No
- Do you frequently have jaw pain/soreness? ❑Yes ❑No
- Have you ever had jaw surgery? ❑Yes ❑No
- Do your gums bleed when you brush your teeth? ❑Yes ❑No
- Do you often get oral lesions/sores in your mouth (cold sores/fever blisters/ulcers?) ❑Yes ❑No
- Do you have trouble with bad breath? ❑Yes ❑No
- Have you ever had any past or present orthodontic treatment (braces)? ❑Yes ❑No
- If so, are you satisfied with the outcome of your orthodontic treatment? ❑Yes ❑No
- Do you have any crooked/crowded teeth that you would like to be straight? ❑Yes ❑No
- How often do you brush your teeth? _____ Floss? _____
- Do you use any other oral aids (rinses/interdental cleaners/waterpiks)? ❑Yes ❑No
- Do you want to learn to control dental disease and retain your teeth? ❑Yes ❑No
- Do you consider yourself to have dental anxiety? ❑Yes ❑No
- If so, what particularly makes you anxious about dental treatment? _____
- Have you ever had a bad dental experience? ❑Yes ❑No
- If so, what happened? _____
- When was your last visit to the dentist? _____
- What is the name and location of your previous dentist? _____
- What did you have done at your last dental visit? _____
- What prompted you to seek dental treatment at this time? _____
- Why did you leave your last dentist? _____

Additional Medical and Dental History Notes

Please list any other medical or dental history notes that were not mentioned on these forms including SURGERIES, HOSPITAL STAYS, OTHER MEDICAL CONDITIONS NOT LISTED:

_____

_____

_____

The above represents my complete medical and dental history to the best of my knowledge.
If there are any changes, I will inform my doctor as soon as possible.

Signature Of Patient/Legal Guardian _____ Date _____

WESTMINSTER
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DENTISTRY

Patient Privacy Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

1. The following person(s) may have knowledge of my (or my minor child's) account status and dental treatment needs (if none other than self, please write "none"):
   _____

2. **Parents/Guardians only:** the following person(s) have my consent to bring my child to appointments and consent to dental treatment in my absence:
   _____

Patient Name: _____

Signature of Patient
or Legal Guardian: _____

Relationship to Patient (if not self):_____

Date: _____

WESTMINSTER FAMILY DENTISTRY

Informed Consent

I understand that thorough communication about my treatment goals and the risks and complications regarding those choices is important to achieve good results. I understand that sometimes, the position of the jaws, limitation of the dental procedure (not choosing a more aggressive approach) or the severe angulations or position of teeth may prohibit achieving my ideal esthetic goal. Sometimes, a functionally and esthetically adequate result must be accepted.

I understand, that whenever possible, my dental team will incorporate "check-steps" into the treatment phases to ensure I am happy with the results before moving on to a more permanent change. If I have been provided esthetic check-steps that I approved, changes that I desire to be made after approval may require additional charges.

I understand that occasionally complications during treatment may occur and may cause the cost/time of treatment to increase. These can include but are not necessarily limited to: treatment plan delays or changes due to unanticipated findings, pain (discomfort), tooth mobility, tooth decay, devitalization (nerve loss), tooth and/or jaw changes, and injury resulting from the use of high speed dental equipment.

I understand that treatment alternatives will be explained (including the consequences of no treatment) as well as the preferred method of treatment for my mouth. I understand that no guarantees or warrantees may be made for treatment, and in order to achieve the most successful result, I must follow these guidelines:

1. Excellent oral hygiene
2. Proper diet and lifestyle choices
3. Strict adherence to post-operative instructions
4. Cooperation in keeping appointments
5. Keeping to a professional maintenance schedule with recommended periodic exams and necessary x-rays based on my dentist's recommendations

In addition, I understand that treatment may be discontinued for patients who fail two appointments without prior notification, are constantly late for their appointments, continue to excessively cancel their appointments, fail to follow dentist recommendations for the proper care of their teeth, are uncooperative with staff providing care, or who do not pay for treatment in a timely manner.

Patient Name: _____

Signature of Patient
or Legal Guardian: _____ Date: _____

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Appointment Policy

As a courtesy to our patients, all treatment rendered will be submitted to your insurance for payment. Any non-covered dental treatment will be paid by patient. Payment is due at the time of service for any non-covered treatment. Acceptable payment methods include cash, check, credit card or care credit health care financing. Any balances that are not paid at time of service must be paid within 30 days to avoid collection agency turn over. Unpaid returned (bounced) checks will be charged a $35 fee.

We are committed to superior service with the latest in technology, done in a timely manner. We require two (2) business days notice to cancel any appointments. Appointments that are cancelled with less than two (2) business days notice, or if a patient is more than 15 minutes late or does not show for their appointment will be considered a broken appointment. Due to the high demand for dental services to our underserved population, it is our policy that **any patient having more than one (1) broken appointment may not be allowed to schedule appointments in the future** and may only be seen for same-day emergency services for 30 days after dismissal letter has been sent.

Please read carefully before signing and dating this agreement.

Patient Name: _____

Signature of Patient or Legal Guardian: _____

Relationship to Patient (if not self): _____

Date: _____

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Financial Policy

For your convenience we offer several options of payment: cash, check, debit or credit card. We also accept Care Credit, a third party financing company; however, other discounts may not be applied with use of this financing. Payment arrangements must be agreed upon before procedure is initiated. If you have dental insurance, we will gladly file your claim for you; however, you are responsible for your account. **Each patient will receive an estimate for treatment needed, which will include their co-pays and deductibles. This is only an estimate and you are responsible for amounts not paid by the insurance. We cannot guarantee what insurance will or will not pay.** As a courtesy, we will submit your secondary insurance claims for you, with secondary payments going to the subscriber. If your insurance neglects to pay within 60 days, the balance on the account becomes your responsibility. If your account becomes delinquent, it will be turned over to a local collection agency and you will incur any collection costs and any related attorney's fees. If you do not have dental insurance, we do have other payment options, you may discuss your options with our financial coordinator. All estimated payments are due at time of service.

We are committed to superior service with the latest in technology, done in a timely manner. We reserve the right to charge **$50 for all broken/cancelled appointments that do not give two business days notice.** If a patient breaks or cancels an appointment with less than two business days notice for any extensive treatment or longer appointments you will be expected to apply a reservation fee for future appointments at the time of scheduling. As our patient, we ask that you keep your account current to allow us to continue providing our highest level of care for you, your family and friends. Your account will be charged a return check fee in the amount of $35 for any check returned unpaid.

Please read carefully before signing and dating this agreement.

Patient Name: _____

Signature of Patient or Legal Guardian: _____

Relationship to Patient (if not self): _____

Date: _____