Patient Information

CHILD'S NAME		BIRTHDATE
ADDRESS		
HOME PHONE NO.	MOM'S CELL NO.	DAD'S CELL NO.
ADDRESS		
NICKNAME	SCHOOL	
HOBBIES		
SIBLINGS NAMES & AGES		

WHOM MAY WE THANK FOR REFERRING YOU ? _____

Insurance/Parent's Information

☐ **Father** ☐ **Stepfather** ☐ **Guardian** ☐ **Mother** ☐ **Stepmother** ☐ **Guardian**

NAME	NAME
ADDRESS (IF DIFFERENT FROM PATIENT) _____	ADDRESS (IF DIFFERENT FROM PATIENT) _____
EMAIL	EMAIL
EMPLOYER/OCCUPATION	EMPLOYER/OCCUPATION
WORK PHONE NO.	WORK PHONE NO.
SOCIAL SECURITY NO.	SOCIAL SECURITY NO.
BIRTHDATE	BIRTHDATE

DENTAL INSURANCE CO.	DENTAL INSURANCE CO.
PHONE NO.	PHONE NO.
GROUP NO.	GROUP NO.
POLICY/ID NO.	POLICY/ID NO.
MEDICAL INSURANCE CO.	MEDICAL INSURANCE CO.
GROUP NO.	GROUP NO.
POLICY/ID NO.	POLICY/ID NO.

M2™
DENTISTRY FOR CHILDREN & TEENS

M2 WEST: 2135 Noll Drive, Suite B Lancaster, PA 17603 TEL. 717.397.7750
M2 EAST: 5351 Lincoln Highway, Suite 1 Gap, PA 17527 TEL. 717.442.5647
Email: M2Dentistry@yahoo.com
www.pediatricdentist.com

Patient Information

CHILD'S NAME: _____

Medical/Dental History

CHILD'S PHYSICIAN	PHONE NO.
DATE OF LAST PHYSICAL EXAM	
LIST OF ALLERGIES	
CURRENT MEDICATIONS/DOSAGES	
DATE OF LAST VISIT TO A DENTIST	NAME OF DENTIST
DATE OF LAST DENTAL X-RAYS	
DATE OF LAST CLEANING/FLUORIDE TREATMENT	

Does your child have Congenital Heart Disease? Y N If YES, is SBE prophylaxis required? Y N

Has your child had any hospitalizations or surgeries? Y N

List all _____

Has your child ever had any history of the following? Please circle all that apply.

ADD/ADHD	Congenital Heart Defect	Kidney/Liver Disease	Other: Please explain
AIDS/HIV	Convulsions/Seizures	Learning Disability	
Anemia	Diabetes	Measles	_____
Asthma	Drug/Alcohol Abuse	Mononucleosis	
Artificial Heart Valves	Epilepsy	Mumps	_____
Autism	Psychological Problems	Rheumatic Fever	
Bladder Problems	Hearing Impairment	Sinus Problems	_____
Fainting	Heart Murmur	Thyroid Problems	
Cerebral Palsy	Hepatitis	Tuberculosis	_____
Chicken Pox	Hemophilia	Cancer/Tumors	

Has your child complained about dental problems? Y N

Does your child brush daily? Y N

Does your child floss daily? Y N

Any unhappy dental experiences? Y N

Does your child take fluoride in any form? Y N

Any injuries to mouth, teeth, head? Y N

Any mouth habits? Y N

□ Thumbsucking □ Fingersucking

□ Pacifier use □ Nail biting

□ Baby bottle use □ Sippy cup use

□ Nursing □ Mouth breathing

Age at weaning _____

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Patient Information

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Miscellaneous Information

Has your child ever had problems with previous dental treatment? Y N Please explain:

_____

_____

_____

Does your child have any special needs or fears that we should be aware of? Y N Please explain:

_____

_____

_____

Are there any specific questions or concerns that you would like us to address during your child's visit? Y N Please explain:

_____

_____

_____

Communication Preferences

HOW WOULD YOU LIKE US TO REMIND YOU OF UPCOMING APPOINTMENTS?

To schedule the next check-up appointment or treatment appointment:

☐ EMAIL ☐ POST CARD ☐ MOM'S CELL PHONE ☐ DAD'S CELL PHONE ☐ HOME PHONE

48 hour appointment reminder courtesy call:

☐ MOM'S CELL PHONE ☐ DAD'S CELL PHONE ☐ HOME PHONE ☐ TEXT MESSAGE

FOR OFFICE USE ONLY:
NOTES

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M2 Dentistry for Children & Teens
Office & Financial Policies

It is our primary goal and responsibility to help our patients achieve good dental health. We enthusiastically direct our time and efforts towards obtaining that goal. Please take your time in reading the following office policies.

Our payment options include: Cash, Personal Checks, Visa, MasterCard, Discover, American Express, and Care Credit. Please note that there is a $25.00 fee charged for all returned checks. Our office reserves the right to charge for multiple missed or cancelled appointments. Please give us the courtesy of a 48 hour notice if you are unable to keep an appointment.

If an account becomes delinquent and all attempts on our part to correct the problem have been exhausted, we will be forced to turn the matter over to a collection agency or to other legal authorities. Please note that any fees incurred in this process will also become your responsibility. Once an account reaches collections status, all of the patients in that account will become inactivated. We can no longer schedule appointments for any and all patients within that account. It is our sincere hope that we do not have to be faced with such an unfortunate turn of events.

Payment in full is expected at the time of treatment unless prior arrangements have been made. The person who accompanies the child to the appointment will be responsible for all of the charges at the time of service. Patients with dental insurance are required to provide accurate, up-to-date and complete insurance information. As a courtesy to you, we will file your insurance benefits. We can often file this information electronically which expedites your reimbursement. Please note that we do not participate with any managed healthcare dental plans. We cannot accept assignment of benefits for these carriers. In these instances, you will be responsible for the full cost of each visit at the time services are provided, and your insurance company will send you the reimbursement check directly.

Please understand that a dental insurance policy does not imply full payment for services. Our office does not determine your dental benefits. Your dental insurance is a contract between your employer and the insurance company. The percentage covered for each procedure is determined by how much your employer has paid for coverage. We aim to provide our patients with the best treatment available and we base our treatment recommendations on what is best for your child and not what your insurance company decides to pay. Our ultimate goal is to provide your child with the best possible treatment in a safe, clean environment, using the highest quality of supplies and equipment. Unfortunately, the goal of most insurance companies is to treat the patients in the cheapest manner, and not necessarily the safest and most effective.

At the initial appointment, we require full payment for services. We will submit the charges to your dental insurance company and obtain reimbursement for you. Once a history of payment is established between our office and your insurance company, we will only require you to pay a co-payment, if necessary, at subsequent visits. You will also be responsible for deductibles and non-covered charges. If your child should need dental services beyond preventive services, that treatment plan will be submitted to your insurance company for predetermination. This will allow you the opportunity to see what the insurance company will and will not cover, and what part, if any, becomes your responsibility.

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Signatures

CHILD'S NAME: _____

Parent/Guardian Legal Information & Consent

I understand that the information I have given is correct and that it will be held in the strictest of confidence. I understand that it is my responsibility to inform the dentist and/or dental team member of any changes in my child's medical status. I authorize the dentist or interdisciplinary team member to perform diagnostic procedures and treatment as may be necessary for proper dental care. I acknowledge that I will be given the opportunity to discuss any recommended treatment prior to my child's appointment. I authorize the release of any information concerning my child's health care for advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits.

PLEASE PRINT YOUR NAME	
SIGNATURE	DATE

Office & Financial Policies

CONSENT & AUTHORIZATION: I authorize dental treatment for my child and agree to pay all related professional fees. I have read and fully understand the office and financial policies of M2 Dentistry for Children & Teens in its entirety. Without reservations, I agree to abide by the policies outlined herein.

I certify that my child is covered by _____INSURANCE COMPANY NAME) and I assign directly to M2 Dentistry for Children & Teens/Maria L. Meliton, DMD, all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the use of my signature on all insurance submissions, whether manual or electronic.

My child does not have dental insurance coverage. Please check: ☐

PLEASE PRINT YOUR NAME	
SIGNATURE	DATE

Receipt of Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1966 requires that healthcare providers provide patients a copy of the office's Notice of Privacy Practices and make a good faith effort to obtain acknowledgement of receipt of the same. I acknowledge that I have received a copy of the Notice of Privacy Practices.

PLEASE PRINT YOUR NAME	
SIGNATURE	DATE

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