



# Maggie N. Davis, D.M.D.

Board Certified Pediatric Dentist

## PATIENT INFORMATION

Patient: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Preferred Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F  
School: \_\_\_\_\_ Grade: \_\_\_\_\_  
Home Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Preferred phone number for confirmation of appointments? \_\_\_\_\_  
May we text message appointment confirmation? If so, which phone number? \_\_\_\_\_  
Email address: \_\_\_\_\_  
Who has legal custody of this patient? \_\_\_\_\_  
Person responsible for payment of account: \_\_\_\_\_ DOB: \_\_\_\_\_  
How did you hear about our dental practice? \_\_\_\_\_  
Reason for today's visit: \_\_\_\_\_  
How do you think your child will respond to dental treatment? \_\_\_\_\_

### MOTHER'S INFORMATION

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Driver's License #: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Cell Phone #: \_\_\_\_\_ Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

### FATHER'S INFORMATION

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Driver's License #: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Cell Phone #: \_\_\_\_\_ Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

## FINANCIAL & INSURANCE INFORMATION

### PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Billing Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Cell Phone #: \_\_\_\_\_ Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

### INSURANCE INFORMATION

Dental Insurance Company: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Insurance Company Address: \_\_\_\_\_  
Name of Insured: \_\_\_\_\_ SSN/ID#: \_\_\_\_\_ DOB: \_\_\_\_\_  
Group/Policy #: \_\_\_\_\_ Employer: \_\_\_\_\_

### \*\*\*IMPORTANT NOTE REGARDING INSURANCE\*\*\*

Dr. Maggie Davis' office will gladly help file insurance estimates & forms, but we are not a 'Participating Provider' for any Insurer and we are considered 'Out of Network'.  
Balances not paid by your insurer are your responsibility.

Initial here to acknowledge:

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## PATIENT MEDICAL QUESTIONNAIRE

Pediatrician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Date of last Dr. Appt: \_\_\_\_\_ Reason: \_\_\_\_\_ Are your child's immunizations up to date? Y N

Y N Has your child ever been hospitalized? If yes, please describe when & why: \_\_\_\_\_

Y N Has your child ever been treated in the emergency room? If yes, please describe when & why: \_\_\_\_\_

Y N Has your child ever had surgery? If yes, please describe when & why: \_\_\_\_\_

Y N Has your child ever had pre-medication with antibiotics before dental appointment?

List all current medications the patient is taking (prescription & over the counter), including the reason for taking the medication:

Please list any known allergies: \_\_\_\_\_

Has your child ever been diagnosed with or treated for the following?

- |                              |                              |                                  |                         |
|------------------------------|------------------------------|----------------------------------|-------------------------|
| Y N Acid Reflux              | Y N Cancer/Tumor/Malignancy  | Y N Heart Murmur                 | Y N Seizure/Epilepsy    |
| Y N ADHD/ADD/Hyperactivity   | Y N Cerebral Palsy           | Y N Hepatitis                    | Y N Sensory Issues      |
| Y N Allergies                | Y N Chemotherapy/Radiation   | Y N HIV/AIDS                     | Y N Sickle Cell Disease |
| Y N Anemia                   | Y N Cleft Lip/Palate         | Y N Kidney Disease               | Y N Sinus Problems      |
| Y N Arthritis                | Y N Developmental Delay      | Y N Latex Sensitivity/Allergy    | Y N Sleep Apnea/Snoring |
| Y N Asthma                   | Y N Down Syndrome            | Y N Liver Disorder               | Y N Speech Delays       |
| Y N Autism/Spectrum Disorder | Y N Diabetes                 | Y N Premature Birth              | Y N Transplant          |
| Y N Birth Defects            | Y N GI/Stomach Disease       | Y N Profound Mental Impairment   | Y N Tuberculosis        |
| Y N Bleeding Problems        | Y N Hearing Impairment       | Y N Psychologic/Nervous Disorder | Y N Vision Problems     |
| Y N Breathing Problems       | Y N Heart Condition/Disorder | Y N Rheumatic Fever              | Y N Other               |

If other, please specify: \_\_\_\_\_

Please provide more information on any of the above marked yes: \_\_\_\_\_

## PATIENT DENTAL QUESTIONNAIRE

What is your main concern about your child's teeth? \_\_\_\_\_

Y N Do you assist your child in brushing his/her teeth? \_\_\_\_\_ Y N Was your child bottle fed? Until what age? \_\_\_\_\_

Y N Does your child use dental floss? \_\_\_\_\_ Y N Was your child breast fed? Until what age? \_\_\_\_\_

Y N Do you or your child have any concerns about the appearance of his/her teeth? Describe: \_\_\_\_\_

Y N Does your child have a current or previous pacifier or thumb/finger sucking habit? \_\_\_\_\_ Until what age? \_\_\_\_\_

Y N Has your child ever had an accident or injury involving the teeth/jaws? When & where? \_\_\_\_\_

Please check below if your child has had problems or concerns with any of the following:

- |                                    |  |   |  |  |
|------------------------------------|--|---|--|--|
| <input type="checkbox"/> Cavities  | <input type="checkbox"/> Gum Infection | <input type="checkbox"/> Grinding/BruXism | <input type="checkbox"/> Tooth Sensitivity | <input type="checkbox"/> Crooked Teeth |
| <input type="checkbox"/> Toothache | <input type="checkbox"/> Canker sores  | <input type="checkbox"/> Jaw Pain         | <input type="checkbox"/> Tooth Color       | <input type="checkbox"/> Missing Teeth |

When was your child's last dental visit? \_\_\_\_\_ When was your child's last dental x-rays? \_\_\_\_\_

Previous dentist's name and phone #: \_\_\_\_\_

Why did your child leave his/her previous dentist? \_\_\_\_\_

Is there something in particular that we should know about your child that may guide us in rendering care for them? \_\_\_\_\_

## FLUORIDE EXPOSURE

Your child drinks water primarily from:  Tap Water [County? \_\_\_\_\_]  Well Water  Bottled Water [Brand? \_\_\_\_\_]

Y N Does your child use toothpaste with fluoride? \_\_\_\_\_ Y N Do you have a reverse osmosis water filter? \_\_\_\_\_

Y N Does your child use a fluoride rinse? \_\_\_\_\_ Y N Does your child take prescription fluoride tablets/drops? \_\_\_\_\_

The information provided in this form is complete to the best of my knowledge. I will notify Dr. Maggie Davis Pediatric Dentistry at future visits if any of the information changes. Person completing this form please print name & relationship to patient.

Print Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# Maggie N. Davis, D.M.D.

Board Certified Pediatric Dentist

## PARENT INFORMATION

Thank you for choosing our pediatric dental office for your child's care. It is our goal to make each child's dental visit a positive experience and to treat every child as our own. Parents are welcome to come back to our treatment area, but both as experienced dental professionals, and—most importantly—as parents ourselves, we recommend parents wait in our reception area as we guide your child through his or her appointment. Similar to a learning environment at school, children are more likely to socialize and interact without a parent present. Dr. Maggie and her staff have excellent communication skills to help your child feel relaxed and we would like the best opportunity to explain, complete, and celebrate your child's successful dental appointment while having fun! With that being said, we understand that every child is unique and we encourage your presence if your child is very young, has special needs or you simply feel your child needs you present. Please let us know at check-in if you wish to come back, as we are happy to accommodate. We only ask that you act as a silent observer and other siblings wait in the reception play area. Should you decide to wait in the reception area but want to check on all the fun your child is having, please ask our front desk staff to bring you back for a 'peek-a-boo' visit where you can observe your child without being in their direct line of sight. At the end of every visit we will always discuss your child's oral hygiene with you and you will have the opportunity to ask as many questions as you would like.

Name of Guardian: \_\_\_\_\_ Signature: \_\_\_\_\_

## APPOINTMENT POLICY

We reserve your appointment time specifically for you! If you need to reschedule, please give us at least 24 hours notice so that we may give someone else the opportunity to use that time. A fee, up to \$67, may be charged for late cancellations (less than 24 hour notice) and/or missed appointments. This fee must be paid before a new appointment is scheduled. After three broken appointments within one year's time, we unfortunately will need to assist you in transferring the patient's records to another dentist. If your child is under the age of 6, we ask that you schedule a morning appointment. Younger children often respond better to new environments when they are well rested.

Name of Guardian: \_\_\_\_\_ Signature: \_\_\_\_\_

## CONSENT FOR TREATMENT

I, the undersigned parent/legal guardian, authorize Dr. Maggie Davis and her staff to examine this child, clean his/her teeth, apply topical fluoride, perform necessary dental treatment, and obtain other records necessary for an accurate diagnosis for my child. I further request and authorize the taking of dental radiographs (x-rays) as may be considered necessary by Dr. Maggie Davis to diagnose and/or treat my child's dental condition. I will allow photographs to be taken of my child and/or my child's teeth for diagnostic or educational purposes only. 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. Maggie will provide an environment likely to help children learn to cooperate during treatment by using praise, distraction and story telling techniques, & child-friendly demonstration of procedures and instruments.

Name of Guardian: \_\_\_\_\_ Signature: \_\_\_\_\_

## FINANCIAL POLICY

- **Payment is due in full** at the time service is provided. Please be aware that the adult accompanying the child to our office is responsible for payment of all charges. In situations of divorce we are unable to serve as a mediator to your financial arrangements, but will rely on you to handle discussion of parental payment responsibility outside of our offices. We are happy to provide a detailed statements and other financial information to help families work through such issues. Our office accepts cash, personal checks, MasterCard, Visa, Discover, and CareCredit. Returned checks will be subject to additional fees. In the unfortunate event that it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection or legal fees including a surcharge of up to 35%.
- **Dental Insurance:** We are dedicated to providing all our patients with the *finest treatment available* and base our treatment recommendations on what will be best for your child and not what your insurance company does or does not pay. Please read the following in regards to your dental insurance coverage.
  - We must emphasize that as your dental care provider, our relationship is with you and not your dental insurance company. Your dental insurance is a contract between your employer and the insurance company. The percentage covered is determined by how much your employer has paid for coverage or which level plan you have chosen.
  - As a courtesy, we will be happy to file your insurance benefits. **Any amount determined not to be covered by your insurance company is payable at the time services are rendered;** these fees may include deductibles, co-payments, certain procedures not covered by your insurance policy, and the difference between our fees and the amount covered by your insurance company.
  - In the event your insurance carrier will not reimburse our office directly, you will be responsible for the full cost of visits at the time services are rendered and your insurance company will send you the reimbursement check directly.
  - As a courtesy, our office will contact your insurance company ahead of time to obtain a Pre-Treatment Estimate if you provide our office with accurate insurance information five (5) days prior to treatment. If we are not able to obtain an accurate estimate prior to your appointment time, please be prepared to pay a \$35 copay at checkout. After the insurance claim is paid, we will either bill or credit you any remaining balance on the account. Please understand that a Pre-Treatment Estimate is not a guarantee that your insurance will pay exactly as estimated. Please be understanding of the fact that some insurance companies do not release exact figures by design and instead only provide us with a range.
  - Our practice is committed to providing the best treatment for our patients and our fees are usual and customary for our area and for the specialty of Pediatric Dentistry. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates (UCR).
  - We will allow a maximum of 30 days for your insurance company to clear account balances. If payment is not received, your claim is denied, or if there is any unpaid portion, you will be responsible for paying this balance in full after this period. Outstanding balances will be assessed at a rate of 1.5% monthly percentage (18.00% APR) to accounts over 30 days past due.
- **Nitrous Oxide ('Laughing Gas'):** You have chosen a Pediatric Specialist for your child so that we can create the most comfortable setting for your child's dental treatment. Nitrous oxide is sometimes used to achieve this goal, but unfortunately it is not always covered by dental insurance. We thank you for your payment on the date of service.
- **Dental Appliances:** The entire cost of the orthodontic or space maintenance appliance must be paid on the day your child's impressions are taken. This is necessary because our office must pay the laboratory bills when appliances are ordered, not when they are completed.
- **Emergency Treatment:** All emergency treatment must be paid in full at the time the service is rendered. We will of course then submit the insurance claim and any insurance payment will result in a credit to your account, which can then be mailed to you.
- **Past Due Accounts:** If your account becomes past due, we will take necessary steps to collect this debt. An interest fee of 1.5% will be charged for all debts 30 days past due. If we have to refer your account to a collection agency, you agree to pay all our incurred collection costs.

Please remember, even if you have insurance coverage, you are responsible for payment of your account. Please realize that your insurance coverage is a relationship between you, the insured patient, and your insurance company. Your understanding and cooperation with this matter is greatly appreciated. Your understanding of our policies frees our staff to provide timely care to your child while keeping our fees as low as possible. We thank you for the opportunity to serve your child's dental health care needs and welcome any questions you may have concerning your child's care or our financial policy.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MAGGIE N. DAVIS, D.M.D., LLC. I UNDERSTAND THAT RESPONSIBILITY FOR PAYMENT FOR DENTAL SERVICES PROVIDED IN THIS OFFICE FOR MY DEPENDENT IS MINE, DUE AND PAYABLE AT THE TIME SERVICES ARE RENDERED. I FURTHER UNDERSTAND THAT A FINANCE, REBILLING, COLLECTION CHARGE AND/OR ATTORNEY FEE WILL BE ADDED TO ANY OVERDUE BALANCE.

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Date: \_\_\_\_\_ Signature: \_\_\_\_\_





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tel: 727.786.7551  
fax: 727.784.7644

**PARENT/GUARDIAN: COMPLETE THIS FORM**

**IF A NON-PARENT WILL BE BRINGING YOUR CHILD**

**TO DR MAGGIE'S OFFICE**

WHENEVER WE PROVIDE YOUR CHILD WITH DENTAL CARE WE REQUIRE YOUR PERMISSION. IF YOU ARE NOT WITH YOUR CHILD THEN WE NEED YOUR SIGNED AUTHORITY TO RELY ON YOUR DESIGNATED PERSON(S) TO SEEK DENTAL CARE FOR YOUR CHILD IN YOUR ABSENCE. THOSE NAMED HERE ARE ALSO ELIGIBLE FOR PATIENT INFORMATION AS DESCRIBED IN THE NOPP/PHI ACKNOWLEDGEMENT.

LET US KNOW WHO YOU DESIGNATE BY COMPLETING THIS FORM.

REGARDING PATIENT:

\_\_\_\_\_

As \_\_\_\_\_'s parent/legal guardian, I give permission for Dr. Maggie Davis, DMD to accept the authority of the following person(s) in my absence for dental treatment of my minor child. I understand that no treatment can be given in my absence without this statement or a similar written statement of permission. I hold Dr. Maggie Davis DMD LLC harmless in using this consent for treatment, and acknowledge that this is valid until revoked by me in writing. I am responsible for all charges in connection with the treatment rendered. With this consent Dr. Davis is also authorized to share medical and /or billing information with these same individual(s)

I authorize: \_\_\_\_\_ Relationship \_\_\_\_\_

I authorize: \_\_\_\_\_ Relationship: \_\_\_\_\_

I authorize: \_\_\_\_\_ Relationship: \_\_\_\_\_

I authorize: \_\_\_\_\_ Relationship: \_\_\_\_\_

Date \_\_\_\_\_ Signature \_\_\_\_\_  
(circle one): parent legal guardian other \_\_\_\_\_

3840 Tampa Road, Palm Harbor, FL 34684