

Dear Parent or Guardian,

Welcome to our office and thank you for choosing us as your child's dentist. We will continually strive to provide your child with the finest care available.

To help accomplish this, we would like you to read the following:

- Please have your child use the restroom after checking in for the appointment.
- Please arrive 15 minutes prior to the appointment time. This allows relaxation and playtime for your child. If you are more than 1/2 your appointment time late, you will be rescheduled.
- Due to OSHA regulations food and drink are prohibited in our treatment area.
- We have two offices to serve you.

Our Amberglen office is located on Amberbrook Dr. just off Cornell Rd. between 206th Ave and Macy's. Other landmarks include: Bugatti's, Quizno's Subs, and Bally's Total Fitness.

Our Murrayhill office is located in the Murray Scholls Town Center, at the corner of Scholls Ferry and Murray Blvd. We are behind the stores and restaurants, across the parking lot from 24 Hour Fitness. Other landmarks: Starbucks, Mark's Video, Walgreens, and Kaiser.

- Due to new Federal Trade Commission regulations regarding Identity Theft Red Flags Rule, you will be required to show photo identification with your submitted paperwork. Please keep in mind that the parent or legal guardian must also be present at the appointment in order for your child to be seen.

We are looking forward to meeting you and your child! Please give us a call if you have any questions at Amberglen, 503.641.8800 or at Murayhill, 503.579.0304.

Sincerely,
Dr. Downey, Dr. Carolyn and staff

About your child:

Child's full name: _____ Sex: Male Female
Nickname: _____ Birthdate: _____ Age: _____
Child's Home Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Social Security#: _____

Parent Information: Mother Father Step Mother Step Father Guardian

Full Name: _____ Birthdate: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Occupation: _____ Social Security #: _____
Marital status: Married Single Separated Divorced Widow Do you have dental insurance? No Yes
Employer's Name (Company): _____
Insurance Company: _____ Insurance Phone #: _____
Claims mailing address: _____
City: _____ State: _____ Zip: _____
ID# (If different than SS#): _____ Group #: _____

Parent Information: Mother Father Step Mother Step Father Guardian

Full Name: _____ Birthdate: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Occupation: _____ Social Security #: _____
Marital status: Married Single Separated Divorced Widow Do you have dental insurance? No Yes
Employer's Name (Company): _____
Insurance Company: _____ Insurance Phone #: _____
Claims mailing address: _____
City: _____ State: _____ Zip: _____
ID# (If different than SS#): _____ Group #: _____

Responsible Party Information: Mother Father Step Mother Step Father Guardian

(This person is responsible for the account). If different than above, please continue.

Full Name: _____ Birthdate: _____
Relationship to Patient: _____ Social Security #: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

Health History

Has your child had any difficulty with previous dental visits? No Yes
Does your child suck/bite lips? No Yes Does your child suck thumb/pacifier? No Yes
Does your child take fluoride? No Yes
Does your child require pre-medication for dental appointments? No Yes
How often does your child brush? _____ How often does your child floss? _____
Date of child's last dental visit _____ Previous Dentist _____
Are there records to request? No Yes

Reason for today's visit: _____

Dentist's Review: _____ **PG:** _____ **BC:** _____

Date: _____ **Signed Dr.** _____

Name of Pediatrician _____

Does your child have a health problem? No Yes

Is your child under care of a physician? No Yes

If yes, since when and why? _____

Is your child receiving any medication? No Yes If yes, what? _____

Is your child allergic to penicillin, antibiotics, or other drugs? No Yes If other, what? _____

Does your child have other allergies? No Yes If yes, what? _____

Has your child had any serious illness? No Yes

If yes: When _____ What _____

Has your child ever had surgery? No Yes

Does your child have a congenital heart defect? No Yes

If yes: Name of Cardiologist _____

Does your child experience severe or prolonged bleeding? No Yes

Does your child have AIDS or has he/she tested HIV positive? No Yes

Has your child tested positive for hepatitis? No Yes

Is your child subject to nervous disorders? No Yes

Fainting Seizures Dizziness Behavioral/Learning problems

Does your child have frequent headaches? No Yes

Has your child had history of: (Circle Responses) diabetes, heart trouble, asthma, kidney infection, rheumatic fever, epilepsy, cerebral palsy, liver problems, congenital birth defects, mental retardation, eyesight problems, cancer, infections, speech impairments, hearing loss.

Describe other medical concern _____

Special needs _____

Who is responsible for making dental appointments?

Name _____ Home Phone _____ Work Phone _____

Best time to call (time) _____ (days) _____

How did you hear about our office? _____

CONSENT FOR TREATMENT

I hereby authorize Dentistry for Children at Murrayhill, P.C. or the designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my child's dental needs. Upon such diagnosis, I hereby authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I agree that parents are responsible for fees and services rendered for treatment of a child. **I understand that my estimated portion is due in full at each appointment.**

Parent/Guardian's Signature _____ Date _____



Screening of Developmental Progress

Child's Name:	Date:
---------------	-------

*Following are some questions that help us understand your child's development.
Your answers help us, help you.*

Developmental Questions

Does your child seem 'younger' than his/her age?	Yes	No
Does your child seem 'older' than his/her age?	Yes	No
Are you concerned about the way your child is learning in general?	Yes	No
Are you concerned about the way your child is learning at school?	Yes	No
Does your child have an Individual Education Plan at School (Special Education)?	Yes	No
Are you concerned about your child's misbehavior?	Yes	No
Are you concerned about your child's anxiety?	Yes	No
Are you concerned about your child's sadness?	Yes	No
Are you concerned about your child's social skills?	Yes	No
If you answered yes to any of the above questions, would you like us to give you a recommendation to another provider who can determine whether you should be concerned?	Yes	No

Medical, Mental Health & Dental

List any MEDICAL diagnoses your child has:	
List any MENTAL HEALTH diagnoses your child has:	
List any MEDICATION your child is taking:	

During dental appointments my child may experience: (Circle all that apply)

No worries, this is a pro!	Confusion	May not understand your words
Fear	Sensitivity to sound	Refusal to comply
Anger	Sensitivity to touch	Other: _____

If your child gets upset, what is likely to happen? (Circle all that apply)

Run away from the chair	Crying
Physical aggression (kick/bite)	Refusal to comply
Verbal aggression (yell/scream)	Other: _____

What will motivate your child, so we can do our best today? (Circle all that apply)

Verbal praise	Star or sticker chart	Food reward
Reassuring pats	Earning a toy when finished	Other _____

Diet

Is your child's diet typical? Yes No	
If not please describe your child's diet:	
Food Item	How often is this eaten per day?
Drink other than water	
Drink of water	
Fruit	
Vegetable	
Other snack	

Evaluation of Senses

	Less Sensitive than Typical Kids	Typical	More Sensitive than Typical Kids
Visual			
Sound			
Touch			
Smell			
Taste			

Communication

How does the child communicate?			
	Doesn't use this type of communication	Typical to other kids	Primary means of communication
Verbal Direction (Words)			
Visual Direction (Prompting)			
Physical Directing (Herding)			

DENTISTRY FOR CHILDREN
APPOINTMENT AND FINANCIAL POLICY

WHEN WE WELCOME A NEW FAMILY TO OUR PRACTICE, WE ALSO WELCOME ANY COMMENTS OR QUESTIONS YOU MAY HAVE ABOUT OUR POLICIES. PLEASE READ THE FOLLOWING, SIGN AND RETURN ON THE FIRST VISIT.

An appointment written in our schedule, with your child's name on it, is a bond of trust that we will be here to serve you and that you will be present and on time for that appointment. For all of us, time is important and we do our best to ensure that you are seen promptly. Working with small children, as we do, there are no guarantees. We appreciate your patience. Please be assured that your child will also receive the same extra attention.

As a courtesy to our patients, we will attempt to confirm your scheduled appointment. Feel free to leave a message on our 24 hour voicemail if you have any questions or concerns. However, once you have made an appointment, remembering and keeping it is your responsibility. Confirmation is simply a courtesy to you.

We make every effort to be on time, we hope you will also. If you must change an appointment, we request 48 hours advance notice. In the event of illness, call the office as soon as possible. Feel free to leave a message on our 24 hour voice mail. We have many children waiting for earlier appointments. We reserve the right to charge a fee for broken appointments.

Our office provides dental care as determined by the American Dental Association and the American Academy of Pediatric Dentists. Insurance companies may have limits or exclusions for the recommended treatment. It is up to you to know your insurance policy and any possible limitations and exclusions.

Payment is requested at the time treatment is provided. We accept most insurance plans and will bill your primary and/or secondary for you. If you have dental insurance we collect the estimated amount not covered at each appointment. You need to provide us complete insurance information and answer any insurance inquiries. In the event of insurance delays or disputed claims beyond 45 days, you will need to pay your account in full and arrange for reimbursement by your carrier. Please remember that insurance companies only assist in payment and rarely cover your full costs. If your dental plan does not pay the amount we have estimated, the balance is your responsibility.

Finance charges are not assessed on **current** accounts. For accounts 60 days past due, a finance charge will be imposed on services not paid in full. The finance charge is a monthly rate of 1.25%, which is equal to a yearly rate of 18%, with a minimum charge of \$1.00. A billing fee is imposed after 60 days at the fee of \$5.00 per month.

A claim will be submitted to my insurance carrier, if applicable, and authorize release of any necessary information to them. I understand that Dr. Downey and Dr. Carolyn are not participating/ preferred providers with my insurance plan and that I am responsible for any balance not covered by such plans. I authorize my insurance company to send payment directly to Murrayhill Pediatric Dentistry P.C. I agree to pay all costs of collections, including, but not limited to, reasonable attorney fees.

Method of Payment: Cash Check Credit Card Third Party Dental Lending

A \$38.00 fee is charged to your account for any bank returned check (NSF). An \$85 processing fee will be assessed if your account is deemed delinquent and you will be dismissed from our practice. We will refund any credit back to you as soon as we can. If you paid via a credit card your credit will be refunded to your card and you will be notified by phone or mail. If you paid via check it will take 14 business days before your credit will be refunded to you. We will mail you a check to the address we have on file.

I acknowledge I have read this financial policy and I am responsible for all charges whether or not paid by insurance. If I have insurance, I hereby authorize payment of the dental benefits, otherwise payable to me, directly to Eric A. Downey, DDS or Carolyn Muckerheide, DDS.

Signature _____ Date _____

Print Name _____