WELCOME

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Small World Children's Dentistry, S.C.

14430 West Greenfield Avenue • Brookfield, WI 53005 • (262) 780-9996 • Fax (262) 797-1426

About Your Child

Child's Name: _____

Nickname: _____ ❑ Female ❑ Male

Child's Birthdate: ___/___/___ Age _____

Does child live with ❑ Both Parents ❑ Mom ❑ Dad ❑ Guardian

❑ Foster Parents ❑ Stepmother ❑ Stepfather ❑ Other

Child's Address: _____

City _____ State _____ Zip _____

If child does not live with both parents please provide addresses of both parents.

Mom: _____

_____

Dad: _____

_____

Who is Accompanying the Child Today?

Name: _____

Relation to Child: _____

Name of person with legal custody of the child?

_____

Other family members seen by us:

Whom may we thank for referring your child?

_____

Parent's Information

Mother's Name: _____ DOB ___ / ___ / ___

Mother's Employer: _____ SS# _____

Father's Name: _____ DOB ___ / ___ / ___

Father's Employer: _____ SS# _____

Telephone Numbers

Mom's Home #: _____ Mom's Work #: _____

Mom's Cell #: _____ Dad's Home #: _____

Dad's Work #: _____ Dad's Cell #: _____

Emergency Contact #: _____ Name of Contact: _____

Relationship: _____

Please Complete Backside ➥

Dental History

Any current dental complaints? _____

_____

Has the child ever had a problem associated with previous dental work? ❑ Yes ❑ No Specify if yes: _____

_____

Is the child's water fluoridated? ❑ Yes ❑ No
Is the child taking fluoride supplement? ❑ Yes ❑ No If yes, what? _____
Does the child brush his/her teeth daily? ❑ Yes ❑ No
Floss his/her teeth daily ❑ Yes ❑ No
Is this your child's first dental visit? ❑ Yes ❑ No
If no, who was the last Dentist? _____ Last visit date: _____

Oral Habits

Please indicate any history of the following:
Taken off bottle at age _____
Y N Thumb / Finger Sucking / Pacifier
Y N Nail Biting
Y N Lip Sucking/Biting
Y N Speech Impairment

Specify if yes to any questions _____
_____
_____

Has the child ever had the following medical problems?

Please indicate any history of the following and write in detail (dates, etc.) below:

Y N Heart Murmur	Y N Hemophilia	Y N Congenital Heart Defect	Y N Shunts
Y N Cancer	Y N Asthma	Y N Convulsions / Epilepsy	Y N Any stays in hospital
Y N Diabetes	Y N Hepatitis	Y N Abnormal Bleeding	Y N Kidney / Liver Problems
Y N Rheumatic Fever	Y N Tuberculosis	Y N Hearing Impairment	Y N Handicaps / Disabilities
Y N HIV+ / AIDS	Y N Anemia	Y N Any Operations	Y N Allergies
Y N Physical or psychological development delay		Y N Other _____	

Please discuss any medical problems the child has had: _____

_____

Child's Physician: _____ Phone #: _____ Last Visit Date: _____

Any current medical complaints? _____

_____

Please list all drugs the child is currently taking: _____

_____

Please list all drugs / latex that the child is allergic to: _____

_____

I understand the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status.

I authorize the dental staff to perform the necessary dental services my child may need. I accept full responsibility for full payment (regardless of my insurance or marital status) of the treatment performed. It is my understanding that two (2) consecutive broken appointments without explanation will lead to dismissal of my child as a clinic patient.

Signature _____ **Date** _____

Relationship to child _____

POS® Reorder # 0624262

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Insurance / Financial Statement

Dental Insurance

Primary Insurance Company

Name of Insured: _____

Insurance Company Name: _____

Phone #: _____

Group #: _____

Secondary Insurance Company

Name of Insured: _____

Insurance Company Name: _____

Phone #: _____

Group #: _____

PLEASE READ THE FOLLOWING CAREFULLY

Payment is due when services are rendered. We accept cash, personal checks, Care Credit and Visa/Mastercard. I understand and agree that regardless of my insurance or marital status I am ultimately responsible for the balance on this account for any professional services rendered. I understand that SWCD files insurance claims as a courtesy to me and that dental insurance is a contract between my insurance and myself and SWCD does not have a contract with my insurance company. We can only assist you in estimating your portion of the cost of treatment, we at no time guarantee what your insurance will or will not do with each claim. We also can not be responsible for any errors in filing your insurance, once again we file claims as a courtesy to you. I assign dental benefit payments to be paid directly to Small World Children's Dentistry, S.C. from my insurance company. I have read the above information and understand my obligations.

Signature of Responsible Party: _____ Date _____

Read Reverse Side ➥

Facts About Insurance

Fact 1 - NO INSURANCE PAYS 100% OF ALL PROCEDURES
Dental insurance is meant to be an aid in receiving dental care. Many patients think that their insurance pays 90%-100% of all dental fees. This is not true! Most plans only pay between 50%-80% of the average total fee. Some pay more, some pay less. The percentage paid is usually determined by how much you or your employer has paid for coverage or the type of contract your employer has set up with the insurance company.

Fact 2 - BENEFITS ARE NOT DETERMINED BY OUR OFFICE
You may have noticed that sometimes your dental insurer reimburses you or the dentist at a lower rate than the dentist's actual fee. Frequently, insurance companies state that the reimbursement was reduced because your dentist's fee has exceeded the usual, customary, or reasonable fee ("UCR") used by the company.

A statement such as this gives the impression that any fee greater than the amount paid by the insurance company is unreasonable or well above what most dentists in the area charge for a certain service. This can be very misleading and simply is not accurate.

Insurance companies set their own schedules and each company uses a different set of fees they consider allowable. These allowable fees may vary widely because each company collects fee information from claims it processes. The insurance company then takes the data and arbitrarily chooses a level they call the "allowable" UCR Fee. Frequently this data can be three to five years old and these "allowable" fees are set by the insurance company so they can make a net 20%-30% profit.

Unfortunately, insurance companies imply that your dentist is "overcharging" rather than say that they are "underpaying" or that their benefits are low. In general, the less expensive insurance policy will use a lower usual, customary, or reasonable (UCR) figure.

Fact 3 - DEDUCTIBLES & CO-PAYMENTS MUST BE CONSIDERED
When estimating dental benefits, deductibles and percentages must be considered. To illustrate, assume the fee for service is $150.00. Assuming that the insurance company allows $150.00 as its usual and customary (UCR) fee, we can figure out what benefits will be paid. First a deductible (paid by you), on average $50, is subtracted, leaving $100.00. The plan then pays 80% of $100.00 or $80.00 leaving a remaining portion of $70.00 (to be paid by the patient). Of course, if the UCR is less than $150.00 or your plan pays only at 50% then the insurance benefits will also be significantly less.

MOST IMPORTANTLY, please keep us informed of any insurance changes such as policy name, insurance company address, or a change of employment.