

REGGIE H. BROOM, D.M.D., P.A.
PEDIATRIC DENTISTRY



Child's Name _____ Name Child Prefers _____ Male Female

Birthdate ____/____/____ Age _____ Hobbies _____

Attending what school _____ Grade _____

Home Address _____ City, State, Zip _____ Phone # _____

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

Names and ages of brothers and sisters _____

Father: Full Name _____ Birthdate ____/____/____ Social Security # _____

Employer _____ Address _____ Work Phone # _____

Father's Cell Phone # _____

Dental Insurance Co. Name _____ Phone # _____

Dental Insurance Co. Address _____ Group # _____

Mother: Full Name _____ Birthdate ____/____/____ Social Security # _____

Employer _____ Address _____ Work Phone # _____

Mother's Cell Phone # _____

Dental Insurance Co. Name _____ Phone # _____

Dental Insurance Co. Address _____ Group # _____

Primary Insurance coverage is provided by the child's: Father Mother

MEDICAL INFORMATION

- | | Yes | No | If yes, please explain in the space provided
Location (City) _____ |
|---|--------------------------|--------------------------|---|
| A. Child's primary physician _____ | | | |
| B. Is your child now under the care of a physician? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| C. Is your child taking any medications? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| D. Is your child allergic to any medications? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| E. Does your child have any other allergies? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| F. Has your child ever been treated in a hospital or ER? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| G. Does your child take any type of fluoride? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| H. Does your child now have or ever had any of the following: | | | |

- | | Yes | No |
|----------------------|--------------------------|--------------------------|
| ADD / ADHD | <input type="checkbox"/> | <input type="checkbox"/> |
| AIDS (HIV Infection) | <input type="checkbox"/> | <input type="checkbox"/> |
| Anemia | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> |
| Autism | <input type="checkbox"/> | <input type="checkbox"/> |
| Birth Defects | <input type="checkbox"/> | <input type="checkbox"/> |
| Bladder Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood Disorders | <input type="checkbox"/> | <input type="checkbox"/> |
| Brain Damage | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| Cerebral Palsy | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> |

- | | Yes | No |
|---------------------------|--------------------------|--------------------------|
| Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Murmur | <input type="checkbox"/> | <input type="checkbox"/> |
| Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Mental Retardation | <input type="checkbox"/> | <input type="checkbox"/> |
| Pregnancy | <input type="checkbox"/> | <input type="checkbox"/> |
| Respiratory Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> |
| Sickle Cell Disease/Trait | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> |
| Other _____ | | |

DENTAL INFORMATION

- Does your child have a history of the following after one year old? (If yes, please check)
 thumbsucking taking a bottle pacifier
- How has your child reacted to past medical/dental experiences? _____
- Does your child brush his teeth? Yes No How often? _____ Floss? Yes No How often? _____
- What concerns do you have about your child's teeth? _____
- Previous Dentist _____ Location (City) _____ Date of last visit _____
- Reason for last visit _____ Date of last cleaning _____

I certify that the above information is correct and it is my responsibility to inform this office of any change in my child's medical status.

Parent/Guardian _____ Relationship to Child _____ Date _____

Do you have legal custody of this child? Yes No

Reggie H. Broom, D.M.D., P.A.
Pediatric Dentistry
1635 East Pass Road, Gulfport, MS 39507
228-896-5197

FINANCIAL AGREEMENT

Thank you for choosing us to provide your child's dental care. We consider it an honor to have been chosen by you to do so. Our philosophy in serving people is to be informative, honest and forthright. Nowhere is that more important than in the area of finances. This **Financial Agreement** is indicative of our respect for your right to know ahead of time what our expectations are in the area of finances. If you have any questions or concerns about our **Financial Agreement** please do not hesitate to ask our business office staff.

PAYMENT POLICY AND OPTIONS: Payment for treatment is due at the time it is provided. We offer several options to you in order to make the treatment we deliver affordable and acceptable to your budget.

1. We accept cash, personal checks and debit cards.
2. We also accept Visa and MasterCard for your convenience.
3. If you require an extended payment plan we offer qualifying parents a variety of options from which to choose. Please ask our business office staff for details.

DENTAL INSURANCE: As a courtesy we will gladly file your claims and accept assignment of dental insurance benefits provided you agree to the following:

- You must provide us with an insurance card and all the information necessary to verify your child's coverage and file your claim.
- Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you and not your insurance company.
- You are responsible for our fees and not what your insurance company allows or considers "usual, customary and reasonable" all of which vary from one company to another.
- Although we may estimate your insurance benefits we are not responsible for their accuracy. Knowledge of benefits as well as benefit amounts, limitations, exclusions, waiting periods, etc. is entirely YOUR responsibility. Receiving our services indicates your acceptance of responsibility to pay regardless of our estimate.
- All charges not paid by your insurance company are your responsibility regardless of the reason for nonpayment. Not all the services we provide are covered benefits. Benefits differ from one company to another. Fees for noncovered services, along with deductibles and copayments are due at the time of treatment.

- If the insurance company does not pay in full within 30 days, it will be your responsibility to pay the balance due within two weeks.
- We do not file claims for medical insurance or more than one dental insurance company per patient.

FINANCE CHARGES AND COLLECTION FEES: Finance charges will be applied to all balances 60 days past the date of service regardless of the reason for the balance. It is your responsibility to ensure your insurance company pays promptly so you can avoid finance charges. A service fee of 33% will be added to the account if we have to utilize an attorney, collection agency or court (plus court costs) to collect balances owed. Returned check fees will be applied to returned checks.

We understand temporary financial problems may affect timely payment of your balance. In those situations we encourage you to communicate any such problems immediately so we may assist you in the management of your account.

BROKEN APPOINTMENTS: Appointments not kept or changed with less than 48 hours notice are considered broken. Broken appointments will be rescheduled during the morning hours and subject to additional fees. Broken appointments prevent others from receiving the dental care they deserve. We take them seriously so please be considerate and inform us in advance if you need to change your appointment.

RECORDS AND REIMBURSEMENTS: Original records including radiographs are the property of this office. If you desire we will provide you with a copy of your child's record or radiographs for a nominal duplication fee two business days after your request.

Reimbursements for overpayment are mailed by our accountant within two weeks of your request.

RESPONSIBLE PARTY IN DIVORCE: In cases of divorce the parent accompanying the child to our office and signing this financial policy is the parent financially obligated for payment. While your divorce proceedings may state your former spouse is responsible for dental fees, our office is not a party to nor affected by those proceedings. If your former spouse is to be responsible to you for dental fees we will provide you with a receipt of your payment so you may collect from him or her.

THANK YOU: Again, thank you for choosing us to provide quality dental care for your child. We appreciate your trust in us and value the opportunity to serve you. It is our desire to work with you and arrange a method of payment that is affordable and acceptable to your budget. We want to help your child receive the many benefits pediatric dentistry has to offer.

I have read this **Financial Agreement** and understand what is expected of me as a parent/guardian of a patient in this practice. I agree to abide by the stipulations herein.

SIGNATURE OF PARENT/GUARDIAN _____

CHILD'S NAME _____ DATE _____

RELATIONSHIP _____ WITNESS _____