Welcome To Our Practice

We are pleased to welcome you and your child to McLean Pediatric Dentistry! Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health!

Date _____

Patients Name _____
Last First MI

Nickname _____ Birthdate ____/____/____ Sex M____ F____

Home Address _____
Street City State Zip

I UNDERSTAND THAT MCLEAN PEDIATRIC DENTISTRY WILL BE CONTACTING BY PHONE, TEXT OR EMAIL TO CONFIRM ALL APPOINTMENTS THAT I SCHEDULE WITH THE OFFICE.
I AUTHORIZE THE OFFICE TO CONTACT ME AT THE FOLLOWING NUMBERS AND EMAILS

Parent 1 Name _____ Parent 2 Name _____

Parent 1 Cell # _____ Parent 2 Cell # _____

Email(s) _____

Our automated system will send you a text message to confirm your child's appointment. Please reply with "C" to confirm. If the appointment is not confirmed, additional reminder texts will be sent until confirmation is received. If you need to cancel, please call or text us at least 24 hours in advance to avoid the $50 cancellation fee

How did you hear about us? _____

Pediatrician/General Physician _____
Name Office Phone Number

Under the care of any other physicians? ☐ Yes ☐ No If yes, for what? _____

MEDICAL HISTORY:

- Please list any medications the child is taking:

- Please list any allergies your child may have (latex, food or dye, medication, etc):
  ****ALLERGIC TO:**

- Has your child had any history of or difficulty with any of the following? If yes please (√).

____A.I.D.S./H.I.V.	____Cerebral Palsy	____Heart Problems	____Sensory Issues
____ADD/ADHD	____Developmentally Delayed	____Hepatitis	____Sinus Issues
____Anemia	____Diabetes	____Kidney Disease	____Thyroid Issues
____Asthma	____Epilepsy	____Liver Disease	____Tuberculosis
____Autism	____Fainting	____Mononucleosis	____Other
____Cancer	____Hearing Problems	____Seizures	_____

☐ **I WILL INFORM THE OFFICE OF ANY FUTURE MEDICAL CHANGES CONCERNING MY CHILD**

FINANCIAL AND INSURANCE INFORMATION:

If you have an insurance company that we <u>do not</u> submit for, you will be required to pay in full at the time of service. We will provide you with an insurance claim that you may submit for your reimbursement.

WE PARTICIPATE WITH:

- AMERITAS	- GEHA	- OMAHA LIFE	
- CIGNA	- HUMANA	- PREMERA BCBS	- UNITED CONCORDIA
- DELTA DENTAL PREMIER	- INNOVATION	- PRINCIPAL	- TRICARE
- DOMINION	- LINCOLN	- SUNLIFE	- UHC
- GUARDIAN	- MEDICAID	- UMR	

Policy Holder's Name _____ Birthdate _____ / _____ / _____

Employer _____ Plan Name _____

Soc. Sec # _____ Group # _____ Policy #_____

Insurance Mailing Address_____

Secondary Dental Insurance ☐ No ☐ Yes If Yes, Plan Name _____

☐ I authorize the dentist to release all information needed to secure the payment of benefits and I authorize the use of my signature on all my insurance submissions, whether manual or electronic.

☐ I understand that I am financially responsible for all charges whether or not paid by insurance.

If it is necessary for your child/children to have extensive dental treatment, a monthly payment plan can be arranged with the office. A credit card must be placed on file in order to pay in monthly installments. Any balance remaining unpaid for 30 days will be charged a $5 late fee for every month unpaid for.

CONSENT AND AUTHORIZATION

I am the parent, guardian, or personal representative for the above patient and there are no court orders in effect that would prevent me from signing this consent. I hereby request and authorize the doctors of this practice and the dental staff to perform necessary dental services, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when treatment is rendered.

To the best of my knowledge, the above information is complete and correct. I have read and understand this document in its entirety outlining office policies, patient and family responsibilities, and agree to abide by all terms stated herein.

Date _____

Signature _____ Print Name _____