PEDIATRIC DENTISTRY OF PLEASANT HILL

AMYBETH HARMON, D.D.S.
DIPOMATE, AMERICAN BOARD OF PEDIATRIC DENTISTRY

ROBERT L. HARMON, D.D.S.
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Dear Parent,

Welcome to Pediatric Dentistry of Pleasant Hill. We are looking forward to meeting you and your child at your scheduled appointment.

As pediatric dental specialists, we are committed to improving the oral health of children. Our goal is to provide thorough and quality care while promoting a positive attitude toward dentistry. Equally dedicated to this goal are the members of our staff. Your child's visit to our office will be a unique and pleasant experience.

In preparing your child for this visit, a simple statement the day before might be, "Tomorrow we are going to meet your new dentist. She/he especially likes children and will look at your teeth and bright smile." Please avoid fearful stories and anxiety producing words such as "hurt", "pain", "pull" and "shot." Instead, tell your child we will explain all procedures and will answer his/her questions. Treat this appointment in a matter-of-fact way and so will your child. Remember, you can easily transmit your past dental fears. Do not hesitate to let us know if you have any special concerns.

Enclosed is a health history form. Please fill it out completely and bring it with you the day of the visit. If you have dental insurance, please provide us with the social security number of the insured parent, the name of your insurance company, their address and your group number.

For a preview of our office, dentists, staff and helpful information, please view our web site at Phkidsdentist.com. Again, welcome to our pediatric dental practice. We look forward to meeting you and your child.

The Doctors and Staff of
Pediatric Dentistry of Pleasant Hill

2710 PLEASANT HILL ROAD • PLEASANT HILL, CALIFORNIA 94523 • 947-1188 • FAX 947-0252
Phkidsdentist.com

PEDIATRIC DENTISTRY OF PLEASANT HILL

2710 Pleasant Hill Road • Pleasant Hill, CA 94523• 947-1188 • Fax 947-0252

Child's Name ______________________________ Nickname ________ Sex (F) (M) Birthdate ________
First Middle Last

Purpose of visit ________________ Concerns ________________ Last dental visit________

Name and age of brothers and sisters________________ Is your child adopted? ________

Child's Interests ________________ Name of pet ________

Child's attitude toward previous dental care ________________ Any phobias________

Does your child have any special needs?________________

Child's learning: slow_____ average _____ accelerated ______ Child's previous dentist________________

Family Dentist ________________ Who may we thank for referring you to us?________________

Health History

Child's Pediatrician ________________ Phone number ________ Last Physical ________

Is your child under a physician's care now?______ Reason________________ Has your child received all immunizations? ______

Is your child taking any medication or drugs?____ What kind ________ Reason ________________

Has your child ever been hospitalized?_________ Reason ________________

Is your child allergic to any medications?___________ Please list ________________

Does your child have allergic reaction to: eggs_______soy _________foods_______pollen_____dust________latex________animals________other__________

Does your child have any of these habits: finger/thumb sucking______pacifier_____lip sucking__mouth breathing__________snoring________teeth grinding_____

Has your child had any injuries to teeth, mouth or head?___________Describe________________

Has your child had a history or difficulty with any of the following:

YES	NO		YES	NO		YES	NO		YES	NO	
____	____	Premature Birth	____	____	Earaches	____	____	Speech Disorder	____	____	Nosebleeds
____	____	Heart	____	____	Kidney	____	____	Hearing	____	____	Asthma
____	____	Seizures	____	____	Bleeding	____	____	Brain injury	____	____	Liver
____	____	Immune disorder	____	____	Cerebral Palsy	____	____	Bruising	____	____	Bone disorder
____	____	Allergy to medication	____	____	Anemia	____	____	Bladder	____	____	Rheumatic fever
____	____	Diabetes	____	____	Motion sickness	____	____	Fainting or dizziness	____	____	Cancer or malignancies
____	____	Hepatitis	____	____	Delayed Development	____	____	Emotional or school problems	____	____	Tuberculosis
____	____	Autism	____	____	ADD/ADHD	____	____	Any medical condition not on this form			

How may we help to make this visit a positive experience for your child?________________

____

GENERAL INFORMATION

Father (full name) ________________ SS No. ________ Birthdate ________ Drivers License No.________

Mother (full name) ________________ SS No.________ Birthdate________ Drivers License No.________

Single ________ Married ________ Divorced ________ Child resides with: both parents ________ mother ________ father ________

Home address________________ Phone________
Street City Zip

Father employed________________ Phone________
(if self, please state business name)

Business address ________________ Cell Phone ________
Street City Zip

Mother employed ________________ Phone________
(if self, please state business name)

Business Address________________ Cell Phone ________
Street City Zip

Email address ________________ Person financially responsible for child's dental care________________

Relative not living with you________________
Full Name Street City State Zip Phone

The permission of parent or guardian is necessary for dental treatment of a minor. I give the dentist permission to use such measures as deemed necessary in his/her professional judgement to render the best dental treatment for my child. I understand, a late charge of 1 1/2% per month, or a minimum monthly late charge of $10.00 will be added to unpaid balances over 30 days past due and where appropriate, credit bureau reports may be obtained.

SIGNATURE ________________ Relationship________ Date ________

INSURANCE INFORMATION

Do you have dental insurance coverage for this child?________

Father's Insurance: Name of insurance company________________ Group No. ________

Address of insurance company ________________ Zip ________

Mother's Insurance: Name of insurance company________________ Group No.________

Address of insurance company ________________ Zip ________

I hereby authorize payment to the above named dentist of the group dental benefits, otherwise payable to me but not to exceed the charges shown on the claim. I understand I am financially responsible for any charges not covered by my insurance or by this authorization.

SIGNATURE ________________ RELATIONSHIP________________DATE________

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CREDIT POLICY

Welcome to our dental office for children! It is our primary goal and responsibility to help our patients obtain good dental health and we wish to direct our time and energy toward obtaining that goal. We have prepared this letter so you may be aware of our credit policy.

Payment in full is expected at the time of treatment. When this is not possible, financial arrangements must be made prior to treatment. We accept all major credit cards for your convenience.

A late charge of 1 ½% per month, or a minimum late charge of $10.00 will be added to unpaid balances over 30 days past due.

DENTAL INSURANCE

Patients with dental insurance must provide accurate and complete insurance information so we may assist you in filing your dental claims promptly. You will be required to pay your portion the day of treatment. **Remember that professional services are rendered and charged to the patient and not to the insurance company.**

Even though you may have insurance claims pending, you will receive a statement each month for the outstanding balance on your account. We cannot accept responsibility for collecting insurance claims or for negotiating a disputed claim. Insurance reimbursement is a contract between you and your carrier. You are responsible for payment of your account within the usual limits of our credit policy. If your insurance does not pay within 60 days we shall expect payment in full from you.

If you have any questions we will, of course, assist you. Your eventual reimbursement will be determined by your insurance carrier.

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