Welcome to Pediatric Dentistry!

We strive to make each of your child's visits pleasant and comfortable. Our goal is to teach your child oral habits which will help keep their smile beautiful for their lifetime.

PATIENT # _____

DATE _____

How did you hear about us?

- ❑ Advertisement
- ❑ Friend
- ❑ Your Doctor
- ❑ Your Dentist
- ❑ Other

Name _____

Your Child

Name _____
Nickname _____ Sex _____ Age _____ Grade _____
Birthdate _____ School _____
Child's Home Address _____
City, State, Zip _____ Phone (____)_____
Who to Contact in Case of Emergency: Name _____
Relationship to patient _____ Phone (____)_____

Mother

Name _____
Address _____
City, State, Zip _____
Home Phone _____
Work or Cell Phone _____
Social Security # _____
Employer _____
Occupation _____
Birthdate _____

Stepmother/Guardian

Name _____
Address _____
City, State, Zip _____
Home Phone _____
Work Phone _____
Social Security # _____
Employer _____
Occupation _____
Birthdate _____

Father

Name _____
Address _____
City, State, Zip _____
Home Phone _____
Work or Cell Phone _____
Social Security # _____
Employer _____
Occupation _____
Birthdate _____

Stepfather/Guardian

Name _____
Address _____
City, State, Zip _____
Home Phone _____
Work Phone _____
Social Security # _____
Employer _____
Occupation _____
Birthdate _____

Siblings

Name Age

_____
_____
_____
_____

Parents Marital Status

❑ Single ❑ Divorced ❑ Separated
❑ Married ❑ Widowed

Who is responsible for making appointments

Name _____ Phone_____
Work Phone _____ Ext _____
Best Time to call _____
(Time) (Days)

Verbal confirmation is required to reserve appointments.

24 Hours Notice Required for Changing or Cancelling Appointments

Primary Dental Insurance

Insured's Name _____ Address if Different from Child _____
Phone _____ Relationship _____ Birthdate _____ Social Security # _____
Employer _____ Date Emp. _____ Occupation/Dept. _____
Insurance Co. & Address _____ Group # _____ Emp. # _____
Ins. Co. Phone _____ Deductible _____ Amount Already Used _____ Max annual Benefit _____
Orthodontic coverage ❑ Yes ❑ No

Secondary Dental Insurance

Insured's Name _____ Address if Different from Child _____
Phone _____ Relationship _____ Birthdate _____ Social Security # _____
Employer _____ Date Emp. _____ Occupation/Dept. _____
Insurance Co. & Address _____ Group # _____ Emp. # _____
Ins. Co. Phone _____ Deductible _____ Amount Already Used _____ Max annual Benefit _____
Orthodontic coverage ❑ Yes ❑ No

Additional Dental Insurance

Insured's Name _____ Address if Different from Child _____
Phone _____ Relationship _____ Birthdate _____ Social Security # _____
Employer _____ Date Emp. _____ Occupation/Dept. _____
Insurance Co. & Address _____ Group # _____ Emp. # _____
Ins. Co. Phone _____ Deductible _____ Amount Already Used _____ Max annual Benefit _____
Orthodontic coverage ❑ Yes ❑ No

CONTINUED ON BACK

No Changes/Date_____

Authorization, Release, and Agreement to Pay For Service Rendered

I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

If I have dental insurance, I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependents during the period of such dental care to third party payors and/or other health practitioners.

I authorize and hereby request my insurance company to pay directly to the dentist (or dental group) insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services and I am responsible for any balance even if they pay nothing.

I authorize any employment and credit checks that are necessary. I agree that all information on this form is correct to the best of my knowledge.

Please note the following:

If you are married, your spouse must sign below, **or**

Any of the following must also sign below: guardian, divorced parent, step-parent, grandparent, other responsible party

In the case of a minor child with divorced parents, we need the signatures of both parents.

We must have all required signatures or we will be unable to bill your insurance. Therefore, payment will be due in full on date of service and you will need to get reimbursed from your insurance company.

x_____ _____

Signature of parent — Date

x_____ _____

Signature of spouse (or other parent) — Date

x_____ _____

Signature of guardian or other responsible parties — Date

Financial Arrangements

Payment is to be paid in full at each appointment. If you have dental insurance, your deductible and patient portion is due on date of service. Please keep in mind that we can only estimate your insurance and it is not a guarantee of payment. You are responsible for any balance. If you are sending a minor child in by themselves or with a friend or relative, you will need to send payment with them.

For your convenience, we offer the following methods of payment.

____ Cash ____ Personal Check

_____ Visa _____ MasterCard _____ Discover Card

Card # _____ Expiration Date _____ _____

Signature

For larger balances, our outside financing companies are American General and Norwest Financial. You may make monthly payments for up to one year with no interest or finance charges. You pay back only the amount that you borrow. Ask for an application if you are interested. You must be pre-approved.

If you have any questions concerning financial arrangements, please ask for assistance.

Late Charges

If there is any remaining balance after your insurance company pays, the balance is due upon receipt of statement. A service charge of 1.5% will be added after 30 days on any unpaid balance and will be assessed each month. Failure to keep this account current may result in our being unable to provide additional dental services to you except for dental emergencies or you may be required to pre-pay for any future services. In the case of default of payment on this account, you will be responsible for and billed for all collection costs, court fees and attorney fees incurred in collecting this amount or any future outstanding account balances.

MISSED OR CANCELLED APPOINTMENTS

Every effort is made to keep on schedule, so we ask our patients to be prompt and to keep their appointments. We try to remind patients by telephone prior to their appointment, but please do not depend on this courtesy. If we are unable to contact you, your appointment card will serve as the confirmation of your appointment and implies your obligation to be present. That time has been reserved especially for you. We have an extensive list of patients who are waiting for an appointment. If you need to change your appointment, **we require at least 48 hours notice to avoid a charge for lost time**. Exceptions to this rule can be determined only on an individual basis according to circumstances. Repeated instances of missed appointments may result in you being asked to pre-pay for your appointment or you may be dismissed from our practice.

Thank you for taking the time to fill out this form completely and making yourself familiar with our office policies. Our goal is to provide you with a positive, comfortable and satisfying dental experience as one of our valued patients. The information you have provided will help us to serve your dental healthcare needs more effectively and efficiently. If you have any questions at any time, please ask us. We are always happy to help.

Patient Initials _____