Welcome to Fox Point Dental!

The information on this form will help us give you more reliable and successful treatment.
Please fill out both sides carefully and completely. Thank you.

Patient Name:_____ Birthdate: _____
Parent/Guardian Name:_____ Residence Phone:_____
Parent Email:_____
Residence Address:_____ City: _____ State: _____ Zip:_____
Social Security Number:_____

If someone other than the patient is responsible for payment, please fill out the following section.

Person Responsible For Payment: _____Date of Birth:_____
Relation To Patient: _____
Occupation: _____ Social Security Number: _____
Employer: _____ Business Phone: _____
Business Address: _____ City: _____ State: _____ Zip:_____

If there is any form of dental coverage, please complete the following:

Name of Carrier:_____
Employer or Union: _____ Group Number: _____
Employee Name:_____
Employee Social Security Number: _____
Policy Holder's Date of Birth: _____
Has patient had care under this plan? _____ When? _____
Is patient covered under another plan? ❑ YES ❑ NO

Person not at your address to be contacted in case of an emergency.
Name:_____
Address: _____ City: _____State:____ Zip:_____Phone:_____

Treatment Authorization
I agree to diagnostic procedures and dental treatments as found necessary and desirable for the patient named above. This includes the use of study models, radiographs (x-rays), local anesthetic, and relaxing agents.
I agree to be financially responsible for treatment rendered.

_____ _____
Patient, Parent, or Legal Guardian Date

Who may we thank for referring you to our office?_____

FOX POINT DENTAL - FINANCIAL AGREEMENT

DENTAL BENEFITS

If you have dental benefits, we are eager to help you receive your maximum allowable benefits. In order to achieve this goal we need your assistance and your understanding of our payment policy.

You will be asked to update your personal and dental benefit information periodically, including providing our office with copies of your benefit card. We are required by law to obtain your signature for permission to release information to your insurance carrier. We will gladly submit fees for your covered dental services to your insurance company. However, we expect payment of all services within 90 days. **It may become necessary for you to pay your account in full if your insurance company fails to pay for services within 90 days**. It is your responsibility to understand your coverage and benefits, including pre-authorizations and authorization requirements. We will, however, assist you to ensure that all plan requirements are met.

Please initial _____

Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. While the filing of insurance claims is a courtesy that we extend to patients, all charges are your responsibility from the date the services are rendered.

Please initial _____

PAYMENT FOR SERVICES

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance. We accept cash, checks, MasterCard, Visa and Discover.

Please initial _____

Returned checks will result in a $35 fee that will be posted to your account. Returned checks, balances older than 90 days and failure to pay account balances as promised may be subject to external collection and additional collection fees, including attorney and other court fees.

Please initial _____

We will attempt to give you an estimate of your patient payment. This estimate may be altered by your dental plan, as it is subject to annual deductibles, maximums, waiting periods etc. However, regardless of an estimate that you may have received, any difference between the fee charged and the amount paid by the insurance company is your responsibility.

Please initial _____

GENERAL

We will gladly discuss your proposed treatment and answer any questions relating to your benefits. Your benefits are a contract between you, your employer and the insurance company. We are not a party to that contract. *W*e must emphasize that as a dental care provider, our relationship is with you, not your insurance company.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

CANCELLED APPOINTMENTS

Charges may be incurred for broken, confirmed appointments and appointments canceled without 48 hours notice. Your cooperation in canceling your scheduled appointment well in advance allows us the opportunity to offer your appointment to a person who needs dental care**. Failure to show for (or cancel) a scheduled, confirmed appointment may result in a $75 cancellation fee.**

Please initial _____

If you have any questions about the above information, please do not hesitate to ask us!

Thank you,
Fox Point Dental, Turner PLLC

My signature below constitutes acknowledgment and acceptance of this policy.

_____	_____	_____
Patient name-Printed	Patient or guardian signature	Date

Pediatric Health History

Patient Name: _____ Date:_____

Name of Physician or Clinic:_____
Last visit to their medical provider?_____
Any SLP, OT, Myofunctional Therapy, IBCLC, or other medical specialist in the past? ❑ YES ❑ NO
If yes, please explain: _____

Does your child have, or have they ever had, any of the following? Please check.

❑ Abnormal Blood Pressure
❑ Allergies
❑ Anemia or Blood Disorder
❑ Asthma
❑ Bleeding Problems
❑ COVID-19
❑ Cancer
❑ Diabetes
❑ Epilepsy
❑ Heart Disease or surgery
❑ Heart Murmur
❑ Hepatitis
❑ High Blood Pressure
❑ Liver or Kidney Disease
❑ Lung Disease
❑ Rheumatic Fever
❑ Sinus Problems
❑ Sleep Apnea
❑ Stroke
❑ Thyroid Disease
❑ Tongue or Lip Tie
❑ Tonsil/Adenoid Removal
❑ Tuberculosis
❑ Tumor History
❑ Ulcers
❑ Upper Airway Resistance
❑ Other:_____

Do your child have a medical problem? ❑ YES ❑ NO If yes, please explain: _____
Have they been hospitalized in the past five years? ❑ YES ❑ NO If yes, please explain: _____
Are they taking any prescribed medications? ❑ YES ❑ NO If yes, please list below:
Taking: _____
Are they taking any supplements or vitamins? ❑ YES ❑ NO If yes, please list below:
Taking: _____
Have they ever had a bad reaction or allergy to medication? ❑ YES ❑ NO If yes, please explain:_____
Have they had problems with: ❑ Codeine ❑ Penicillin ❑ Aspirin ❑ Local Anesthetic (Novocaine) ❑ Other
Do they have any limitations in their activities? ❑ YES ❑ NO If yes, please explain:_____

I attest that the medical and dental history provided are true.

Parent or guardian Name: _____ Relationship: _____

Parent or guardian Signature: _____ Date: _____

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Medical History Reviewed: _____Date: _____

Pediatric Dental History

Patient Name: _____ Date:_____

How can we help you? What is your immediate dental concern? What are your treatment goals?

_____

Date of Last Dental Visit:_____ Date of last full mouth x-rays:_____
Previous Dentist:_____ City: _____ State: _____

Is your child presently having dental pain? ❑ YES ❑ NO If yes, where?_____
Have you noted any unusual changes in or around your child's mouth? ❑ YES ❑ NO If yes, where?_____
Are you pleased with the appearance of your child's teeth? ❑ YES ❑ NO If yes, please explain:_____
Has your child lost any teeth? ❑ YES ❑ NO If yes, from what cause?_____
Has your child had any orthodontic treatment? ❑ YES ❑ NO If yes, how old were they?_____
Was your child breastfed? ❑ YES ❑ NO For how long:_____
Was your child bottlefed? ❑ YES ❑ NO For how long:_____
Any difficulty with breastfeeding or bottlefeeding? ❑ YES ❑ NO If yes, please explain:_____
Do you help your child with brushing or flossing? ❑ YES ❑ NO
How often are they brushing? _____ How often are they flossing? _____
Does your child avoid brushing or chewing in any part of their mouth? ❑ YES ❑ NO
Do you have any speech concerns with your child? ❑ YES ❑ NO If yes, explain: _____
Does your child have feeding issues (for example, "picky eater")? ❑ YES ❑ NO If yes, explain:_____
Was your child premature? ❑ YES ❑ NO If yes, explain:_____
Any history of cleft lip, cleft palate, tongue or lip ties? ❑ YES ❑ NO
Any family history of cleft lip, cleft palate, tongue or lip ties? ❑ YES ❑ NO
Any history of reflux or digestive issues? ❑ YES ❑ NO
Does your child sleep restlessly (for example, messed up covers)? ❑ YES ❑ NO If yes, explain:_____
Does your child sleep noisily (for example, snoring or loud breathing)? ❑ YES ❑ NO If yes, explain:_____
Does your child sleep with an open mouth (mouth breathe)? ❑ YES ❑ NO
Does your child sit regularly with an open mouth (mouth breathe)? ❑ YES ❑ NO
Does your child clench or grind their teeth, day or night? ❑ YES ❑ NO
Does your child have flattened or shortened teeth? ❑ YES ❑ NO
Does your child have a history of bedwetting? ❑ YES ❑ NO If yes, how frequently?_____
Does your child have dry lips? ❑ YES ❑ NO
Does your child typically sleep through the night? ❑ YES ❑ NO If no, please explain:_____
Is there anything we should know to give your child better, more comfortable care? ❑ YES ❑ NO
If yes, please explain:_____

For Office Use Only----------

Dental History Reviewed: _____Date: _____