WE KNOW YOU HAVE A CHOICE…
THANKS FOR CHOOSING US!!

CHILD FORMS THROUGH AGE 17

Date: _____

PATIENT INFORMATION

Last Name: First Name: MI:

Date of Birth: Preferred Name: Gender Identification: □ M □ F □ Other

Mailing Address:

Responsible Party's Phone Number:

PARENT OR GUARDIAN INFORMATION

Parent/Guardian 1:

Name: Date of Birth: SSN:

Cell: Work: Email: Relationship:

Insurance Information:

Plan Name: Group Number Member ID:

Parent/Guardian 2:

Name: Date of Birth: SSN:

Cell: Work: Email: Relationship:

Insurance Information:

Plan Name: Group Number Member ID:

ALTERNATE EMERGENCY CONTACT:

1310 Belmont Avenue, Suite 301 **Salisbury, Md. 21804** **410-742-3000**

CHILD HEALTH INFORMATION

Primary Care Physician: Phone #

Pharmacy: Phone #

Date of last well check: _____

Has your child been hospitalized within the past 2 years? If so when and why:

_____

Does your child take any medications (prescription or over the counter)?

_____

Has your child had any surgeries?

_____

Please list any allergies to medications/food/other:

_____

Please List ANY medical conditions:

_____

_____

Does your child use fluoride? ☐ Yes ☐ No If Yes, ☐ Rinse ☐ Tablet

Does or did your child have a finger sucking/pacifier habit? Yes ☐ No ☐ If yes, what age did it stop? ____

Is your child prone to ear Infections? Yes☐ No☐ If yes, how many in a year?____

Were tonsils removed? Yes☐ No☐ If yes, at what age? ____

Were adenoids removed? Yes☐ No☐ If yes, at what age? ____

Did your child have tubes placed in their ears? Yes☐ No☐ If yes, at what age? ____

Is your child being treated by an orthodontist? Yes☐ No☐ If yes, doctor's name?_____

What type of water does your child usually drink? (Circle) Tap Well Filtered Bottled

Any additional information that may help us in caring for your child:

_____

_____

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FINANCIAL AGREEMENT

The statements below must be READ and INITIALED prior to your appointment. Failure to do so may result in refusal of treatment.

1) I acknowledge that if my account becomes delinquent and goes to collections, all applicable collection fees will become my responsibility. _____(initial)
2) I acknowledge that if a check is returned from the bank, I will be charged a $30 fee. _____(initial)
3) I understand that I am responsible for all fees incurred by me or dependents on my account at Delmarva Dental Services. Any amount not paid by the insurance company will become my responsibility and I will pay the balance promptly. _____(initial)
4) Except in the case of an emergency, I acknowledge if I cancel an appointment with less than 24 hours' notice or do not appear for my appointment there will be a $50 fee applied to my account. _____(initial)

The medical information I have provided is complete and accurate to the best of my knowledge. I have not knowingly withheld information and have had the opportunity to ask questions and receive answers regarding this medical profile.

Responsible Party: □ Parent □ Guardian

(Please print)

Signature: □ Date

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Joseph P. Harmon, D.D.S. Leigh D. Auchey, D.D.S.
Jessica A. Harrison, D.D.S.

Delmarva Dental Services is Out-Of-Network with ALL insurance carriers.

What does this mean?

Our office is non-contracted with ALL insurance companies. Some plans require you to go to a contracted office. If your plan is like this, they will not pay anything for your visits with us.

Some dental plans allow you to go to any dentist you choose, however, your out-of-pocket costs are usually higher.

Information about insurance payments:

If your insurance does not pay us directly, we will collect the full fee from you. As a courtesy, we will send the claims to your insurance company, and you will receive the amount that they are going to reimburse directly from them.

If your insurance sends payment to us, we will estimate what they will pay towards the visit and collect your portion at that time. If the insurance pays less than what we estimated, we will send you a bill. If the insurance pays more than what we estimated, we will reimburse you in check form or you can leave it on your account here for future visits.

I acknowledge I have read the above information regarding my insurance plan and understand that Delmarva Dental Services is out-of-network with ALL insurance.

I also acknowledge that once my insurance payment has been received, any remaining balance is my responsibility, and payment is due in a timely manner.

Name: Date:

(Please print)

Signature:

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