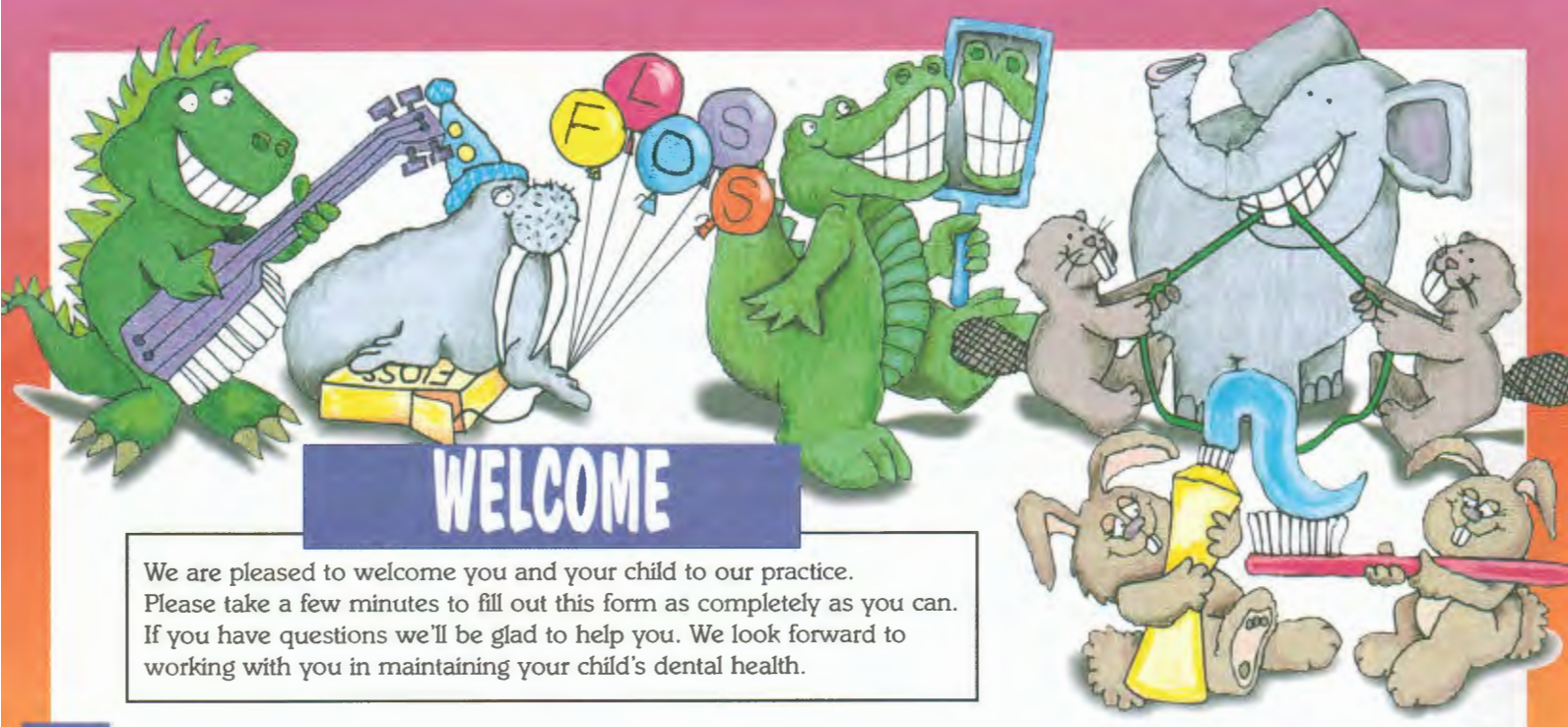

WELCOME

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.

PATIENT INFORMATION

Date _____ SS/HIC/Patient ID # _____ Birthdate _____

Name of Minor/Child _____ Sex ☐ M ☐ F Age _____
Last Name First Name Middle Initial

Nickname _____ Hobbies _____ Phone (____) _____

Home Address _____
Street City State Zip

Mailing Address _____
Street City State Zip

School Name _____ School Phone (____) _____

Person financially responsible _____ Home (____) _____ Work (____) _____

Whom may we thank for referring you? _____

INSURANCE

Father's/Guardian's Name _____

Address (if different from patient's) _____

Home (____) _____ Work (____) _____
(if different from above) (if different from above)

E-mail _____

Employer _____

Soc. Sec. # _____ Birthdate _____

Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name _____ Phone (____) _____

Address _____

Group # _____ Policy # _____

Mother's/Guardian's Name _____

Address (if different from patient's) _____

Home (____) _____ Work (____) _____
(if different from above) (if different from above)

E-mail _____

Employer _____

Soc. Sec. # _____ Birthdate _____

Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name _____ Phone (____) _____

Address _____

Group # _____ Policy # _____

Is your child eligible for treatment under Medical Assistance? ☐ Yes ☐ No Child's Medical Assistance I.D. # _____

DENTAL HISTORY

Date of last visit to a dentist _____ For what service? _____

	YES	NO
Has child complained about dental problems?	☐	☐
Does child brush teeth daily?	☐	☐
Does child use floss every day?	☐	☐

	YES	NO
Is fluoride taken in any form?	☐	☐
Any injuries to mouth, teeth, head?	☐	☐
Any unhappy dental experiences?	☐	☐

Any mouth habits - thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc? ☐ ☐

MEDICAL HISTORY

Minor/Child's Physician _____ City/State _____ Phone (____) _____

Date of last physical examination _____ Results _____

	YES	NO
Is Minor/Child under care of physician now?	☐	☐
Receiving any medication or drugs?	☐	☐
Ever been hospitalized?	☐	☐
Ever had surgery?	☐	☐
Is there excessive bleeding when cut?	☐	☐

Medications _____

_____

_____

Allergies _____

_____

Has minor/child had any history of or difficulty with any of the following? If yes, please check (✔).

☐ A.I.D.S./H.I.V.	☐ Cerebral Palsy	☐ Epilepsy	☐ Kidney Disease	☐ Rheumatic Fever
☐ Anemia	☐ Chicken Pox	☐ Fainting	☐ Liver Disease	☐ Sinus Problems
☐ Asthma	☐ Convulsions	☐ Hearing Problems	☐ Measles	☐ Thyroid Disease
☐ Bladder Problems	☐ Diabetes	☐ Heart Problems	☐ Mononucleosis	☐ Tuberculosis
☐ Cancer	☐ Drug/Alcohol Abuse	☐ Hepatitis	☐ Mumps	☐ Other

EMERGENCY CONTACT

In the event of an emergency, whom should we contact?

Name _____ Relationship _____ Phone (____) _____

Name _____ Relationship _____ Phone (____) _____

AUTHORIZATION

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

Minor/Child Consent

I am the parent, guardian, or personal representative of _____

Please Print Name of Minor/Child

and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

Insurance Assignment and Release

I certify that my dependent(s) is covered by insurance with _____

Name of Insurance Company(ies)

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my minor/child's health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Parent, Guardian or Personal Representative — Relationship to Patient

UPDATE

TO BE COMPLETED AT LATER VISIT

Has there been any change in patient's health since last dental appointment? ☐ Yes ☐ No

If yes, please describe _____

Is patient taking any new medications? ☐ Yes ☐ No If yes, please list _____

Date _____ Parent/Guardian Signature _____

Date _____ Dentist Signature _____

We believe it is important to not only provide the highest quality of dental care, but to make the care affordable to our patients. We have made arrangements for our patients, which allow payment to be convenient and flexible. We are committed to helping you receive the dental care you desire and the most pleasant dental experience possible.

Please initial each paragraph after reading, if you have any questions please ask our Financial Coordinator prior to initialing.

____ 1. Full payment for profession services is due at the time of service. As a courtesy to our patients, we will bill your insurance company. Your estimated co-pay and deductible is due at the time of service.

____ 2. If your insurance company was billed and payment is not received *within 60 days,* the balance will be transferred to the patient's responsibility. It is the patient's responsibility to obtain a payment from the insurance company or negotiate a settlement on any disputed claim. Any portion of the bill not paid, by the insurance carrier, will be the patients' responsibility.

____ 3. You must inform our office if you have a new insurance carrier or if the insurance carrier has located to a new address. Please send us a copy of the front and back of your new insurance card to update our records. In the event your insurance coverage plan or plan participation changes where we are not a participating provider, you will be responsible for payment of all fees at the time services are rendered.

____ 4. *We do not accept any assignment of benefits from secondary insurances.* Nevertheless, as a courtesy to you we will gladly submit a claim to your secondary insurance for reimbursement directly to you.

____ 5. Upon receipt of payment from your insurance company, you will receive a statement specifying your balance due. Payment is expected within *fourteen (14) days,* unless prior financial arrangements have been made.

____ 6. We make every effort to clarify and allow payments to be flexible through mutually agreed arrangements. In the event payment is not received according to these arrangements, your account will be sent to our professional collection agency. You will be charged an additional 30% of your outstanding balance. Information given to them may include, but is not limited to; you name, address, phone number, social security number, employer and employer phone number.

____ 7. Our office does request and appreciate a 48 hour notice for any appointment changes. Please understand the appointments you've scheduled with us is reserving this time with Doctor and our staff specifically for you. Failure to notify our office will result in a *$75 fee for an appointment with our hygienist and $100 for an appointment with the doctor.*

I authorize the release of any necessary information regarding my dental health to my dental insurance companies. I hereby authorize payment directly to Advanced Dental Care, PLLC of the group insurance benefits otherwise payable to me. I understand that *a $35 fee will be applied for each returned check.*

_____ _____

Patient Signature or Responsible Party Date