TLC PEDIATRIC DENTISTRY, LLC
266 SILAS DEANE HIGHWAY
WETHERSFIELD, CT 06109

Personal Questionnaire for New Patients

(PLEASE PRINT IN INK)

Child's Name: _____ Sex: M / F Nickname:_____

Birthdate: _____ Age: _____ Favorite Hobbies/Toys/Sports: _____

Street Address: _____ Home Phone: _____

City, State, Zip: _____ Other Phone: _____

**** Email:*** _____ **** Cell Phone***: _____

Father's Name: _____ Mother's Name: _____
Father's DOB: _____ Mother's DOB: _____
Father's SS#:_____ Mother's SS#:_____
Father's Work: _____ Mother's Work: _____

Why did you bring your child to the dentist today?_____

Health Information

Child's Pediatrician: _____ Phone: _____
Date and Results of Last Physical Exam: _____
Does your child have regular check-ups? Yes No
Are Immunizations up to date? Yes No
Does you child have any chronic or long-term medical problems? Yes No
If yes, please explain: _____
Is your child taking any medication? Yes No
If yes, please list drug, dosage, reason: _____
Has your child had any unfavorable reactions to medication, antibiotics or latex? Yes No
If yes, please explain: _____
Has your child ever been hospitalized? Yes No
If yes, please list date(s) and reason(s): _____
Has your child sustained any serious injuries or illnesses? Yes No
If yes, please list date(s) and reason(s): _____

Does your child have, or has ever had, any of the following: (please give age)

(Please circle all that apply)

ADD/ADHD
Allergies
Anemia
Artificial Joints
Asthma
Autism
Bleeding Disorders
Breathing Problems
Cancer/Tumors
Cerebral Palsy
Chicken Pox
Cleft Lip/Palate
Developmental Delay
Diabetes
Digestive Problems
Drug/Alcohol Abuse
Epilepsy/Seizures
Eye Problems
Growth Disorders
Head Injuries
Hearing Problems
Heart Disease
Heart Murmur
Hepatitis (type __)
HIV
Kidney Disease
Leukemia
Measles
Mumps
Pregnancy
Radiation Treatment
Rheumatic Fever
Sinus Problems
Tuberculosis Frequent Colds
Frequent Ear Infections
Frequent Headaches

Are there any other significant problems? Yes No
If yes, please explain:

_____
_____
_____

Dental History

Date of last visit: _____Date of last x-rays: _____

Name & Address of previous dentist: _____
Has your child ever had any injuries to the teeth,
mouth or face? Yes No
If yes, please explain:_____
Has your child ever had a toothache? Yes No
If yes, please explain: _____
Has your child ever had any complications following dental treatment? Yes No
If yes, please explain: _____
Do you have a reason to believe your child may be nervous/afraid/upset? Yes No
If yes, please explain: _____
Does your child have any of the following habits? (please circle)

Thumb/finger sucking Pacifier Nail Biting Nursing

Bottle Feeding Tooth Grinding Mouth Breathing Snoring

Has your child ever had orthodontic treatment? Yes No
The source of home water (please circle) city water/well water/bottled water
Has your supply been tested for fluoride level? Yes No
If yes, please write concentration: _____ppm
Does your child receive a fluoride supplement? Yes No
If yes, please list name and dosage: _____
Does your child brush his/her teeth? Yes No
How many times a day? _____
Does a parent help with brushing? Yes No
with flossing? Yes No
Are there any other concerns that you would like to express?

_____
_____

With your permission, may we request release of your child's medical record if needed for our reference?
Yes No

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If there is any change in health, I will inform the doctor at the next appointment without fail.

Print Your Name: _____ Relationship to Child _____

_____ Date: _____
(Signature of parent of guardian)

Primary Dental Insurance Information

Name of Insured: _____ Birth Date _____ / _____ / _____
Last First MI

Relationship to patient: _____ ID # _____ Group # _____

Insurance Plan Name: _____ Phone: _____

Insurance Plan Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Consent for Services

We hope you understand that our credit and collection policies are a necessary part of assuring the service and resources needed to maintain the highest standards of our practice for you and your family.

I acknowledge that this office, as a courtesy, will file with my insurance company for its portion of the fees incurred the date of my visit and will credit any such collections to my account. However, I understand that all dental services furnished are charged directly to the patient and that I am personally responsible for payment of all dental services, including any balances not paid by my insurance carrier as my policy is a contract between me, my employer, and the insurance company. Notifying this office of any change in my insurance coverage is my responsibility.

My portion of fees for procedures performed is due upon completion (regardless of insurance coverage) unless prior financial arrangements have been made. Such arrangements must be in writing.

I understand and agree that I am responsible for any unpaid balance on my account and that a service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. This includes any dependents for whom I am responsible.

I have been advised that my account will be referred to a collection agency if the past due balance exceeds 90 days and any collection fees will be charged to my account. Notice of this referral constitutes notice of intent to discontinue treatment and will automatically release this office of any future professional services to me and my account is then terminated. The office has also informed me that there will be a $25.00 service charge on any returned check.

I understand that the fee estimate listed for any dental care can only be extended for a period of 90 days from the date of the patient examination.

I acknowledge that this office reserves the right to charge a $50.00 fee for broken or cancelled appointments with less than 48 hours notice.

I authorize this office to provide any insurance company, health care service plan, self-insurers, or their representatives, any and all information and records about my medical history, or about services rendered or treatment given to me that is needed to review, investigate or evaluate any claims for benefits.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____
Signature of Parent, or guardian

Print Name: _____ Relationship to Patient: _____

I have received a copy of the HIPPA Privacy Policy: _____ Date: _____
Signature of Parent, or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐ Another Family ☐ Dental Office ☐ Yellow Pages

☐ Newspaper ☐ School ☐ Work ☐ other _____

Name of person or office referring you to our practice: _____

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Payment Policy

Thank you for choosing the office of Dr. Laura B. Miner, as your dental health care provider. We are committed to the success of your dental treatment and want to provide you with the best service available. To help reduce our administrative costs and keep our fees to you as low as possible, we require payments to be made at or prior to the time that your child receives treatment. Please indicate below the method of payment that you intend to use.

My preferred payment option is:

_____ Cash

_____ Check

_____ Major Credit Card (Visa or MasterCard)

A note for patients with dental insurance:

Dental insurance usually does not cover the total cost of your treatment. Based on your plan, we usually can estimate the amount of your co-payment. When treatment is delivered to you, your co-payment WILL BE EXPECTED at that time. If your insurance company fails to pay within 60 days after we submit the claim, you will be responsible for the full fee. All accounts that reach 90 days past due will be sent to collections.

Acceptance Agreement

I understand and agree with the above financial policy. I agree that the parent or legal guardian bringing a child for dental treatment is responsible for all fees incurred at the visit. I further understand that I am responsible for ALL fees, regardless of insurance coverage.

Responsible Party: _____
Printed Name

X _____ _____
Signature Date

Circle One: Mastercard Visa

Account # _____

Expiration Date: _____ / _____

Code: _____ _____ _____

Cancellation, Reschedule and No Show Policy

We are committed to providing the highest level of care to each of our patients and families. Thank you for choosing Dr. Laura for your child(ren)'s care.

TLC reserves the right to charge a broken appointment fee for missed appointments. This policy is not meant to impose financial hardship for our families. This policy is meant to encourage families and patients to keep appointments that they have chosen to schedule or to give us at least ***48 Business Hours*** notice if they need to reschedule.

We define missing an appointment as:

- No call/no show, or
- Canceling or rescheduling with less than ***48 Business Hours*** notice

After a family misses two (2) appointments, we will send the patient a reminder letter regarding the cancellation policy. After the third missed appointment in a 24-month period, we reserve the right to discharge the patient from the practice.

Habitually rescheduling appointments creates much disruption and deprives other patients of appointment opportunities and negatively impacts the work hours of our staff.

Thank you. We look forward to providing your care.

Please let us know of any questions regarding this policy, or if you may have difficulty keeping your appointments.

Family's Name: _____

_____ _____

Signature Date

Received by: _____ Signed copy given to family: _____ Scanned: _____ Other: _____