Medical History

General Health Review: Please review your child's past and present medical history. Mark *only* if your child has the condition now, or has been treated for it in the past.

Allergy: □ Latex □ Drug □ Food □ Other Explain: ______________________________

□ ADHD	□ Cleft lip/Palate	□ Heart Disease
□ Anemia	□ Cold Sores	□ Heart Murmur
□ Asthma	□ Diabetes	□ Hepatitis
□ Autism	□ Downs Syndrome	□ Kidney Disease
□ Asperger Syndrome	□ Epilepsy	□ Liver Disease
□ Blood Disorder	□ Hearing problems/Deaf	□ Respiratory Problems
□ Cancer	□ Heart Disease	□ Recurring Headaches
□ Cerebral Palsy	□ HIV/AIDS	□ Vision Impaired/Blind
□ Social Disorder	□ Mental Delays	□ Physical Delays

□ Other: ______________________________

Is Pre-medication required before dental appointments? Y N ______________________________

Has child ever been hospitalized? Y N ______________________________

Is your child taking any medication? Y N ______________________________

FINANCIAL POLICY:

Thank you for choosing Dr. Brumbaugh and Dr. Shaw for your child's dental care. Our goal is to provide optimal dental care while incorporating proper dental education which allows kids to remain cavity free. We encourage you to ask questions and be involved in treatment decisions. This includes understanding of any treatment plans as well as our financial policy.

Payment is expected when services are rendered. For your convenience we accept Visa, MasterCard, Discover, and American Express, as well as cash or check. We **DO NOT** provide in-office payment plans. If you are in need of a payment option, please see our insurance specialist about applying for a loan thru CareCredit. Any checks returned to our office as Non-Sufficient Funds will be charged a $30.00 fee per check.

As a courtesy to our insured patients, **we file ALL Dental Insurance Plans**, **however**, ***we are ONLY IN-NETWORK with DELTA DENTAL PREMIER!***

Insurance will be filed for all cleaning/exam appointments and you will be billed after your insurance pays for any remaining balance that was not covered. If your child is in need of additional treatment such as fillings, crowns, etc… a **PRE-TREATMENT ESTIMATE** will be provided BEFORE services are scheduled. When arriving for your child's treatment appointment, the out-of-pocket amount will be due. If your insurance has not paid within 90 days of services rendered, you will need to make payment in full to our office and will be reimbursed if/when your insurance pays.

Please indicate your understanding and acceptance of these financial policies by signing below.

Signed: ____________________ Print: ____________________ Date: __________