NEW PATIENT FORMS

NEW PATIENT INFORMATION:

Child's Name: _____ Nickname: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

SSN: _____ Sex: Male _____ Female ____

Child's Physician: _____ Phone: _____

Physician's Address: _____ City: _____ State:_____ Zip:_____

PARENT/GUARDIAN INFORMATION:

1. Parent/Legal Guardian: _____ Relationship to Patient: _____

Employer: _____ Work Phone: _____ Home Phone: _____

Cell Phone: _____ Date of Birth: _____ SSN: _____

Email: _____

2. Parent/Legal Guardian: _____ Relationship to Patient: _____

Employer: _____ Work Phone: _____ Home Phone: _____

Cell Phone: _____ Date of Birth: _____ SSN: _____

Email: _____

3. With whom does the child reside? _____

4. How would you like to receive appointment reminders? Phone__ Email__ Both___

INSURANCE INFORMATION: (*Primary Insurance Coverage)*

Subscriber: _____ Date of Birth: _____ SSN: _____

Carrier: _____ Subscriber#: _____ Group#: _____

Provider Benefits and Claims Department Phone: _____

Address: _____ City: _____ State:_____ Zip:_____

EMERGENCY CONTACT INFORMATION:

Name: _____ Relationship to Patient: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

REFERRAL SOURCE: _____ Phone: _____

CHILD'S DENTAL HISTORY:

- Please tell us the reason for your child's dental visit: _____
- Has your child ever visited a dentist before? …….. YES_____ NO_____
- Name of previous dentist: _____ Phone: _____

Date of last cleaning? _____ Were x-rays taken? YES_____ NO_____

- Has your child experienced any unfavorable reaction from previous dental care? YES_____ NO_____
  If yes, please explain: _____
- Has your child ever had an adverse reaction to local anesthetic, nitrous oxide sedation, oral sedation or general anesthesia? _____
- Does your child have an oral habit? *(Please check)*: THUMB___ FINGER___ PACIFIER___ OTHER _____
- Do you have concerns about how your child's teeth fit together *(crooked/crowded)*? YES_____ NO _____
- Does your child go to bed with a bottle or sippy cup? ..... YES_____ NO _____
- Does your child snack frequently? ..... YES_____ NO_____
- Is your home water supply fluoridated? ..... UKNOWN____ YES _____ NO_____
- Do you still help your child brush and floss? ..... YES_____ NO_____
- Is your child experiencing dental pain/infections? ..... YES_____ NO_____
- Has your child experienced dental trauma? YES___ NO___ Please explain: _____
- Is there anything we should know about your child that would make his/her experience more enjoyable?

CHILD'S MEDICAL HISTORY:

- Is your child in good health? YES___ NO___ Date of last exam: _____
- Has your child ever been hospitalized? YES___ NO___ Please explain: _____
- Does your child have any allergies? YES___ NO___ Type: _____
- Is your child currently taking any medications? YES___ NO___
  If so, please list medication/dose/reason: _____
- Are your child's immunizations current? YES___ NO___
- Has your child been told to take antibiotics before dental treatment? YES___ NO___
- Were there any complications at your child's birth? YES___ NO___
  If so, please explain: _____
- Do you consider your child to be *(please check one)*?
  __ Advanced in the learning process __ Progressing normally __ Slow in the learning process

PLEASE CHECK if your child has been treated for any of the following:

_ Heart Disease	_ Heart Murmur	_ Bleeding/Transfusions
_ Anemia	_ Blood Problems	_ Tonsil/Adenoid Problems
_ Liver/GI Disease	_ Sickle Cell Disease/Trait	_ Diabetes
_ Kidney Disease	_ Rheumatic fever	_ Hepatitis
_ Speech/Hearing	_ Seizures	_ Cleft Lip/Palate
_ Eyesight	_ Congenital Birth Defects	_ Mental Health
_ Recurrent Headaches	_ Hormone/Growth Problems	_ Adverse Drug Reactions
_ Significant Injuries	_ Frequent Ear Infections	_ Autism
_ ADHD/ADD	_ Spina Bifida	_ Asthma/Breathing
_ Tuberculosis	_ HIV/AIDS	_ Mental Delays
_ Physical Delays	_ Cancer/Tumors	_ Cerebral Palsy

Other: _____

Please explain any of the conditions: _____

CONSENT FOR DENTAL TREATMENT:

I am the parent, legal guardian, or personal representative of the patient and there are no court orders now in effect that prevent me from signing this consent. I do hereby request and authorize Sunshine Children's Dentistry to perform any necessary dental services including but not limited to a comprehensive examination, cleanings, fluoride treatment, any necessary dental treatment for my child's teeth, x-rays as necessary to diagnose and/or treat my child's dental problem, and administration of anesthetics that are deemed advisable by Sunshine Children's Dentistry, whether or not I am present when the treatment is rendered. The usual and most frequent risks or complications occurring from dental operative treatment include but are not limited to, the possibility of pain or discomfort during treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of a temporomandibular joint disorder, temporary or permanent numbness, and allergic reactions. I understand that dental treatment for children includes efforts to guide their behavior by helping them understand the treatment in terms appropriate for their age. Sunshine Children's Dentistry will provide an environment that will help your child cooperate during treatment including praise, explanations, and demonstrations of procedures and instruments, and using variable voice tones.

I affirm that the information above is correct to the best of my knowledge. I understand it is my responsibility to inform Sunshine Children's Dentistry of any changes in my child's medical status.

LEGAL GUARDIAN SIGNATURE: _____ DATE: _____

DOCTOR NOTES & ATTESTATION: _____

_____

_____ DATE: _____

Sunshine Children's Dentistry

NEW PATIENT QUESTIONNAIRE

WELCOME!

My Name is: _____

But I like to be called: _____

My favorite Song is: _____

I go to School at: _____

I'm in Grade #: _____

My Favorite Subject: _____

Someday I am going to be a _____ when I grow up.

My favorite Game is: _____

My Friends _____ _____ _____ _____ come to see the dentist here too.

I am really good at: _____ _____

My favorite foods are: _____ _____

I have a Pet Named: _____

And it is a _____

I Play: _____ _____ (Sport or Instrument)

My Favorite Movie: _____

My Favorite Show: _____

We look forward to getting to know you!

Sunshine Children's Dentistry - "Where Children Have FUN & SMILE"
1911 S. 17th Street #140, Wilmington, NC 28401 * 910.762.7736 * (F) 910.251.8845 * SunshineChildSmile.com * Office.PointDentistry@gmail.com

APPOINTMENT POLICY

Welcome to Sunshine Children's Dentistry! We value your child as our patient. And we hope in return, you value your child's dentist. And we hope in return, you value your child's dentist. Please initial after reading.

BROKEN/MISSED APPOINTMENTS:

Cancellation / Reschedule: Your child's scheduled appointment is reserved specifically for them. If a cancellation is unavoidable, please call our office at least 2 business days in advance so that we may give your child's appointment to another patient. If you miss an appointment without 2 days prior notice, our office reserves the right not to schedule any subsequent appointments for your child/family. _____

Illness / Emergencies: We understand illnesses and emergencies in your family life may occur, but we request as much notice as possible if you need to change your child's appointment. _____

Reoccurring Cancellations: TWO MISSED APPOINTMENTS (without phone call or notice) or Repetitive last minute cancellations, is grounds for potential dismissal from our practice. _____

Operative Appointment Cancelation: If a patient misses an operative appointment with less than 24 hours' notice, that is grounds for potential dismissal from our practice. _____

Missed Appointment Fee: If you are a private pay patient and you miss an appointment or cancel without a 24 hr notice, you will incur a $25 missed appointment fee. _____

LATE ARRIVALS:

If you arrive more than 15 minutes late for your child's appointment, you may be asked to reschedule for the next available appointment time. Again, please call in advance if a delay/cancellation is unavoidable. _____

Thank you for your consideration. We look forward to treating your child!

I have read and understand the above Appointment Policy.

PATIENT'S NAME: _____ **DATE:** _____

PARENT / GUARDIAN'S NAME: _____ **SIGNATURE:** _____

* APPOINTMENT DELAY DISCLAIMER:

We strive to see all patients on time for their scheduled appointment. We make every effort to stay on schedule. Please remember, we run on children's time, not adult time. Additionally, there are times when our schedule is delayed in order to accommodate an injured child or an emergency. Please accept our apology in advance should this occur during your child's appointment. We will provide you the same courtesy if your child is in need of emergency treatment. If you have to wait more than 15 minutes, please ask our administrative staff the reason for the delay.

FINANCIAL GUIDELINES

Thank you for choosing us as your child's dental health care provider.
We are committed to the successful treatment of your child. Please understand payment of your bill is considered part of your child's treatment. The following is a statement of our Financial Guideline that we require you read, agree to, and sign prior to beginning treatment.

***Payment is due at the time services are rendered.**
As a courtesy to you we will gladly assist in the filing of your primary dental insurance. On the date of service we will collect your estimated portion. Please note, If we are unable to verify insurance coverage, you will be expected to pay in full for your child's visit on the day of service. If your insurance has not paid within 30 days of your child's visit, you are responsible for the balance. If your child's insurance pays more than expected, a refund will be issued to you. It is also your responsibility to inform us of any changes in your child's insurance coverage.

If your child is covered by Medicaid or Health Choice, you must be able to provide your child's subscriber ID and be active in the NC Tracks system.

For Private Pay Patients *(those not filing insurance):*
We offer a 10% discount for visits over $300.00 when paid in full on the day of treatment, or a 7% discount for treatment over $300.00 when paying with a debit or credit card.

Accepted Payment Methods:
We accept cash, personal checks, and money orders, Visa, Mastercard, Care Credit, and Discover as forms of payment. Thank you for understanding.

I have read, understand, and agree to the provisions of this Financial Guideline.

PATIENT'S NAME: _____ DATE: _____

PARENT / GUARDIAN'S NAME: _____ SIGNATURE: _____

Thank you!

INSURANCE GUIDELINES

OFFICE POLICY REGARDING DENTAL INSURANCE

Thank you for understanding that we file dental insurance as a courtesy to the parents/guardians of our patients. We are currently contracted with Delta Dental, Cigna, Blue Cross and Blue Shield, Aetna, United Healthcare, Metlife, Principle, Ameritas, NC Health Choice, and Medicaid. We are not responsible for how your insurance company handles its claims or for what benefits they pay on a claim. We can provide assistance with estimating your portion of the cost of treatment. However, we cannot guarantee what your insurance company will cover in regard to each filed claim.

If we have received all of your insurance information on the day of your child's appointment, we will be happy to file the claim for you. Please become familiar with your insurance benefits, as on the date of service we will collect your estimated portion. If we are unable to verify insurance benefits due to insufficient or inaccurate information, you will be responsible for paying the full amount of your child's visit. By law your insurance company is required to pay claims within 30 days of receipt. We file most insurance electronically, so your insurance company should receive each claim within several days of your child's treatment. You will be responsible for any balance remaining on your account after 30 days, whether insurance has paid or not. We will be glad to send you a refund once your insurance has paid us.

Please carefully read the following information that will help you understand some general guidelines about dental insurance benefits.

- Most insurance companies do not pay 100% on ALL procedures – many parents assume their insurance pays 90%-100% of all dental fees. Most plans only pay between 50%-80% of the average total fee.
- For dental coverage, the percentage paid is usually determined by how much you or your employer has paid for coverage or the type of contract your employer has set up with the insurance company.
- Sometimes your dental insurer reimburses you or the dentist at a lower rate than the dentist's actual fee. Frequently, insurance companies state that the reimbursement was reduced because your dentist's fee has exceeded the usual, customary, or reasonable fee (UCR) used by the company. A statement such as this gives the impression that any fee greater than the amount paid by the insurance company is unreasonable or well above what most dentists in the area charge for a certain service. This can be very misleading and simply is not accurate. Insurance companies set their own schedules and each company uses a different set of fees they consider "allowable".
- Some dental insurers will not reimburse the provider (Sunshine Children's Dentistry) directly for treatment but rather the subscriber (you). In this case, the parent/guardian who brings the child for treatment is responsible for paying the full amount for treatment rendered on the day of service.

The following checklist is to assist you in preparing for your child's first visit with us. Your verification of this information will greatly help with filing your claim and speed up any refund you may be owed.

1. Be sure your child can currently receive benefits from your dental insurance policy. It may be necessary to add a child if there have been any changes to the policy or if the policy is new.
2. Please bring your current insurance card that includes the following: ID number, group number, address, and phone number for the insurance company. Some dental insurance plans do not provide a card; therefore, we will need the social security number and date of birth for the parent who carries the policy.
3. The person who carries the insurance is the subscriber. We will need the subscriber's date of birth and employer information to expedite the processing of the claim.

PATIENT'S NAME: _____ DATE: _____

PARENT / GUARDIAN'S NAME: _____ SIGNATURE: _____

REQUEST FOR RELEASE OF RECORDS / RADIOGRAPHS

Name of Patient: _____ Date of Birth: _____

Patient's Address: _____

Parent/Dental office/Medical office to receive information:

Name: _____

Address: _____

Email: _____ Phone: _____

Reason for Records Release: _____

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address above. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. This authorization shall be in force and effect until the requested items have been delivered or the information has been reviewed by the parent.

Signature of Parent / Legal Guardian: _____

Print Name of Parent / Legal Guardian: _____

Relationship to Patient: _____

Date: _____

FOR OFFICE USE ONLY

Date Sent: _____ VIA: ___ Email ___ Mail ___ Pickup

Print Name of Employee: _____

Signature of Employee: _____

PHOTO RELEASE PERMISSION FORM

Sunshine Children's Dentistry has my permission to use my photograph or my child's photograph publicly to promote their dentist office. I understand that the images may be used on their website, marketing materials, and/or social media. I also understand that no royalty, fee, or other compensation shall become payable to me due to such use.

Parent/Guardian's Signature: _____ Date: _____

Parent/Guardian's Name: _____

Child's Name (if under 18): _____

Phone Number: _____

Other Comments: _____

Thank you!

IN HOUSE DENTAL MEMBERSHIP PLAN

This program pays for itself in preventative care alone and will save you money on any additional treatment, if needed. Join our plan and experience all the benefits of membership without the hassles of dental insurance.

CHILDREN 0-4
$249/YR
-Two preventive cleanings
-Two exams
-Two fluoride treatments
-Discount of 10% on other treatments
-Discount of 10% on other treatments

CHILDREN 5 AND UP
$349/YR
-Two preventive cleanings
-Two exams
-Two fluoride treatments
-One routine set of x-rays

Everything you need for routine preventive care for your child
****Savings of over $100 a year****
Unused benefits do not roll over
Plan starts the day you sign up AND payment is received

Disclaimer: Membership plans are not insurance but a contract arrangement provided by Sunshine Children's Dentistry for services. They are valid for one year and require to be renewed each year. Memberships are provided exclusively to uninsured patients of our practice and are considered pre-payment for preventive services or payment for access to discounted services. It is solely the patient's responsibility to schedule and keep their appointments. No refunds will be issued under any circumstances, including failure to schedule and maintain appointments. Missed appointments or appointments canceled with less than 24 hour notice will incur a $25 missed appointment fee to reschedule per our appointment policy.

I have read and agree to the terms and conditions of Sunshine Children's Dentistry In House Dental Membership Plan.

Patient's Name: _____ Date: _____

Parent/Guardian's Name: _____ Signature: _____

IN HOUSE DENTAL MEMBERSHIP PLAN

PATIENT INFORMATION:

Patient's Name: _____

Patient Date Of Birth: _____

Parent/Guardian's Name: _____

Phone Number: _____

Email: _____

OFFICE USE:

Plan Start Date: _____

Plan End Date: _____

Payment type: _____

Date of payment: _____

Employee Initial: _____