Healthy Smiles Start Here

J.Khoury DMD **(760)-635-5995**

THE BRUSH STOP
Pediatric Dentistry & Orthodontics

Please complete one medical history per child & email to: info@thebrushstopdental.com

Child's Name_____ Nickname _____

Sex: ☐ M ☐ F Birth Date_____ Age_____ Reason for this visit? _____

Is this your child's first dental visit?_____ Date of last visit_____ Previous Dentist _____

Your child's attitude toward previous dental care? _____

Names of siblings: Name_____ Age_____ Name_____ Age _____

Name_____ Age_____ Name_____ Age _____

Is your child adopted?_____ Who has legal guardianship of your child? _____

How did you hear about our office? _____

MEDICAL INFORMATION

Dr.'s Name_____ Address_____ Phone _____

Is your child taking any medication?_____ What kind? _____

Reason_____

Has your child ever been hospitalized? When?_____ Reason _____

Has your child had a difficulty with any of the following:

☐ Seasonal Allergies	☐ Asthma/Breathing Problems	☐ Arthritis
☐ Autism	☐ Anemia/Bleeding	☐ Bones
☐ Cancer/Tumors	☐ Cerebral Palsy	☐ Cleft Lip/Palate
☐ Developmental	☐ Diabetes	☐ Eyes, Ears, Nose, Throat
☐ Hearing	☐ Heart	☐ Kidney/Liver
☐ Hepatitis	☐ Immune Deficiency	☐ Liver
☐ General Anesthesia/Surgery	☐ Seizures/Epilepsy/Convulsions	☐ Stomach/Intestinal
☐ Syndromes	☐ Other _____	

Please specify from above _____

Does your child have any emotional or school problems? _____

Allergies to Food or Medications _____

DENTAL INFORMATION

Was your child bottle fed?_____ Until what age?_____ Or breast fed?_____ Until what age? _____

Does your child have any mouth habits, such as: finger/thumb sucking_____ pacifier_____ other _____

Has your child ever had any injuries to his teeth, mouth or head?_____ When? _____

Details _____

Does your child brush regularly?_____ Does an adult assist with brushing? _____

Does your child floss?_____ Does an adult assist in flossing? _____

Has either parent or child been treated orthodontically?_____ Name of Orthodontist? _____

How would you expect your child to behave in our office? _____

Describe your child: ☐Outgoing ☐Shy ☐Stubborn ☐Anxious ☐Frightened ☐Age Appropriate

How may we help to make this visit a positive experience for your child? _____

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RESPONSIBLE PARTY

First Name_____ Last Name_____ Middle Initial _____

Address_____ City, State, Zip _____

Home Phone_____ Work Phone_____ Cell _____

Birth Date_____ Soc Sec_____ Employer _____

Email_____ (we do most our communications via email and NEVER spam.)

Who can we thank for referring you to our practice?

MOTHER'S INFORMATION (if different from responsible party)

Name_____ Employer_____ Occupation _____

Address_____ Cell #_____ Date of birth _____

PRIMARY DENTAL INSURANCE

Policy Holder Name_____

Social Security #_____

Ins. Company Name_____

Policy/Group Number_____

Ins. Address_____

Ins. Phone_____

SECONDARY DENTAL INSURANCE (if any)

Policy Holder Name _____

Social Security # _____

Ins. Company Name _____

Policy/Group Number _____

Ins. Address _____

Ins. Phone _____

I certify that the above information is true to the best of my knowledge.

_____ _____ _____

SIGNATURE **RELATIONSHIP TO CHILD** **DATE**

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FINANCIAL POLICY

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the most comprehensive dental care using only the highest quality materials and technology available in the market today. All charges you incur for any treatment that is provided are **your responsibility regardless of your insurance coverage**. We will always recommend treatment based upon your child's dental needs, not based on insurance coverage,.

Payment is due at time of service. We accept all major credit cards, personal checks, or care credit. You may also use your flexible spending account through your employer, as long as they have provided you with a debit card.

If you have dental insurance, we will be happy to file your dental insurance claim as a courtesy to you. However, your estimated portion is just that**, an ESTIMATE**. You should be aware that your insurance company **does not guarantee payment** over the telephone. We will not know the exact amount they pay until they respond to the claim that we file. **Regardless of what your insurance company decides to pay, you remain responsible for payment of your bill in full.** Once we receive payment on your claim, we will send you a bill for any balance remaining on your account. If there is any remaining balance after we receive payment from your insurance company, that balance will be due within 15 days of notification. Any unpaid balance after 30 days will be subject to an interest charge of 1.8% monthly (21.6% annually). Failure to pay your account balance will result in your account being turned over to a collection agency. At such time, additional processing fees may be added and this action will adversely affect your credit rating.

APPOINTMENT POLICY

We value your time and always try to serve you in a timely manner. We request that you extend the same courtesy to us. Should you need to change a scheduled appointment, we require being informed at least 48 hours in advance. Failure to notify our office within 48 hours may result in a fee of $50.00 to your account. This fee must be paid before any subsequent appointments will be scheduled. A broken appointment is considered a "no show", or canceling an appointment the same day. Emergencies will be taken into consideration. If you are over 15 minutes late for your scheduled appointment it may be necessary to change your appointment. We reserve the right to stop seeing patients who are habitually late or miss appointments.

PATIENT SAFETY & PRIVACY

For your comfort, one adult is welcome, but not required to accompany your child to the operatory. We do encourage independence to help promote growth and development of your child. All others, including children not scheduled at this appointment, are asked to remain in the reception area to maintain the safety and privacy of other patients. Young children in the reception area will need adult supervision. Please refrain from bringing strollers into treatment areas should they block common pathways. The use of cell phones is strictly prohibited in the operatory. The extra conversation by others in the clinical area can be distracting to other children and may prevent us from providing close attention to each young patient. We thank you for your understanding and consideration in these matters.

The signature below signifies that I have read and reviewed the Office Policies.

X_____ _____

Signed (patient, parent or legal guardian if minor) **Date**

INSURANCE AUTHORIZATION SIGNATURE ON FILE

The following authorizations are included on all dental claims. Because we submit the claims for you, a 'Signature on File' must be kept in your record.

The signature below hereby authorizes and directs payment of the dental benefits otherwise payable to me, directly to Jenna Khoury DMD or Jenna Khoury DMD Inc.

X_____ _____

Signed (patient, parent or legal guardian if minor) **Date**

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