DENTAL CENTER OF MADISON, S.C.

madisonkidsdentist.com

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7001 Old Sauk Road, Suite 200 • Madison, WI 53717-1010 • 608-833-6545 • Fax 608-833-8516
5116 American Family Drive • Madison, WI 53718-8331 • 608-825-7500 • Fax 608-825-0010
250 N City Station Drive • Sun Prairie, WI 53590 • 608-453-5600 • Fax 608-318-1104

About Your Child

Child's Name: _____

Preferred Name: _____ Gender: _____

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.

Parent/Guardian: _____

_____

Parent/Guardian: _____

_____

Who is Accompanying the Child Today?

Name: _____

Relation to Child: _____

Name of person with legal custody of the child?

_____

Whom may we thank for referring your child?

_____

Other family members seen by us:

_____

_____

Legal Guardian

Parent's/Guardian's Name: _____ DOB ___/___/___

Parent's/Guardian's Employer: _____

Telephone Numbers: Home _____ Cell _____ Work _____

E-mail: _____

Parent's/Guardian's Name: _____ DOB ___/___/___

Parent's/Guardian's Employer: _____

Telephone Numbers: Home _____ Cell _____ Work _____

E-mail: _____

Dental Insurance

Do you have dental insurance? Yes ☐ No ☐

Primary insurance co. name, address, phone. Ins. ID # _____

_____

_____

Subscriber for primary insurance is: _____

Provide us with their name, relationship to patient, social security #, employer and birth date.

_____

_____

Secondary insurance co. name, address, phone. Ins. ID # _____

_____

_____

Subscriber for primary insurance is: _____

If other is checked provide us with their name, relationship to patient, social security #, employer and birth date.

_____

_____

Do you have Wisconsin Medical Assistance? ☐ Yes ☐ No

MA ID# _____

If you have WI Medical Assistance, you are required to bring your child's card to each appointment.

Alternate Contact Information

(Other than legal guardian)

Name: _____

Relation: _____

Home # _____

Cell # _____

Work # _____

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 a 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)*

Currently using bottle? Y N
If no, what age discontinued. _____
Currently breastfeeding? Y N
If no, what age discontinued. _____
Pacifier Y N If no, what age discontinued. _____

Y N Thumb/Finger Sucking
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 ADD/ADHD
Y N Heart Murmur
Y N Cancer
Y N Diabetes
Y N Rheumatic Fever
Y N Physical or psychological developmental delay
Y N Anxiety
Y N HIV+/AIDS
Y N Hemophilia
Y N Asthma
Y N Hepatitis
Y N Tuberculosis
Y N Depression
Y N Anemia
Y N Congenital Heart Defect
Y N Convulsions/Epilepsy
Y N Abnormal Bleeding
Y N Hearing Impairment
Y N Any Operations
Y N Other _____
Y N Shunts
Y N Any stays in a hospital
Y N Kidney/Liver Problems
Y N Handicaps/Disabilities
Y N Allergies
Y N Autism/Autism Spectrum

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: _____

Drug allergies? ❑ Yes ❑ No If yes, indicate specific drugs: _____

Latex allergy? ❑ Yes ❑ No

I understand the information I have given is 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 of the treatment performed. It is my understanding that two (2) consecutive broken appointments without explanation may lead to dismissal of my child as a clinic patient.

FINANCIAL POLICY

Payment is due when services are rendered. We accept cash, personal checks and all major credit cards. We realize that some procedures are more extensive than others and we will be more than willing to work out alternative financial arrangements prior to treatment. I understand and agree that, (regardless of my insurance status or marital status), I am ultimately responsible for the balance on this account for any professional services rendered.

I have read the above information and understand my obligations.

Signature _____ Date _____

Relationship to child _____

Patient Name: _____

DOB: _____

MR #:

Index to Consent – Treatment/Procedures

Date: _____

Access Community Health Centers
Children's Dental Center of Madison (CDC)

ACHC AND CDC GENERAL CONSENT FOR TREATMENT AND ASSIGNMENT OF BENEFITS

1. **Consent:** I consent to receive health care services by my dentist, and any other clinician as advised.

   Services may include:
   - routine diagnostic procedures,
   - radiology and laboratory procedures,
   - medication administration,
   - dental services, and
   - oral surgery services.

I understand that no guarantees have been made to about dental services I receive from Access Community Health Centers (Access) and Children's Center of Madison (CDC) on my condition.

2. **Release of Information:** I understand that all medical records will be kept confidential to the full extent of the law. I authorize Access and CDC to release any necessary information from my medical record to:
   a. Other medical providers who treat me, which could include providers who treat me who are not part of Access and CDC.
   b. Payors, organizations, or insurance companies which are responsible, in whole or in part, for obtaining insurance benefits for me, for billing and/or paying my bill, and for filing appeals of denial of benefits, so that Access and CDC may be paid for the services that I receive.
   c. Companies that Access and CDC use to bill for services.
   d. Independent auditors or review agencies retained by any third-party payors and insurers to analyze the charges for services provided to me.
   e. Improve the quality and cost of care provided to Access and CDC patients through the review of care provided by Access, CDC and its providers.

3. **Valuables:** I understand that Access and CDC are not responsible for any valuables or personal items that I may bring with me to any Access or CDC appointment.

4. **Payment:** I assign and authorize payment for any and all services provided to me at Access and CDC or by Access and CDC providers. Payment will be made directly to Access and CDC from my insurance company or third-party payor including, but not limited to: Medicare, Medicaid, commercial health insurance, automobile no-fault insurance and workers disability compensation insurance. I acknowledge that I am responsible for all reasonable charges, that are not paid by my insurance or any applicable health benefit, related to my care and treatment at Access and CDC or by Access and CDC providers. This means I may need to pay for deductibles, co-payments, or non-covered services. I understand that it is my responsibility to pay Access and CDC for the charges based on services I received despite of any disputes or disagreements between my insurance company and myself.

5. **Receipt of Notice of Privacy Practices and Client Rights:** By signing this form, I acknowledge that I have been offered and/or received the Access and CDC Notice of Privacy Practices. I also acknowledge that any questions I may have had about Access and CDC's privacy practices were answered to my satisfaction.

6. **Telephone/Email:** I authorize Access and CDC to contact me about services, payment for services, scheduling appointments and healthcare operations using text messaging, an automatic telephone dialing system, or prerecorded voice at the telephone number(s) I provide. I understand that my calls may be monitored or recorded for any purpose. If I provide Access and CDC with an email address, I agree to receive email messages from Access and CDC. These emails may contain my health information and may not be encrypted. Unencrypted emails create potential privacy and security risks. If I do not want to receive unencrypted emails, I will not provide my email address to Access and CDC.

By signing below, I agree that (1) I have read this **entire form**, (2) I understand the form and information listed, (3) I have had the chance to ask questions and have had them answered, and I understood the answers, and (4) I agree to comply.

Signature of Patient/Representative: _____ Date: ____/____/____ Time: _____
If signed by person other than the patient, print name and state relationship and authority to do so.

Print Name: _____ Relationship: _____

- Patient is: ☒ Minor ☐ Incompetent/Incapacitated
- Legal Authority: ☐ Legal Guardian ☐ Parent of Minor ☐ Health Care Agent ☐ Other: _____

Access Reviewed by: _____ Date: ____/____/____ Time: _____