Dear Patient,

On behalf of the whole Cape Cod Pediatric Dentistry team, we welcome you to our practice!

We know how important the health of your child is and we are grateful that you have entrusted us with their care. Our mission statements below reflect a continued commitment to our patients.

- **Deliver the best dentistry possible**
- **Never compromise patient care**
- **Create a positive dental experience**
- **Present our patients with all of their treatment options**
- **Don't assume what our patients want**
- **Do dentistry with our patients**

In summary, we strive to foster patient relationships based on mutual trust, excellent customer service, and the best patient care available.

- Patients of record with a dental emergency after hours can call and speak with one of our on call dentists.

- With regards to broken appointments please be advised that we ask for at least 48 hours notice of your need to change your appointment. Should we not hear from you at least 48 hours prior to appointment, there will be a $50 charge.

- As a ***courtesy*** to our patients, we will submit for services rendered, to dental insurance companies on ***your*** behalf. Your dental insurance status is typically updated on the day of your visit. Co-payments are calculated and collected at time of service unless alternative arrangements have been made. Our patients are responsible for informing the office of changes to their dental insurance coverage. Ultimately our patients are responsible for services not covered by their dental insurance.

- Payment is expected at time of services rendered. Acceptable methods of payment include cash, check, or credit card. Third party financing including interest free options are available.

- Return of bounced checks are subject to $75 fee.

- During the winter months in the event of snow, please be assured that we will make every attempt to call you, should the office need to close.

- For more information visit us at www.capecodpediatricdentistry.com.

Guardian Signature______________________________________ Date______________

Practice Administrator __________________________________ Date______________

PATIENT INFORMATION

Patient Name:____ Date:____________
Name child would like to be called:____________ Birthdate:___________ Age:_____ Sex:___
Address:_______________________________ City:___________________ Zip:_________
Home Phone:______________ Cell Phone:_______________ Email:___________________
School:____ Grade:_______________
Names and ages of other children in the family:_________________________________
Siblings we treat:____
Mother:_______________________________ Mother's Employer:_____________________
Social Security #:______________________ Work Phone:___________________________
Birthdate:_______________________ Email:_____________________________________
Father:_______________________________ Father's Employer:______________________
Social Security #:______________________ Work Phone:___________________________
Birthdate:_______________________ Email:_____________________________________
Who has legal custody of the patient?____
Person Responsible for payment of the account?____________________________________
Whom may we thank for referring you to us?____
What is the reason for your child't dental visit?___________________________________

INSURANCE INFORMATION

Does your child have dental insurance?__________
Insurance Company:_________________________ Employer:_______________________
Name of Insured:___________________________ Relationship to Insured:_______________
Insured Social Secuirty #:_____________________ Insured Birthdate:___________________
Insured Policy #:___________________________ Insured Group Number:________________

HEALTH HISTORY

☐ Yes ☐ No Is your child in good health?

Name of child's physician:____

Date of last physical exam:____

Child's weight:______________________ height:______________________

☐ Yes ☐ No Has your child ever had a health problem?________________________________

☐ Yes ☐ No Are your child's immunizations up-to-date?_______________________________

☐ Yes ☐ No Is your child taking any medications, vitamins, or dietary supplements?____

☐ Yes ☐ No Were there any problems at birth?______________________________________

☐ Yes ☐ No Is your child allergic to anything?_____________________________________

☐ Yes ☐ No Has your child ever had surgery?______________________________________

☐ Yes ☐ No Did your child have a reaction or problem with anesthesia?

☐ Yes ☐ No Is there a family history of a reaction or problem with anesthesia?

☐ Yes ☐ No Has your child ever been hospitalized?___________________________________

☐ Yes ☐ No Are there any psychological or emotional problems you would like to bring to our attention?-

____

Does your child have any of the following?

☐ Complications before or during birth, prematurity, birth defects, syndromes, or inherited conditions

☐ Problems with physical growth or development

☐ Sinusitis, chronic adenoid/tonsil infections

☐ Sleep apnea/snoring, mouth breathing, or excessive gagging

☐ Congenital heart defect/disease, heart murmur, rheumatic fever, or rheumatic heart disease

☐ Irregular heart bear or high blood pressure

☐ Asthma, reactive airway disease, wheezing, or breathing problems

☐ Cystic fibrosis

☐ Frequent colds or coughs or pneumonia

☐ Frequent exposure to tobacco smoke

☐ Jaundice, hepatitis, or liver problems

☐ Gastroesophageal/acid reflux disease (GERD), stomach ulcer, or intestinal problems

☐ Lactose intolerance, food allergies, nutritional deficiencies, or dietary restrictions

☐ Prolonged diarrhea, unintentional weight loss, concerns with weight, or eating disorder

☐ Bladder or kidney problems

☐ Arthritis, scoliosis, limited use of arms or legs, or muscle/bone/joint problems

☐ Rash, hives, eczema or skin problems

☐ Impaired vision, hearing or speech

☐ Developmental disorders, learning problems/delays, or intellectual disability

☐ Cerebral palsy, brain injury, epilepsy, or convulsions/seizures

☐ Autism/Autism spectrum disorder

☐ Recurrent or frequent headaches/migraines, fainting, or dizziness

☐ Hydrocephaly or placement of a shunt (ventriculoperitoneal, ventriculoatrial, ventriculovenous)

☐ Attention deficit/hyperactivity disorder (ADD/ADHD)

☐ Behavioral, emotional, communication, or psychiatric problems/treatment

☐ Abuse (physical, psychological, emotional, or sexual) or neglect

☐ Diabetes, hyperglycemia, or hypoglycemia

☐ Precocious puberty or hormonal problems

☐ Thyroid or pituitary problems

☐ Anemia, sickle cell disease/trait, or blood disorder

☐ Hemophilia, bruising easily, or excessive bleeding

☐ Transfusions or receiving blood products

☐ Cancer, tumor, other malignancy, chemotherapy, radiation therapy, or bone marrow or organ transplant

☐ Mononucleosis, tuberculosis (TB), scarlet fever, cytomegalovirus (CMV), methicillin resistant staphylococcus aureus (MRSA), sexually transmitted disease (STD), or human immunodeficiency virus (HIV)/AIDS

IF YES FOR ANY OF THE ABOVE PLEASE PROVIDE DETAILS HERE:____

____

☐ NONE OF THE ABOVE

DENTAL HISTORY

What is your primary concern about your child's oral health?________________________________

☐ Yes ☐ No Has your child ever been examined or treated by another dentist?

If YES: Date of first visit:________ Date of last visit:_________ Reason:_______________

Were x-rays taken of the teeth or jaws? ☐ Yes ☐ No Date of x-rays:______________

Has your child ever had a difficult dental appointment? ☐ Yes ☐ No

If YES, describe:____

☐ Yes ☐ No Has your child ever had orthodontic treatment (braces, spacers, or other appliances)?

How do you expect your child will respond to dental treatment?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

☐ Yes ☐ No Is there anything we should know before treating your child?

If YES, describe:____

☐ Yes ☐ No Does your child participate in any sports or similar activities?

☐ Yes ☐ No Does your child wear a mouthguard during these activities?

Does your child have any of the following?

☐ Inherited dental characteristics

☐ Mouth sores or fever blisters

☐ Bad breath

☐ Bleeding gums

☐ Cavities/decayed teeth

☐ Toothache

☐ Injury to teeth, mouth or jaws

☐ Clenching/grinding teeth

☐ Jaw joint problems (clicking, popping, etc)

☐ Excessive gagging

☐ Sucking habit after one year of age

If yes, which: ☐ Finger ☐ Thumb ☐ Pacifier ☐ Other___________________________

For how long?____

ORAL HYGIENE AND FLUORIDE

How would you describe:

Your child's oral health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Your oral health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

The oral health of your other children? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

☐ Yes ☐ No Is there a family history of cavities?

Check all that apply: ☐ Mother ☐ Father ☐ Sister ☐ Brother

How often does your child brush his/her teeth?________times per_____________

☐ Yes ☐ No Does someone help your child brush?

How often does your child floss his/her teeth?________times per_____________

☐ Yes ☐ No Does someone help your child floss?

What type of toothbrush does your child use?____

What type of toothpaste does your child use?____

What is the source of your drinking water at home?

☐ City/community supply ☐ Private well ☐ Bottled water

Please check all sources of fluoride your child receives:

☐ Drinking water ☐ Toothpaste ☐ Over-the-counter rinse
☐ Prescription rinse/gel ☐ Prescription drops/tablets/vitamins ☐ Fluoride treatment in the dental office ☐ Fluoride varnish by pediatrician/other practitioner

DIET

☐ Yes ☐ No Does your child regularly eat three meals each day?
☐ Yes ☐ No Is your child on a special or restricted diet?
☐ Yes ☐ No Is your child a 'picky' eater?
☐ Yes ☐ No Does your child have a diet high in sugar or starches?
☐ Yes ☐ No Do you have concerns regarding your child's weight?

How frequently does your child have the following?

Candy or other sweets ☐ Rarely ☐ 1-2 times/day ☐ 3 or more times/day
Product_______________________________________
Chewing gum ☐ Rarely ☐ 1-2 times/day ☐ 3 or more times/day
Type_______________________________________
Snacks between meals ☐ Rarely ☐ 1-2 times/day ☐ 3 or more times/day
Usual snacks_______________________________________
Soft drinks* ☐ Rarely ☐ 1-2 times/day ☐ 3 or more times/day
Product_______________________________________
(*this includes juice, fruit-flavored drinks, sodas, colas, carbonated beverages, sports drinks, or energy drinks)

Please note other significant dietary habits:____

SUPPLEMENTAL QUESTIONS IF YOUR CHILD IS AN INFANT/TODDLER

☐ Yes ☐ No Was your child born prematurely?
If YES, what week?_________________

What was your child's birth weight?__________________

How long was your child breast-fed?
☐ N/A ☐ Less than 6 months ☐ 6-11 months ☐ 12-17 months ☐ 18-23 months ☐ 2 years or more

How long was your child bottle-fed?
☐ N/A ☐ Less than 6 months ☐ 6-11 months ☐ 12-17 months ☐ 18-23 months ☐ 2 years or more

☐ Yes ☐ No Did/do you feed your child infant formula?
☐ Yes ☐ No Does/did your child sleep with a bottle?
☐ Yes ☐ No Does/did your child use a no-spill training cup (sippy cup)?

Child's age (in months) when first tooth appeared in mouth____________________

☐ Yes ☐ No Has your child experienced any teething problems?

When did you bring brushing your child's teeth?
☐ N/A ☐ Less than 6 months ☐ 6-11 months ☐ 12-17 months ☐ 18-23 months ☐ 2 years or more

When did you begin using toothpaste?
☐ N/A ☐ Less than 6 months ☐ 6-11 months ☐ 12-17 months ☐ 18-23 months ☐ 2 years or more

Signature of parent/guardian:_____________________________ Relationship to child:_______

Signature of staff member reviewing history:_________________________ Date:__________

FINANCIAL AND APPOINTMENT POLICY

Thank you for choosing Cape Cod Pediatric Dentistry for your child's dental home! We are committed to their successful treatment and prevention! Please understand that payment of your bill is considered a part of your child's treatment.

Please be aware that the parent bringing the child to Cape Cod Pediatric Dentistry is legally responsible for payment of all charges. We cannot send statements to other persons.

Co-Payments and Deductibles are to be paid at each appointment as services are rendered. For your convenience we accept cash, personal checks, Visa, and MasterCard. Please know our office does not accept post-dated checks. There will be a **$75 fee** for any returned checks.

Dental Insurance – We strongly urge you to thoroughly review your insurance plan guidelines/booklet prior to the appointment. There is NO direct relationship between our office and your insurance company. The type of plan chosen by you, and/or your employer determines your insurance benefits. As such, we have no say in the selection of your insurance company, no control over the terms in the contract, the methods of reimbursement or the determination of your insurance benefits. As a courtesy to our patients if we have received all of your insurance information on the day of the appointment, we will electronically file your dental insurance claims and bill your dental insurance company for treatment you receive when this is possible. However, in the event the insurance company, for any reason does not pay the estimated portion of the bill, the balance will become the patient's responsibility and will be billed directly to you. Balances unpaid by your insurance company will be billed to you and must be paid within **thirty (30) days**.

Emergency Treatment – All emergency treatment must be paid in full at the time the service is rendered. There is an additional fee not covered by insurance for after hours and/or holiday treatments that is also due at the time of service.

Hospital Appointments – A **five-hundred ($500) dollar deposit** is required to book an appointment for your child at one of the hospitals Dr. Fugate has privileges at. This deposit will be put towards the patient financial responsibility of the surgery booked. You must give **two (2) weeks notice** to change the date of your surgery, as it is an extensive process to book your child. If you do not give two (2) weeks notice and/or you do not present for your appointed surgery your deposit will be forfeited to the practice and Cape Cod Pediatric Dentistry reserves the right to dismiss the patient from the practice. We thank you in advance for understanding this policy.

Appointments – If your child is under the age of 9 years old we ask that you schedule a morning appointment. Younger children do better when they are well rested. We pride ourselves in providing extra time for the personal attention each patient deserves. We respect your time and make every effort to keep you from waiting. We require you to provide us with at least 48 hours notice if you need to reschedule your appointment. If this notice is not given a fee will be incurred and if it happens twice (2 times) Cape Cod Pediatric Dentistry will assist you in finding a dental home that accommodates your schedule better. If no notice is given, the patient is considered a "no show" and Cape Cod Pediatric Dentistry reserves the right to dismiss the patient.

We strive to provide our patients with the best possible care. Therefore, late arrivals cause schedule delays for patients who arrive promptly to their appointment. Late arrivals will be worked into the schedule if time allows or re-appointed to another day. With more than two (2) late arrivals Cape Cod Pediatric Dentistry will assist you in finding a dental home that has hours that accommodates your schedule better. During the school months, late afternoon appointments are in high demand. We try to honor after school requests and ask that you help us by understanding when we need to appoint during school hours. We will gladly provide you with a school excuse for your child.

We understand that under unusual circumstances an account balance may be incurred. Cape Cod Pediatric Dentistry requires that all outstanding balances be paid in full within **thirty (30) days** unless other arrangements have been made. Also note, if we have not received payment or you have not contacted us in thirty (30) days, further action may be taken with a collection agency or with Small Claims Court. You will be responsible for any fees incurred including court costs and attorney fees. We reserve the right to apply an interest rate of twenty five (25%) percent from the date of service. Thank you in advance for your understanding of our financial policy.

I have read Cape Cod Pediatric Dentistry's Financial and Appointment Policy and agree to abide by its contents.

Parent/Guardian: ____ Date: _________________