365 Wekiva Springs Rd, Suite #121
Longwood, Florida 32779
Phone: (321) 295-7893
Fax: (321) 295-7896
eMail: office@longwoodpediatricdentist.com

Personal Info:

How did you hear about us? ____

Tell Us About Your Child! ○ ***Male*** ○ ***Female***

Child's Information Only

First Name ____________________ M.I. ___ Siblings Treated ___________________

Last Name _____________________________ Goes by ___________________

D.O.B __/___/____ Age____ Grade Level____ School ____________________________

S.S.N. ___ - __ - ____ Home Address __________________________________

Home Phone (___) ___ - _____ City ______________________________

eMail _____________________ State/Zip _________________ /_________

Mother's Information ○ ***Mother*** ○ ***Stepmother*** ○ ***Guardian***

First Name ____________________ M.I. ___ Employer _______________________

Last Name ____________________________ Work Phone (___) ___ - _____ ext. ___

D.O.B __/___/____ Home Phone (___) ___ - _____ Cell Phone (___) ___ - _____

S.S.N. ___ - __ - ____ Home Address __________________________________

Drive License # ____________________ City ______________________________

eMail _____________________ State/Zip _________________ /_________

Father's Information ○ ***Father*** ○ ***Stepfather*** ○ ***Guardian***

First Name _____________________ M.I. ___ Employer _______________________

Last Name _____________________________ Work Phone (___) ___ - _____ ext. ___

D.O.B __/___/____ Home Phone (___) ___ - _____ Cell Phone (___) ___ - _____

S.S.N. ___ - __ - ____ Home Address __________________________________

Drive License # ____________________ City ______________________________

eMail _____________________ State/Zip _________________ /_________

Who is Accompanying the Child Today? Name _______________________________________

Do you have legal custody of child? ○ ***Yes*** ○ ***No*** Relationship to child _________________

Preferred Method of Confirmation and Communications? ○ ***Call*** ○ ***Text*** ○ ***eMail***

Call (___) ___- _____ Text (___) ___- _____ eMail ____________________________

Medical History:

Dental History

Is this your child's first visit to the dentist? ○ ***yes*** ○ ***no*** last visit to the dentist ____/____/______

Previous Dentist ______________________________ Families General Dentist_________________________

Were X-Rays Taken? ○ ***no*** ○ ***yes*** by who?____

Have there been any injuries to the teeth, face, or mouth? ○ ***no*** ○ ***yes*** please explain ________

____

____

Why did you bring the child to the dentist today? ____

____

____

Has the child ever had a serious or difficult problem associated with previous dental work?

○ ***no*** ○ ***yes*** please explain ____

____

____

Does the child have any of the following?

Lip Sucking / Biting? ○ ***yes*** ○ ***no*** Nail Biting? ○ ***yes*** ○ ***no***

Nursing / Bottle Habits? ○ ***yes*** ○ ***no*** Thumb / Finger Sucking? ○ ***yes*** ○ ***no***

Is the child's water fluoridated? ○ ***yes*** ○ ***no***

Does the child take fluoride supplements? ○ ***yes*** ○ ***no***

Has the child ever had any pain or tenderness in their jaw / joint (TMJ/TMD)? ○ ***yes*** ○ ***no***

Does the child brush his / her teeth daily? ○ ***yes*** ○ ***no***

Does the child floss his / her teeth daily? ○ ***yes*** ○ ***no***

Health History

Is the child currently under the care of a physician? ○ ***yes*** ○ ***no***

Child's Physician ____ Phone (___) ____ - ______

Please describe the child's current physical health? ○ ***Good*** ○ ***Fair*** ○ ***Poor***

Does the child have any of the following?

Abnormal bleeding? ○ ***yes*** ○ ***no*** Disabilities / Special Needs? ○ ***yes*** ○ ***no***

Allergies to any Drugs?	○ ***yes*** ○ ***no***	Hearing Impairment?	○ ***yes*** ○ ***no***
Any Hospital Stays?	○ ***yes*** ○ ***no***	Heart Disease / Murmur?	○ ***yes*** ○ ***no***
Any Operations?	○ ***yes*** ○ ***no***	Hemophilia / Blood Disorders?	○ ***yes*** ○ ***no***
Asthma?	○ ***yes*** ○ ***no***	Hepatitis?	○ ***yes*** ○ ***no***
Cancer?	○ ***yes*** ○ ***no***	H.I.V. + / A.I.D.S.?	○ ***yes*** ○ ***no***
Congenital Birth Defects?	○ ***yes*** ○ ***no***	Kidney / Liver Conditions?	○ ***yes*** ○ ***no***
Convulsions / Epilepsy?	○ ***yes*** ○ ***no***	Rheumatic / Scarlet Fever?	○ ***yes*** ○ ***no***
Pregnancy?	○ ***yes*** ○ ***no***	Allergies to Latex Products?	○ ***yes*** ○ ***no***
Tuberculosis?	○ ***yes*** ○ ***no***	Diabetes?	○ ***yes*** ○ ***no***
A.D.D. / A.D.H.D?	○ ***yes*** ○ ***no***	Autism?	○ ***yes*** ○ ***no***

Please discuss any serious medical conditions the child has had? ______________________________

____

____

Please **list all drugs and supplements** the child is currently taking? _________________________

____

Please list all allergies? ____

____

Our Office is committed to meeting or exceeding the standards and mandated put forth by O.S.H.A., C.D.C., H.I.P.A.A., and the A.D.A.

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.

I authorize Children's Dentistry of Longwood and their staff to perform the necessary dental services my child may need.

Signature Parent / Guardian ____ Date___/___/_____

Relationship to Patient ○ ***Mother*** ○ ***Father*** ○ ***Stepparent*** ○ ***Guardian*** ○ ***Other*** __________

Office Use Only:

I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein. Initials _________ Date___/___/_____ Time ___:_____ ○ ***am*** ○ ***pm***

Doctors Comments? ____

____

____

Insurance Info:

Primary Dental Insurance

Insurance Company Name ______________________________ Phone (___) ___ - _____

Group (Plan,Local,Policy) Number ____

Policy Owner's Name ____

Relationship to Patient ◯ ***Mother*** ◯ ***Father*** ◯ ***Stepparent*** ◯ ***Guardian*** ◯ ***Other*** ________

Policy Owner's D.O.B ___/___/_____ Ins. Co. Address ________________________________

Policy Owner's S.S.N. ___ - __ - ____ City __________________________________

Policy Owner's Employer ____________________ State/Zip _________________ /_______

Secondary Dental Insurance

Insurance Company Name ______________________________ Phone (___) ___ - _____

Group (Plan,Local,Policy) Number ____

Policy Owner's Name ____

Relationship to Patient ◯ ***Mother*** ◯ ***Father*** ◯ ***Stepparent*** ◯ ***Guardian*** ◯ ***Other*** ________

Policy Owner's D.O.B ___/___/_____ Ins. Co. Address ________________________________

Policy Owner's S.S.N. ___ - __ - ____ City __________________________________

Policy Owner's Employer ____________________ State/Zip _________________ /_______

Third Dental Insurance

Insurance Company Name ______________________________ Phone (___) ___ - _____

Group (Plan,Local,Policy) Number ____

Policy Owner's Name ____

Relationship to Patient ◯ ***Mother*** ◯ ***Father*** ◯ ***Stepparent*** ◯ ***Guardian*** ◯ ***Other*** ________

Policy Owner's D.O.B ___/___/_____ Ins. Co. Address ________________________________

Policy Owner's S.S.N. ___ - __ - ____ City __________________________________

Policy Owner's Employer ____________________ State/Zip _________________ /_______

Financial Info:

Person Responsible for Account ○ ***Mother*** ○ ***Father*** ○ ***Stepparent*** ○ ***Guardian*** ○ ***Other***

First Name ________________________ M.I. ____ Relationship ________________________

Last Name _________________________________ Work Phone (___) ____ - ______ ext. ____

D.O.B __/___/_____ Home Phone (___) ____ - ______ Cell Phone (___) ____ - ______

S.S.N. ____ - __ - _____ Billing Address _______________________________________

Drive License # _______________________ City _________________________________

eMail ________________________ State/Zip ____________________ /__________

BILLING, FINANCIAL, & OFFICE POLICES

Dr. David Donald, D.D.S.

TREATMENT: The type of treatment you receive from Children's Dentistry of Longwood, PSC is based upon our professional dental judgement, and NOT on whether the procedure is covered by your Dental Insurance Benefit Plan.

DENTAL INSURANCE: Our office is happy to file claims with your dental insurance carrier. However, since **the terms of your coverage is a contract between YOU & YOUR INSURANCE CARIER**, questions, problems, or disputes about your insurance coverage need to be addressed directly to your insurance company. We submit insurance as a curtesy for you and your family. For all non-dental insurance claims, patients must pay in full upfront and will be reimbursed by their non-dental insurance if it applies. Ultimately, the fee and payment is the patient responsibility. It is the patient's responsibility to confirm with your dental insurance company that David E. Donald, D.D.S. is an "in-network" or "out-of-network" provider prior to being seen. In most cases we would be consider an out of network provider or in some cases a PPO provider. The patient is responsible for all charges not covered by their insurance policy.

It is YOUR (the patient's) responsibility to know what your insurance coverage and limitations regardless if your insurance coverage is "In or Out of network", which includes examinations, x-rays, and treatment of any kind. Payment of your copay, deductibles, estimated amount not covered by your dental insurance is due at the time services are rendered. Any amount not covered by your insurance or denial of coverage for any reason by your insurance coverage, or patient refusal to return to this office within 30 days to complete a procedure previously started, such as (but not limited to) laboratory procedures, becomes the patient's responsibility and payment is due immediately with no grace period. Children's Dentistry of Longwood reserves the right to ask for and expect payment in full with no grace period at any time, even prior to submitting dental claims to the patient's dental insurance.

Disputes With your Insurance Company: If you have a dispute with your insurance company (Dental or other) over coverage, that dispute must be resolved between you and your insurance company. The amount owed to David E. Donald D.D.S. during the duration of your dispute is your responsibility and payment is due immediately in full, with no grace period.

Dental Pre-Authorizations: Dental Pre-Authorizations for treatment are submitted in writing ***upon patient request***. Pre-authorizations must be sent with up-to-date diagnostic x-rays, along with all necessary insurance, personal, dental and/or medical information. This can take up to 90 days if not 120 days. This is time from is from your insurance company. If you don't wait for your pre-authorization response before beginning treatment, you are still responsible for any amount not covered by your insurance for any examinations, x-rays and/or treatment. We recommend that you get your pre-authorization response back prior to starting treatment if you are needing to know the exact dollar amount of how much your potion will be.

Laboratory Cases: The day any laboratory procedure (such as but not limited to Space Maintainers) is started, your estimated portion is due in full the day of the first appointment or impression. If insurance denies or covers less than the estimated portion you will be billed for the remaining costs and payment is due immediately with no grace period.

Change of Personal Information: It is your responsibility to notify us, in writing, of any changes in your address, phone number, employment information, school status, insurance coverage and etc. so that you may maximize your insurance benefit. Monthly statements are mailed out as a courtesy when there is any remaining portion after insurance has paid, otherwise all balances are due day of treatment.

Family Balance: ***All balances must be paid in full in order to proceed with future treatment***. Guarantors (the patient or guardians) are responsible for any and all (but not limited to) collection agency recovery fees, attorney fees and/or legal fees, court costs, interest on delinquent accounts, as well as the time the doctor and/or staff spends working on (but not limited to) filing paperwork, appear for court, mediation/proceedings/and/or legal meetings and/or frivolous legal charges. There is a $45.00 charge on all returned checks (per check). At 120 days past due your account may be turned over to our collection agency, court and/or attorney. All of the above stated responsibilities of the patient are due immediately without a grace period. If David E. Donald, D.D.S. is notified as being included in any bankruptcy files, the patient and/or immediate family members will be dismissed as patients of David E. Donald, D.D.S. for failure to meet patient financial obligations to David E. Donald, D.D.S.

Financing: David E. Donald, D.D.S. does not offer in house financing, Care Credit or payment plans. All fees are due at time of service unless expecting insurance to cover. Once all insurance payments or denials have been processed, the balance is due at that time.

Nitrous Oxide/Oxygen: Nitrous Oxide is usually not covered by insurance. It is the guarantor's responsibility to pay for nitrous regardless if Nitrous Oxide is deemed necessary by the doctor or if requested by the patient to ease anxiety during dental procedures.

Copies of Dental Records: Florida State Law mandates that the patient or designated representative is entitled to 1 (one) coy of his/her dental Record's at no charge. If more than one is needed a fee may apply.

By my signature blow, I certify that I have read, understand, accept and agree with as well as agree to adhere to all of the above mentioned polices and understand all of my responsibilities set forth as stated above.

Patient Name: ____

Parent/Guardian: ____ Date: __/___/________

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Section A: The Patient

First Name ______________________ M.I. ____ Phone (___) ___ - ______

Last Name ________________________________ eMail ________________________

S.S.N. ___ - __ - _____ Address _______________________________________

D.O.B __/___/_____ City _________________________________

Patient Number______________ State/Zip ___________________ /__________

Section B: Acknowledgement of Receipt of Privacy Practices Notice

I, ____, acknowledge that I have received a Notice of Privacy Practices from Children's Dentistry of Longwood.

Relationship to Patient ○ *Mother* ○ *Father* ○ *Stepparent* ○ *Guardian* ○ *Other* _____________

Signature ____ Date __/___/_____

If a personal representative signs this authorization on behalf of the individual, complete the following.

Representative's Name ____

Section C: Good Faith Effort to Obtain Acknowledgement of Receipt

Describe your good faith effort to obtain the individual's signature on this form? _____________

____

____

Describe the reason why the individual would not sign this form? ___________________________

____

____

Signature:

I attest that the above information is correct.

Signature ____ Date __/___/_____

Print Name ____ Title ____________

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE