Patient Information

Child's First Name:_____

Middle Name:_____

Last Name:_____

I prefer to be called (Nickname): _____

Address: _____

Home Phone: _____

Work Phone: _____

Cell/Other Phone: _____

Email Address: _____

Birth date:_____

Gender:_____

Social Security Number:_____

Whom may we thank for referring you to our office?

_____

Other family members seen by us:_____

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Responsible Party Information

Full Name:_____

Residence:_____

Mailing Address (if different):_____

Home Phone:_____

Work Phone:_____

Cell/Other Phone:_____

Email Address:_____

Social Security Number:_____

Birth date:_____

Relationship to Patient:_____

Employer:_____

Spouse's Name:_____

Relationship to Patient:_____

Employer:_____

Social Security Number:_____

Birth date:_____

Home Phone:_____

Work Phone:_____

Cell/Other Phone:_____

Email Address:_____

Dental Insurance Information

Insured's Name:_____

Insured's Social Security Number:_____

Insurance Company:_____

Group Number:_____

Local Number :_____

Insurance Company Address:_____

Phone Number:_____

Secondary Insurance

Insured's Name:_____

Insured's Social Security Number:_____

Insurance Company:_____

Group Number:_____

Local Number:_____

Insurance Company Address:_____

Phone Number:_____

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Wichita Pediatric Dentistry
Michael F. Iseman, DDS
Board Certified Specialist

Emergency Information

Name of the nearest relative not living with you:_____

Complete Address:_____

Phone:_____

What concerns you most about your child's teeth?

_____

Is your child presently in any dental pain?

_____

Has your child experienced any unfavorable reaction to dentistry?

_____

Has your child ever lost or chipped any teeth?

_____

Has your child had any injuries to face, mouth or teeth?

_____

Is any part of your child's mouth sensitive to temperature?

_____

Does your child have any type of thumb or tongue habit?

_____

Is your child a mouth breather?

_____

WICHITA
PEDIATRIC
DENTIST
MICHAEL F. ISEMAN, DDS
Board Certified Specialist

Dental History:

Has your child ever seen a dentist?_____

If yes, who? _____

When? _____

Does your child grind their teeth? (circle one)

Yes or No

Medical History

Please fill out this section to the best of your knowledge. It is important for us to be aware of any health issues that may affect the treatment you receive from our office. This information is kept strictly confidential.

Physician:_____

Date of Last Visit:_____

Address:_____

Phone:_____

Please answer following and add any relevant comments.

Is your child taking any medication?

_____

Is your child allergic to any medicines/foods/latex?

_____

Does your child have a history of any major illness?

_____

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Has your child had any major operations?

_____

Is your child required to take antibiotics before dental procedures? Please list name/dosage:

_____

Question: Are there any medical conditions we have not discussed that you feel we should be aware of?

_____

Please circle any of the following that your child has had or currently has:

Abnormal bleeding/Hemophilia	Prolonged Bleeding
Anemia	Radiation/Chemotherapy
Arthritis	Autism
Asthma	Tuberculosis
Bone Disorders	Tumor or Cancer
Congenital Heart Defect	Nervous Disorders
Diabetes	HIV/Aids
Kidney Problems	Cold Sores/Canker Sores
Pneumonia	Cerebal Palsy
Dizziness	Gastrointestinal Disorders
Epilepsy	Heart Murmur
Heart Problems	Hepatitis/Liver Problems

*Please review our HIPAA forms online or in office

Insurance Policy

As a courtesy to our patients, we do file your insurance for you. However, it must be stressed that your insurance is a contract between you, your employer and the insurance company. We are not a party to this contract unless you are a member of a PPO group in which the doctor participates. In such cases, we will handle your claims according to our agreement with the insurance company, if one exists. While we will do our best to help you receive your maximum benefits, we will not become involved in disputes between you and your insurance company regarding covered charges, secondary insurance, reasonable and customary determinations, etc. Not all services are covered by your plan and every plan is different. If you have questions about your benefits, please call your insurance company. It would be helpful for you to know your anniversary date, annual deductible and annual maximum.

You are expected to pay the estimated portion of your fee at the time services are rendered.
However, this is only an estimate – if there is any difference after your insurance pays, we will send you a statement.

You are responsible for the timely payment of your account. If your insurance company has not paid your claim in full within 60 days, the balance and all follow-up with the insurance company becomes your responsibility. As a reminder, after 90 days we assign all accounts over to a collection agency for processing.

I hereby authorize payment of dental benefits otherwise payable to me to be paid directly to Wichita Pediatric Dentistry, PA. Furthermore, I realize that I am ultimately responsible for payment.

_____ ____/____/____
(signature of responsible party) (date)

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Board Certified Specialist

Nitrous Oxide Information and Consent Form

Your child's response to the dental experience is of primary importance to us. Nitrous Oxide or "laughing gas" is an analgesic and mild sedative used by numerous pediatric dentists. It is a safe gas/oxygen mixture, which is inhaled by a nasal mask and takes effect in 5-10 minutes. Nitrous Oxide in the dental office is never used as a general anesthetic. It does NOT put a child "to sleep". For this reason, local anesthetic is still necessary, but much more comfortable to receive.

Nitrous Oxide decreases fear, anxiety, apprehension and pain sensations. The use of Nitrous Oxide can help many children learn to cope with the sometimes-stressful dental experience. Since Nitrous Oxide generally reduces fatigue and provides a pleasant sensation, it enables children to remain relaxed for their dental treatment.

Occasional side affects are nausea and/or vomiting. Many children are withdrawn after Nitrous Oxide sedation. They appear sleepy and unresponsive. This is a natural reaction, much like awakening from a nap.

I have read and understand the above and have no questions or concerns.

_____ ____/____/____

(signature of responsible party) (date)

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Office Policy

Prior to being examined by the Doctor each patient must have a completed Medical History Form. In addition, a single Office Policy and Insurance Policy form will need to be completed for each family.

No Show Policy: We expect patients to be present at all scheduled appointments exclusively reserved for them. We reserve the right to charge a $50 missed appointment/late notice fee without 48-hour notice. This fee must be paid before being scheduled again.

Missed Appointments: After Three "No Show" appointments (missed appointments without 48 hour notification) you will be dismissed from our practice.

Late Arrivals: Late arrival for a scheduled appointments leads to inadequate time to accommodate the remaining patients on the schedule. Late arrivals of greater then 15 minutes risk not being seen. We will try to accommodate late appointments as time permits, however, those patients who are here at their assigned time will be seen first.

Financial Policy: For those without insurance, full payment is due at the time of service, regardless of who accompanies the patient on the day of his/her appointment. As a special service to you, we offer 5% courtesy for Visa, MasterCard and Discover or 10% courtesy if you pay by cash for your entire treatment plan.

For those with insurance, we file claims as a courtesy to our patients and we gladly accept assignment of benefit payments from most insurance companies. This will reduce your immediate, out of pocket expenditures. However, we will collect the estimated portion of your fee at the time of services are rendered, regardless of who accompanies the patient on the day of his/her appointment.

We accept cash and credit cards (Discover, Visa and MasterCard). In addition, we offer Care Credit healthcare financing that allows for low monthly payments – please ask for details.

After 90 days we assign all unpaid accounts to a collection service for processing. You will be responsible for all costs of collection.

Patients that fail to comply with the above policies may be subject to dismissal from the Wichita Pediatric Dentistry, PA family.

Thank you for reading our Office Policy. Please let us know if you have any questions or concerns. We appreciate the trust and confidence you have placed in us for your child's health care.

I have read, understand and agree to abide by the Office Policies of Pediatric Dentistry, PA and further acknowledge that failure to comply may result in dismissal from the practice:

_____ ____/____/____
(signature of responsible party) (date)

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