



Children's Dental Care
Badrieh Edalatpour, D.M.D.
Pediatric Dentistry

Dear New Patient:

Dental insurance is one of the most beneficial and most misunderstood factors in dental treatment today. This explanation will attempt to clear up many common misconceptions about dental insurance.

Dental insurance is a contract between the employer, the patient, and insurance company. It has NO CONNECTION at all to the provider of dental treatment (i.e. the dentist). The extent of coverage varies greatly from company to company, and sometimes within a company. It has absolutely nothing to do with the level of service provided by the dentist and the fee charged for those services.

An often mistaken term used by many insurance companies is "UCR." This is an arbitrary fee ceiling at which the insurance company will stop reimbursement. After this ceiling, coverage for particular procedure will cease. Again, this has nothing to do with the fee charged, but with the level of coverage negotiated by your employer.

We will make every effort possible to assist you with your particular insurance coverage. Although it is not required, we will prepare and submit your insurance claim form at no cost as a courtesy to our patients. We will also provide and estimate that will show expected insurance reimbursement and patient co-payments for every procedure. The patient share will be due at time of treatment unless prior arrangements have been made. Should our estimate of the patient's share be too high, a refund will be made at the time of the payment from the insurance company. Likewise, if the estimate was low, the remainder will be due by the patient at that time. Should no insurance payment be made within ninety days of a submitted claim, the fee will become the sole responsibility of the patient.

If you have any further questions concerning dental insurance please call our receptionist and they will be happy to assist you.

Please sign and date below acknowledging your understanding of and agreement to the above.

Patient signature

Date



Children's Dental Care
Badrieh Edalatpour, D.M.D.
Pediatric Dentistry
370 Main ST
Stoneham, Ma 02180
781-438-0300

General Informed Consent

We are asking you to read and sign the following. It means you understand the recommended treatment plan or alternative treatment plans that have been presented to you.

I, the patient of record have been informed by the dentist of the need to undergo dental oral medicine treatment as presented to me, and the relevant information regarding my treatment has been read by me and explained to me. I have been fully informed about the diagnosis, details and estimated costs of recommended treatment and alternatives. I agree I understand that as treatment proceeds there may be a need to change the treatment plan. If this occurs, I expect to be informed before any change is instituted.

I have been informed that success of treatment depends upon my cooperation in keeping schedule appointments, following home care instructions including oral hygiene and dietary instructions, taking prescribed medications, and reporting to my dentist any changes in my health status. I acknowledge that I have not made any warranties or guarantees concerning treatment or its long term success.

If the patient is under 18 years or incompetent to consent, a parent or legal guardian must sign this general informed consent.

Patient Name: _____

Parent's Name: _____

Date: _____

Case History Information

Child's Name..... Nickname

Date of Birth Home phone #

Address Town State Zip

Father's Name Occupation Work Phone #

E-mail Address Cell Phone #

Mother's Name Occupation Work Phone #

E-mail Address Cell Phone #

Siblings

Primary Dental Ins. Group # Ins. ID No.

Name of Policy Holder Title

Subscriber's S.S.# Subscriber's Birth Date

Secondary Insurance, if any

How did you hear about us?

Child's Health History

Primary Physician Phone

Has your child ever been hospitalized? If yes, please explain:

Reason Date

Does your child have any history of the following? If yes, please check:

Asthma	Kidney/Liver Problems	Epilepsy
Rheumatic Fever	Bleeding Disorders	Diabetes
Heart Trouble	Hyperactivity	Allergies
Heart Murmur	Lead Poisoning	Others

If your child is currently taking any medication, please list:

If your child has ever experienced any unfavorable reaction to medication, ie: Penicillin, Aspirin, Anesthetic or other, please explain

Is this your child's first dental visit? Yes No

Reason for visit: Emergency Cavity Exam Other

If there are any health or other problems that should be brought to the attention of the doctor, please describe:

Signature of parent or legal guardian Date

Continued on the next page

Children's Dental Care CORP.
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Stoneham, MA, 02180
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Fax: (781)438-0336

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Stoneham, MA, 02180
Tel: (781)438-0300
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**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF
PRIVACY PRACTICES**

You May Refuse to Sign This Acknowledgment

I,, have received a copy of this
office's Notice of Privacy Practices.

.....
Please Print Name

.....
Signature Date

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice
of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Other (please specify)

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We take pride in getting to know our families; we may ask some unusual questions. Please answer all or some of the following questions, thank you.

What is most important to you in your child's dental care?

Time

Money

Relationship with the Dentist

Quality

Comfort

Other:

What has to happen in order for you to feel happy with child's dental care?

What's most important to you in your child's relationship with their dental team?

How do you feel about going to your children's dentist?

Thank you for your time and patience with us in understating how to take care of you better.