Tender Care Dentistry

Name of Patient:_____ **Sex:** ☐ **M** ☐ **F**
Last First Middle Nickname

Date of Birth:_____ **Social Security#:**_____

Mailing Address: _____
Street/PO Box

_____
city state zip

How did you hear about us? **Newspaper/Ad Sign Referred from Dr.**_____**/Friend**_____

Father/Guardian's Name:_____
DOB:_____ **SS#:**_____

Mailing Address:_____
Street/ PO Box

_____
City State Zip

Home#:_____
Work#:_____
Cell#:_____
Email Address:_____
Employer Name:_____
Address:_____

Mother/Guardian's Name:_____
DOB:_____ **SS#:**_____

Mailing Address:_____
Street/ PO Box

_____
City State Zip

Home#:_____
Work#:_____
Cell#:_____
Email Address:_____
Employer Name:_____
Address:_____

Legal Guardian of Patient: **Relation to Child:**

Have any of your children been seen in this office? ☐ **Y** ☐ **N** **Names:**

Someone who can reach you in case of an emergency?_____**Relation**_____

Address:_____**Phone#**_____

Primary Dental Insurance
Insurance Name:_____
Address:_____
_____
Phone#_____Group#_____
Policy Holder:_____
ID#_____ DOB_____

Secondary Dental Insurance
Insurance Name:_____
Address:_____
_____
Phone#_____Group#_____
Policy Holder:_____
ID#_____ DOB_____

By Signing, I give my permission to have any insurance reimbursements paid directly to Tender Care Dentistry. I also understand that I am responsible for all co-pays, fees, un-paid balances and services rendered at Tender Care Dentistry for the patient listed above.

Signature of parent/guardian: Relation to child: Date:

Medical and Dental History Form

Patient Name:_____ **D.O.B.**___/___/____ **Gender:** ☐ **Male** ☐ **Female**

What is the Reason for today's visit?

Last Dental Exam: **Where X-rays taken? YES NO** ***If yes, what type?***

Patient's Physician: **Physician's Phone#:**

Physician's Address:

Has your child ever been hospitalized? ☐ **YES** ☐ **NO** ***If yes, When and for what reason:***

Is your child on any medications? ☐ **YES** ☐ **NO**

If yes, please list:_____

Reason:_____

Is your child allergic to any Medications? ☐ **YES** ☐ **NO**

If yes, please list:_____

Any other food or environmental allergies? ☐ **YES** ☐ **NO**

If yes, please list:_____

Has your child ever had any of the following?	YES	NO	*Comments*
ADHD	☐	☐	
Asthma (Mild/Moderate/Severe/Exercise Induced)	☐	☐	
Autism	☐	☐	
Blood Disorders(eg. Anemia, Hemophilia, sickle cell disease)	☐	☐	
Cancer	☐	☐	
Cystic Fibrosis or Respiratory Disease	☐	☐	
Endocrine Disease (eg.Diabetes, Thyroid, Glandular)	☐	☐	
Genetic Disorder/Syndrome (please state)	☐	☐	
Heart Disease (eg. Murmur, surgery, previous endocarditis, congential abnormality)	☐	☐	
Immunocompromise	☐	☐	
Kidney Disease	☐	☐	
Liver Disease (eg. Hepatitis)	☐	☐	
Mental or emotional problems or developmental delays	☐	☐	
Neurological Disease (eg. CP, seizures, TBI)	☐	☐	
STD or HIV	☐	☐	
Severe Headaches	☐	☐	
Sight, hearing, or speech disorder	☐	☐	
Skin, bone , muscle, or joint disease	☐	☐	
Is your child MRSA positive?	☐	☐	
Was your child born prematurely or had complications during birth?	☐	☐	
OTHER	☐	☐	
Injury to the face or teeth?	☐	☐	
Previous orthodontic treatment?	☐	☐	
Do you supervise your child with their brushing?	☐	☐	
Does your water have fluoride?	☐	☐	
Does the child have any oral habits?(eg. Thumb-sucking or pacifier)	☐	☐	

I agree that the information provided is correct to the best of my knowledge and give my permission for treatment by Tender Care Dentistry.

Signature of Parent/Guardian_____**Date:**_____**Doctors Signature**_____

Tender Care Dentistry

Acknowledgement of Receipt of Notice of Privacy Practice

Tender Care Dentistry "Notice of Privacy Practice" provides information about how we may use and disclose protected health information about you. Please acknowledge receipt of this office's notice of Privacy Practice by initialing below.

_____
Initial

Our Notice of Privacy Practice states that we reserve the right to change the terms described.

_____
Initial

You have the right to request restrictions on how our protected health information may be used or disclosed for treatment, payment or health care operations. We are not required to agree to your restrictions, but if we do, we are bound by our agreement with you.

_____
Initial

By signing this form, you consent to our use and disclosure of protected health information about you for the treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.

Signature Date

Tender Care Dentistry

29795 Three Notch Road
P.O. Box 653
Charlotte Hall, MD 20622
(301)290-0001 (301)274-KIDS
Fax: (301)2905633

Dear Tender Care Dentistry,

I _____, give
(Parent/Legal Guardian)

_____ authorization to approve any treatment
(Authorized person(s) other than Parent/Legal Guardian)

_____ may need during his/her dental visits in
(Patient's Name)
Your office.

Date: _____

Signature: _____

****Legal parent/guardian MUST bring patient to their first appointment****

Tender Care Dentistry
Office Policies

Welcome to Tender Care Dentistry. We are excited to be involved in the partnership that will pave the way to your child's healthy and beautiful smile. So that we may work together towards this goal we hope that you will take the time to read and understand our office policies.

PHOTO POLICY

By initialing this section you give Tender Care Dentistry permission to take a photo of your child for identification purposes and in office use.

***Initial*_____**

CONFIRMATION POLICY

You MUST confirm your appointment by 3pm the day before your scheduled appointment. If appointed on a Monday you must confirm by 3pm the Thursday before. Failure to confirm will result in forfeiting your appointment time. Confirmations can be done via text, email or phone call.

***Initial*_____**

CANCELATION POLICY

In order to give you and your child the high quality service you deserve it will be necessary to keep all scheduled appointments. If you absolutely cannot keep the appointment it will be mandatory for you to notify us within 24 hours of your appointment.

***Initial*_____**

CELL PHONE POLICY

The use of cell phones and other hand held devices are extremely disruptive. The use of Cell phones is prohibited outside of the waiting room area.

***Initial*_____**

FOOD AND DRINK POLICY

Eating or drinking within the dental office is prohibited. For safety reasons, OSHA prohibits any food or drink to be consumed in the clinical areas.

***Initial*_____**

By signing below I acknowledge that I have read and understand these policies.

Signature of parent/guardian _____ Date _____

Patients' Name(s) _____Signature of Witness_____

OVER ➡

Financial Policy

All co-pays and deductibles are due at the time services are rendered unless special arrangements are made.

We accept cash, check, Visa, Mastercard, Discover, and CareCredit.

Credit Card Signature Authorization: Signing this section will enable you to make credit card payments over the phone to pay on your account at Tender Care Dentistry. Without a valid signature on file we will be unable to process credit card payments via telephone.

X_____

Primary Insurance: As a courtesy, Tender Care Dentistry will file the primary insurance claim for you. Our helpful staff will attempt to **ESTIMATE** your insurance benefits as accurately as possible. However, changes in benefits and exclusions unique to your policy may result in a refund or balance due after your insurance has paid. ***Please be familiar with your insurance benefits to help us with this process.***

Please remember that your insurance policy is a contract between you and your insurance company; we are not a party to that contract nor are we responsible for procedures that are not covered for any reason. We must have complete and up to date insurance information in order to bill your insurance company on your behalf. In the event that your insurance company has not paid their portion within 60 days the balance will become your responsibility.

_____Initials

Secondary Insurance: Tender Care Dentistry will no longer file any secondary claims unless you are primarily covered by the Federal Blue Cross Blue Shield plan or if your secondary insurance is through the Maryland Medical Assistance Program.

_____Initials

Returned Checks: All checks are electronically deposited in real-time on the day they are written. A $35 fee will be applied to any returned checks.

_____Initials

Unpaid Accounts: Any account **90 days past due** may be sent to a collection agency or settled in small claims court. In these events, you will be responsible for any collection and/or court fees incurred.

_____Initials

By signing below I assume financial responsibility as stated above. I also assume responsibility for all collection and legal fees if my account becomes past due. I have read, understand, and agree to the financial policy.

Signature of Responsible Party_____ Date_____

Patients' Name(s)_____

Tender Care Dentistry

29795 Three Notch Rd Charlotte Hall, MD 20622
Phone: 301-290-0001 Fax:301-290-5633 Email:TCDXrays@gmail.com

Authorization to Release X-rays

Date:_____

I, _____, authorize Tender Care Dentistry to email

my child's,_____, x-rays directly to another dental office

for any of the following reasons:

In the event Tender Care should refer my child to another dental office or specialist for a consultation and/or treatment.

In the event I choose to transfer my child to another dental office for a consultation and/or treatment.

Parent/Legal Guardian signature:_____