Children's Dentistry of Apex ♦ Ronald Venezie, DDS, MS, PA
504 W Williams Street ♦ Apex, North Carolina 27502-1846
Telephone (919) 303-2873 ♦ Fax (919) 303-2926 ♦ www.childrensdentistryofapex.com

Dental Acquaintance Form

Child Demographic Information

First Name ____________________ Middle Initial ______ Last Name ________________________ Sex: M F

Preferred Name ________________ Age _______ Date of Birth _______/_______/_______ SSN ______–_____–______

Address ______________________________________ City __________________________ State ______ Zip __________

Primary Phone # (_____) _____________ Names/ages of siblings ____

Child lives with: Both parents Mother Father Other _______________ Who has legal custody? _________________

What is the reason for today's visit? ____

Parent Demographic Information

Father's Name ____ Father's DOB _______/______/_________

Father's Social Security # ________–_____–________ **[OR]** Driver's License # _______________________ State ________

Primary Phone # (___) ___________ Work Phone # (_____) ___________ Secondary Phone # (___) ___________

Primary E-mail Address ____

Father's Employer ____

Mother's Name ____ Mother's DOB ______/______/_________

Mother's Social Security # _______–_____–________ **[OR]** Driver's License # _______________________ State ________

Primary Phone # (___) ___________ Work Phone # (_____) ___________ Secondary Phone # (___) __________

Primary E-mail Address ____

Mother's Employer ____

Referral Information

How did you hear about Children's Dentistry of Apex? (Circle all that apply)

1. Referral from a friend or relative Name: ____
2. Referral from another dentist Name: ____
3. Referral from my child's physician Name: ____
4. Internet
5. Social Media (please circle one) Facebook Twitter Google+
6. Telephone directory
7. Other (Please explain.) ____

Our greatest reward is the trust shown by families who refer children to our practice.
We sincerely appreciate your recommending our office to your family, friends, and neighbors.

Children's Dentistry of Apex ♦ Ronald Venezie, DDS, MS, PA

Child's Name ____ Date of Birth _______ / ________ / ________

Health History

Child's Physician ____________________________ Phone # (_______) ___________ Date of last exam _________________

Circle One

Yes No Has your child ever had a health problem? Please explain. ______________________________________

____

Yes No Has your child ever been hospitalized? Please give reason(s) and date(s). ___________________________

____

Yes No Is your child allergic to anything? ____

Yes No Is your child currently taking any medications? Please list medication(s) and reasons(s). _______________

____

Yes No Were there any problems at birth? ____

Yes No Was your child breast fed? If so, at what age was it stopped? _______________

Yes No Was your child bottle fed? If so, at what age was it stopped? _______________

Has your child been treated for any of the following?

____ Heart disease
____ Liver disease
____ Kidney disease
____ Bleeding disorders
____ Anemia
____ Asthma
____ Lung problems
____ Seizures
____ Brain injury
____ Cleft lip/palate
____ Diabetes
____ Rheumatic fever
____ AIDS
____ Hepatitis
____ Tuberculosis
____ Cerebral palsy
____ Learning disability
____ Speech disorder
____ Hearing disorder
____ Vision disorder
____ Autism
____ ADD/ADHD
____ Emotional disorder
____ Depression
____ Other (explain)

Please explain any past health problems we should be aware of. ____

____

____

Dental History

Circle One

Yes No Has your child ever been to the dentist? Date of last visit. ______________________________________

Name and phone number of dentist. ____

Yes No Has your child had any unfavorable reaction to previous dental care? Please explain. __________________

____

Yes No Does your child suck a finger, thumb or pacifier?

Yes No Does your child have pain with chewing, yawning, or wide opening?

Yes No Does your child's jaw make noises, and is pain associated with the sounds?

Yes No Is your drinking water fluoridated?

Yes No Does your child use a fluoride toothpaste?

Yes No Do you give your child any other form of fluoride? If so, what? ___________________________________

Consent for Dental Treatment

I request and authorize Dr. Ronald Venezie to examine, clean and provide dental treatment for my child's teeth. I further request and authorize the taking of dental radiographs (x-rays) as Dr. Venezie may consider necessary to diagnose and or treat my child's dental problem(s). I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr. Venezie will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation, demonstration of procedures and instruments and use of variable voice tone.

Signature ____ Relationship to patient _______________________ Date ____________

Children's Dentistry of Apex ♦ Ronald Venezie, DDS, MS, PA
504 W Williams Street ♦ Apex, North Carolina 27502-1846
Telephone (919) 303-2873 ♦ Fax (919) 303-2926 ♦ www.childrensdentistryofapex.com

FINANCIAL POLICIES
Effective March 15, 2015

Assignment of Dental Insurance Benefits

Our vision is to provide the highest caliber of comprehensive dental care for children. To help families manage the cost of that care, our practice can accept payment directly from most dental insurance companies. Please note the following:

- Our office is in-network with Blue Cross Blue Shield of NC. Our office has no direct network relationships with any other dental insurance companies. Your benefits are determined by the type of plan chosen by you and/or your employer. We have no control over the determination of your benefits, the terms of your contract, or the method of reimbursement. **With the exception of BCBSNC plans, you are responsible for payment in full of any portion of our fees not covered by your dental plan.**

- By signing below, you agree to assign your child's dental insurance benefits to our practice if such assignment is permitted by your dental insurance plan.

  Signature: ____

  NOTE: Humana plans, as well as some Delta Dental and federal employee plans, will not make payments directly to out-of-network dentists. They will only send payments directly to the policy holder. Several payment options are available for families covered by these plans, including the option to pay in full for services at the time they are rendered. As a courtesy to these families, our practice will file their dental insurance claims so that they can be reimbursed directly from the insurance company in a timely manner.

- At the time of each visit, you will be expected to pay the portion of our fees not covered by your dental insurance plan. This portion will be an estimate based on coverage information provided by you and/or your dental plan.

- After full payment has been made by your dental insurance company, you will be billed for any outstanding balance due.

- If full payment by your dental insurance company results in a credit on your account, this will be refunded to you. You also have the option to apply any credit to future dental visits for your child or children. Please note that a credit of less than $25.00 will be applied to future visits unless you request a refund.

Failed Appointments

Each appointment time is reserved for a specific child. That allows us to devote the necessary time and attention to the children in our practice. When an appointment is canceled on short notice or when a family does not show up for a scheduled appointment, we are unable to offer that time to another child in need of care. Please note the following:

- If you find it necessary to cancel or reschedule an appointment, we ask that you give us 48 hours notice to allow us to offer that time to another child in need of our care.

- Our practice reserves the right to charge a $50.00 failed appointment fee if you do not show up for a scheduled appointment or if you cancel or reschedule an appointment with less than 48 hours notice.

- In the event of multiple failed appointments, it may be necessary to dismiss a child or family from our practice and schedule no future appointments.

Your signature acknowledges that you are aware of these policies. Your cooperation is greatly appreciated.

Parent Signature: ____ Date: ____________________