



3237 W. Truman Boulevard, Suite 201 • Jefferson City, Missouri 65109
(573) 635-2571 • Fax (573) 635-0248

We would like to welcome you and your child to our office. Our goal, is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

1 Tell Us About Your Child

Today's Date: _____

Child's Name: _____ Male Female

Nickname: _____ Child's Birthdate: ____/____/____ Child's Age: _____

School: _____ Grade: _____ SS#: _____

Child's Home#: (____) _____

Child's Home Address: _____

2 Who Is Accompanying The Child Today?

Name: _____ Relation: _____

Do you have legal custody of this child? Yes No Who may we thank for referring you? _____

Other family members seen by us? _____

Previous / Present Dentist: _____ Last Visit Date: _____

Parent's Marital Status: Single Married Widowed Divorced Partnered Separated

3 Mother's Information

Step Mother Guardian

Father's Information

Step Father Guardian

Name: _____ Birthdate: ____/____/____ Name: _____ Birthdate: ____/____/____

Wk #: (____) _____ Ext: _____ Hm #: (____) _____ Wk #: (____) _____ Ext: _____ Hm #: (____) _____

Employer: _____ Employer: _____

SS #: _____ DL #: _____ SS #: _____ DL #: _____

4 Person Responsible for Account

Name: _____ Relation: _____

Billing Address: _____

Wk #: (____) _____ Ext: _____ Hm #: (____) _____ Employer: _____

SS #: _____ DL #: _____

Who is responsible for making appointments? Name: _____

Wk #: (____) _____ Ext: _____ Hm #: (____) _____

5 PRIMARY DENTAL INSURANCE

SECONDARY DENTAL INSURANCE

Insurance Co. Name: _____ Insurance Co. Name: _____

Insurance Address: _____ Insurance Address: _____

Insurance Co. Phone #(____) _____ Insurance Co. Phone #(____) _____

Group # (Plan, Local or Policy #): _____ Group # (Plan, Local or Policy #): _____

Policy Owner's Name: _____ Policy Owner's Name: _____

Relation To Patient: _____ Relation To Patient: _____

Policy Owner's Birthdate: ____/____/____ Insured's SS#: _____ Policy Owner's Birthdate: ____/____/____ Insured's SS#: _____

Policy Owner's Employer: _____ Policy Owner's Employer: _____

Orthodontic Coverage? Yes No Orthodontic Coverage? Yes No

Continued on the back.

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Why did you bring the child to the dentist today?

Has the child ever had a serious/difficult problem associated with previous dental work? Yes No

Is the child's water fluoridated? Yes No Is the child taking fluoridated supplements? Yes No

Has the child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD)? Yes No

Does the child brush his / her teeth daily? Yes No Floss his / her teeth daily? Yes No

Child's Physician: _____ Phone #: _____ Date of Last Visit: _____

Is the child currently under the care of a physician? Yes No

Please describe the child's current physical health: Good Fair Poor

Has the child ever taken Phen-Fen (Also known as Redux or Pondimin)? Yes No If so, when? _____

Please list all prescription / over the counter or herbal supplement drugs that the child is currently taking:

Please list all drugs / materials that the child is allergic to:

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Has the child ever had any of the following medical problems?

- | | | | | | | | | | | | |
|----------------------------|----------------------------|--------------------------------|----------------------------|----------------------------|-------------------------|----------------------------|----------------------------|--------------------------|----------------------------|----------------------------|------------------------------|
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Abnormal Bleeding / Hemophilia | <input type="checkbox"/> Y | <input type="checkbox"/> N | Asthma | <input type="checkbox"/> Y | <input type="checkbox"/> N | Handicaps / Disabilities | <input type="checkbox"/> Y | <input type="checkbox"/> N | HIV+ / AIDS |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | ADD / ADHD | <input type="checkbox"/> Y | <input type="checkbox"/> N | Cancer | <input type="checkbox"/> Y | <input type="checkbox"/> N | Hearing Impairment | <input type="checkbox"/> Y | <input type="checkbox"/> N | Kidney / Liver Problems |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Any Hospital Stays | <input type="checkbox"/> Y | <input type="checkbox"/> N | Congenital Heart Defect | <input type="checkbox"/> Y | <input type="checkbox"/> N | Heart Murmur | <input type="checkbox"/> Y | <input type="checkbox"/> N | Rheumatic / Scarlet Fever |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Any Operations | <input type="checkbox"/> Y | <input type="checkbox"/> N | Convulsions / Epilepsy | <input type="checkbox"/> Y | <input type="checkbox"/> N | Hemophilia | <input type="checkbox"/> N | <input type="checkbox"/> N | Sickle Cell Disease / Traits |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Artificial Bones / Joints | <input type="checkbox"/> Y | <input type="checkbox"/> N | Diabetes | <input type="checkbox"/> N | <input type="checkbox"/> N | Hepatitis | <input type="checkbox"/> N | <input type="checkbox"/> N | Tuberculosis (TB) |

Please discuss any serious medical problems that the child has had: _____

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Does the child have any of the following habits?

- Y N Lip Sucking / Biting
- Y N Nail Biting
- Y N Nursing Bottle Habits
- N Thumb / Finger Sucking

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I understand that the information that I have given today is correct to the best of my knowledge, that it will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform any necessary dental service that my child may need.

I, the undersigned, a patient of Jason A. Dunville, DDS, request and authorize Jason A. Dunville and his associates, employees, assistants of who may refer me to, to administer such treatment as is medically necessary. I voluntarily consent to said medical/dental care, evaluation and treatment. This consent would include medical/dental services, care diagnostic procedures (would include, but not limited to radiology), and/or treatments as Jason A. Dunville and his associates, employees, assistants or who may refer me to deems reasonable and necessary. In the event that invasive procedures are deemed medically necessary, I further understand that additional consent will be obtained.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover, including all finance/late charges that may occur. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment of examination rendered, to my insurance company.

Signature: _____ Date: _____

OFFICE POLICY REGARDING DENTAL INSURANCE

As a courtesy to our patients, we are happy to file your dental insurance claims for you at the time of your treatment. So that you fully understand how the process works, please read the following.

- You must bring a current DENTAL insurance card. (Medical insurance cards are not the same).
- We will call to verify your coverage at the time of your appointment. You are responsible for providing us with your benefit coverage.
- After Dr. Dunville has seen you, you are responsible for paying the full amount your insurance is not estimated to pay.
- We will file the claim for you (electronically). If the x-rays or narratives are needed, we will send those with the claim.
- If, after 60 days, your account remains unpaid by your insurance, you will be responsible for the balance.
- Please keep in mind that ***not all*** services are covered by your insurance, and that it is the ***patient's responsibility to know their benefits.***

*Your dental insurance is a contract between your employer, and your carrier (we are a third party). Your employer purchases a fee schedule (UCR schedule) from an insurance company. The amount paid by your insurance company is based on the plan "UCR schedule" your employer purchases. For example, if the insurance company covers 80% of the fee, that is 80% of the "UCR schedule" in the plan, **not 80% of our fee schedule.** Our fee schedule is different from the fee schedule your employer purchased. Of course, the higher the plan your employer purchases, the more the insurance company pays. If you have any questions regarding the "UCR schedule" your employer purchased or specific benefit questions, please contact them directly. The 1-(800) number is typically located on the back of your dental insurance card. You may also contact your Human Resources department.*

In cases of divorced parents, the parent bringing the child to the visit will be deemed responsible for payment. Our office will not become involved in custody disputes over which parent is the responsible billing party.

I authorize payment of benefits directly to the provider, release of all necessary information to the insurance carrier and their representatives. I have read this form and agree to be financially responsible.

Signature of Patient (or parent/guardian, if minor)

Date