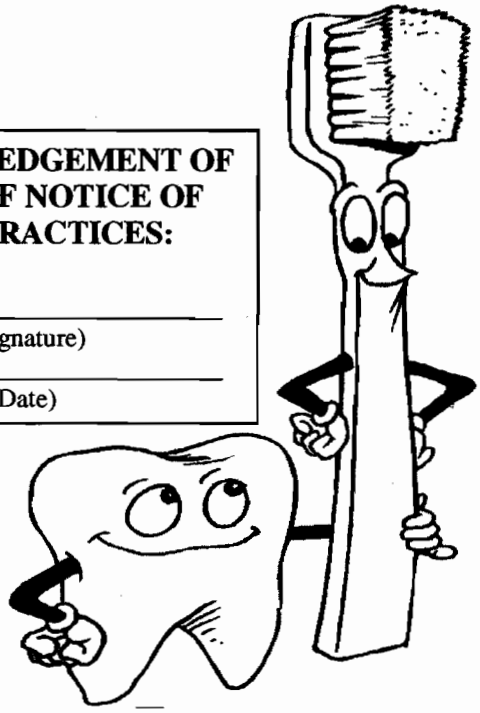
PRINT

Family Dentistry!

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

_____
(Signature)

_____
(Date)



About Your Child

Name:_____

Birthdate:_____

☐Male ☐Female Age:____

SS#:_____

Home Address: _____

_____

City:_____Zip:____

Home Phone: _____

Referred By: _____

About You

Name:_____

Birthdate:_____

SS#:_____

Relationship to child: _____

Home Address: _____

_____

City:_____ Zip:_____

Occupation: _____

Employer: _____

Work Phone: _____ Ext:___

Cell Phone: _____

Insurance Information

Dental Ins. Co.: _____

Insurance Co. Phone #: _____

Group/ Policy #: _____

<u>This Dental Insurance is provided through:</u>
Policy owner's name: _____

Relationship to child: _____

Policy owner's SS #: _____

_____

Policy owner's birthdate: _____

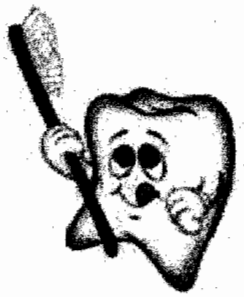
Policy owner's employer:

_____

*if secondary insurance, please ask for additional form.

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA and the ADA.

Dental/Medical History



Has your child been to the dentist before? **Y N**☐
If yes, the approximate date of last visit: _____
Are there any dental problems that you are aware of at present? **Y N**☐
If yes, please explain: _____
Does your child brush his/her teeth daily? **Y N**☐
Is your child currently under the care of a physician? **Y N**☐
Child's Physician: _____
Physician's Phone #: _____
Is your child allergic to any drugs? **Y N**☐
If yes, please list: _____
Is your child taking any prescription drugs? **Y N**☐
If yes, please list: _____
Does your child need to be premeditated before dental treatment? **Y N**☐

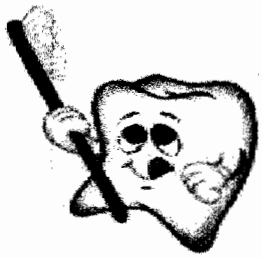
Has your child ever had any of the following medical conditions or problems?
Any hospital stays **Y N**☐
Operations **Y N**☐
Bleeding Problems of Any Kind **Y N**☐
Cancer **Y N**☐
Convulsions/Epilepsy **Y N**☐
Diabetes **Y N**☐
Hearing Impairment **Y N**☐
Heart Murmur **Y N**☐
Heart Problems of Any Kind **Y N**☐
Hemophilia **Y N**☐
HIV+/ AIDS **Y N**☐
Hyperactive **Y N**☐
Rheumatic/ Scarlet Fever **Y N**☐
Are there any medical conditions or problems relating to your child? **Y N**☐
If yes, please list: _____

In the event of an emergency, whom should we contact?
Name: _____ Relationship: _____
Phone: _____ Phone #2: _____

Update *Office Use Only	
_____ initials	__/__/____ date
_____ initials	__/__/____ date
_____ initials	__/__/____ date
_____ initials	__/__/____ date
_____ initials	__/__/____ date
_____ initials	__/__/____ date

Please understand that the information that I have given is correct 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.
The parent or guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.

Signature of parent or guardian: _____ Date: ____/____/_____



Insurance Agreement

To our patients who are requesting that this office carries a balance on their account, to be paid by an insurance company.

This form must be read and signed by the patient or responsible party before we can accept payment directly from an insurance company.

1) I understand and agree that I am responsible for the payment of all treatment fees on my account. If my insurance company fails to pay within 90 days I will be responsible for the full amount.

2) I understand and agree that the amount estimated to remain unpaid by insurance is to be paid by me during treatment.

3) I understand that this office cannot make a totally accurate estimate of the insurance benefits to be paid for me, since it does not have access to all insurance company records.

4) I understand that after the insurance company pays, there could be a balance still remaining to be paid to me.

5) I understand and agree that if upon payment by the insurance company, there is a remaining balance; it is due to be paid in full by me at that time.

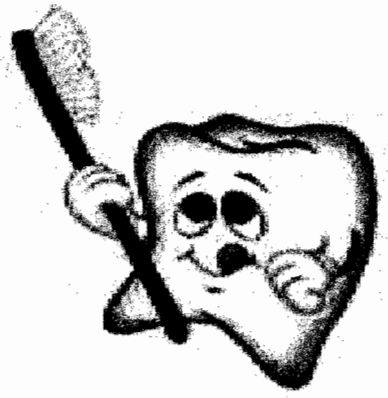
Signature: _____ Date: ____/____/_____

Family Dentistry!

Our mission is to deliver the finest, most cost-effective healthcare treatment available today. Following diagnosis, the doctor will advise you of the recommended treatment plan. In addition, we will discuss with you the cost of today's visit and the cost of future treatment.

Payment for services is due and payable at the time the services are rendered. We are sensitive to the fact that some people may not be able to pay cash for their treatment; therefore, we offer several alternative payment programs for your convenience. They are:

1. Cash or Check (with Bank Guarantee Card)
2. Visa or MasterCard
3. American express
4. Discover
5. Care credit



Appointment times are reserved specifically to meet your needs. If for any reason you are unable to keep your reserved appointment time, 24-hour advance notice is required to avoid being charged. Broken appointment fees vary between $20.00 - $75.00.

Signature: _____ Date: ____/____/_____