



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.

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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?

<input type="checkbox"/> Heart disease	<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cerebral palsy	<input type="checkbox"/> Autism
<input type="checkbox"/> Liver disease	<input type="checkbox"/> Lung problems	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Learning disability	<input type="checkbox"/> ADD/ADHD
<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Seizures	<input type="checkbox"/> AIDS	<input type="checkbox"/> Speech disorder	<input type="checkbox"/> Emotional disorder
<input type="checkbox"/> Bleeding disorders	<input type="checkbox"/> Brain injury	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Hearing disorder	<input type="checkbox"/> Depression
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cleft lip/palate	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Vision disorder	<input type="checkbox"/> 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 _____



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FINANCIAL POLICIES

Effective March 21, 2019

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 and Delta Dental 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 and Delta Dental 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 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: _____



Specializing in Pediatric Dentistry for Infants, Children and Teens
Board Certified, American Board of Pediatric Dentistry
Fellow of the American College of Dentists