Stanley M. Prince, DMD
Family & Cosmetic Dentistry
124 Andrews Way, Suite A
Saint Marys, Georgia 31558
(912) 882-4274

Child's Information, Medical, and Dental History (Please Print Clearly)

Patient Name: ____ DOB: ____________________

Address: ____

City: ______________________________ State: __________ Zip Code: ________________

Father's Name: ____

Father's Cell Phone: _________________________ Father's Home Phone: ___________________

Father's Employer: ___________________________ Father's Work Phone: _________________

Mother's Name: ____

Mother's Cell Phone: _________________________ Mother's Home Phone: __________________

Mother's Employer: ___________________________ Mother's Work Phone: ________________

If parents do not live together, please indicate with whom the child resides: ___________________

Whom may we thank for referring you to our office? ____

CHECK ANY OF THESE CONDITIONS WHICH YOUR CHILD PRESENTLY OR HAS PREVIOUSLY HAD

___ Allergies
___ Anemia
___ Asthma
___ ADHD/ADD
___ Bleed Tendency
___ Blood Transfusion
___ Bone Disorder
___ Brain Disorder
___ Cancer -- Type
____
___ Convulsions
___ Diabetes

___ Epilepsy
___ Eye Disorder(s)
___ Fainting
___ Heart Condition
___ Hepatitis
___ High Blood Pressure
___ HIV/AIDS
___ Hormone Disorder
___ Hyperactivity
___ Immune Deficiency
___ Jaundice

___ Nose/Throat Disorder
___ Prolonged Illness
___ Psychiatric Problems
___ Rheumatic Fever/Scarlet Fever
___ Skin Disease
___ Speech Problems
___ Stomach Problems
___ Other: ______________________
____
____
____

Has your child had the HPV vaccine? (Please circle) YES / NO

_______ AS FAR AS I KNOW, MY CHILD IS HEALTHY AND HAS NONE OF THE ABOVE CONDITIONS.

Child's Physician: ___________________________________ Physician's Phone: __________________

Does your child have any other medical conditions? . . . . ____ No ____ Yes

Is your child taking "any" medicine? If yes, please fill out "Medication List" at the bottom ____ No ____ Yes

Is your child allergic to any medicine or food? If yes, please list: ______________________ ____ No ____ Yes

Has your child ever been hospitalized? If so, when & why: ______________________________ ____ No ____ Yes

Is your child using fluoride tablets, drops, or rinses? . . . . ____ No ____ Yes

Has your child had a toothache recently? . . . . ____ No ____ Yes

Does your child suck a thumb or finger? . . . . ____ No ____ Yes

Has your child ever injured his/her teeth or jaws? . . . . ____ No ____ Yes

Does your child have a dental condition you are concerned about? . . . . ____ No ____ Yes

How often does your child brush his/her teeth?_____________________________________ By Whom: ________

How often does your child floss his/her teeth?_____________________________________ By Whom: ________

What is the source of your child's drinking water? _________ Public _________ Well Water

If you answered "YES" to any of the above questions, please explain below:_________________________________

____

____

Is this your child's first visit to the dentist? . . . . ____ No ____ Yes

If no, how long ago was the last visit to a dentist? ____

What treatment was done? ____

How long ago was the last cleaning and check up?____

Were there any problems with previous dental treatment? . . . . ____ No ____ Yes

Explain those problems: ____

____

Do you have any questions or concerns for Dr. Prince?____

____

Medication List (Please list Medicine and Reason for Taking Medicine):

____

____

____

____

____

____

<u>Any accounts 30 days past due may incur a finance charge and/or billing charges. If sent to collections, the responsible party, (if a minor) will be responsible for all related fees and court costs. If you have any questions related to your account, please do not hesitate to contact our office.**</u>**

Patient Primary Insurance Information

Name of Insured: ______________________________ Relationship to Insured: ______________________

Insured SSN #: ______________________________ Insured Date of Birth: ______________________

Insurance Company: ______________________ Insurance Telephone: ______________________

Subscriber ID Number: ______________________ Group Number: ______________________

Patient Secondary Insurance Information

Name of Insured: ______________________________ Relationship to Insured: ______________________

Insured SSN #: ______________________________ Insured Date of Birth: ______________________

Insurance Company: ______________________ Insurance Telephone: ______________________

Subscriber ID Number: ______________________ Group Number: ______________________

Person Responsible for Payment: ____

<u>PAYMENT POLICY:</u> In compliance with the Truth in Lending Law, here is our credit policy: It is customary to pay fees at the time services are rendered unless other arrangements have been made. To assist you with this, we will accept cash, check, and most credit cards. On reconstruction cases (crown, bridge, and partial and full dentures) 50% of the fee is due at the first appointment and balance due at the time of insertion. If you have dental insurance, we will accept assignment on that portion of your charges which are covered by insurance. However it must be understood that you will be responsible for immediate payment of any deductible amount and co-payment not covered by insurance; in addition, you will be responsible for any portion of the assigned amount not paid by your insurance company within 60 days.

Authorization and Release

I authorize Stanley M. Prince, DMD to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize the release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I hereby authorize payment of insurance benefits to Stanley M. Prince, DMD, otherwise payable to me. I understand that my dental insurance or payer of my dental benefits **may pay less** than the actual bill of services. I understand that **I am financially responsible** for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payments of services not paid, in whole or in part by my dental care payer.

I attest to the accuracy of the information on this page.

Parent or Guardian Signature: ______________________________ Date: ______________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been notified of this office's Notice of Privacy Practices (HIPAA).

HIPAA policies are posted at the reception counter. I understand that I may receive a written copy of the HIPAA practices upon my asking.

I give Dr. Prince and his staff permission to discuss my protected health information to the following people:

(1) Name: ______________________________ Relation: ___________________________
Home Number: _______________________ Cell Number: ________________________

(2) Name: ______________________________ Relation: ____________________________
Home Number: _______________________ Cell Number: ________________________

(3) Name: ______________________________ Relation: ___________________________
Home Number: _______________________ Cell Number: ________________________

_________ Please check if you do not want Dr. Prince or his staff to discuss your protected health information with anyone.

Print name: _______________________________________

Signature: ____ Date: __________________

Terms for Deposit on Dental Treatment

When you have been scheduled for dental treatment, we will require a 25% deposit of the treatment fee (totaling $500 and above OR any scaling and root planing treatment) to reserve the chair time. It is important that you read and understand the terms of placing a deposit on your account.

A deposit is also mandatory for all appointments that involve any dental treatment that requires outside laboratory work, major dental treatment, and lengthy appointment times or in situations of scheduling difficulties.

The deposit will be posted to your account the day the appointment is reserved (Appointments need to be made no further than 2 weeks after deposit is placed). Please note that a deposit is not refundable, unless you give a 72 business hour notice prior to your scheduled appointment (Remember, our office is closed on Fridays).

If you fail to give adequate notice, the deposit will remain on the account until you either schedule the appointment, or it can be used for other dental care that does not require a deposit. If you decide, more than 72 business hours before the scheduled appointment, that you wish to have a refund, we will be happy to issue a refund in full, less any credit card charges if they apply. All checks must have cleared the bank prior to a refund. In the event that you should miss a second reserved appointment time, your deposit will be used to cover the lost chair time.

PAYMENT POLICY: In compliance with the Truth in Lending Law, here is our credit policy: It is customary to pay fees at the time services are rendered unless other arrangements have been made. To assist you with this, we will accept cash, check, and most credit cards. On reconstruction cases (crown, bridge, and partial and full dentures) <u>50% of the fee is due at the first appointment and balance due at the time of insertion</u>. If you have dental insurance, we will accept assignments on that portion of your charges which are covered by insurance. However it must be understood that you will be responsible for immediate payment of any deductible amount and co-payment not covered by insurance; in addition, you will be responsible for any portion of the assigned amount not paid by your insurance company within 60 days.

If you have any questions about the above terms, please ask before scheduling treatment.

Patient: ____

Date: ____

Signature: ____

Revised 01/07/2021 DP

Stanley M. Prince D.M.D., PC

124 Andrews Way, Suite A

St. Mary's, GA 31558

Office Phone: (912) 882-4274

Office Fax: (912) 673-1311

E-Mail: greatsmiles1234@gmail.com

Re: Dental Records Release

Patient's Name(s): ____

Date of Request: ____

I give the office of ___________________ permission to forward a copy of my records to the office of Stanley M. Prince D.M.D.

Signed: ____

Relationship (if not patient): _______________________________________