Pediatric DENTAL CENTER

Patient Information

Patient Name: _____ Date:_____
Last First MI

☐ Male ☐ Female

Social Security #: _____ Birth Date:_____

Phone (Home): _____ (Cell/other): _____ (Work):_____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ ☐ Reason for today's visit:_____

Has the patient ever had any of the following? Please check those that apply:

☐ Allergies (please specify) _____
_____

☐ Asthma (last attack/how frequent)
_____

☐ Cancer (please specify)_____

☐ Diabetes
☐ Epilepsy
☐ Heart Disease
☐ Heart Murmur
☐ ADHD/ADD
☐ Mental Disorders (please specify)__ ____
_____

☐ Pregnancy
Due date:_____

☐ Premature Birth -Gestational Age (weeks) _____

☐ Penicillin Allergy

OTHER:
☐ _____

☐ _____

List any medications_____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:_____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain:_____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:_____
- Name of Primary Care Physician: _____ Phone:_____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Email address:_____

Referral Information

Whom may we thank for referring you to our practice?
☐Another patient, friend/relative
_____

☐ Dental Office ☐ Pediatrician ☐ Ins Co. ☐ School ☐ Work ☐ Other_____

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Parent or Responsible Party Information (please fill out completely)

The following is for: ☐ the patient's Parent ☐ Foster Parent

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext:_____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information of Guardian (*Insurance Policy Holder*)

The following is for: ☐ the Parent ☐ Foster Parent

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Insurance Information (please fill out completely)

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

_____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

Pediatric DENTAL CENTER

Patient Payment Policy

In order to keep dental costs down, we request patients pay at the time services are rendered unless other arrangements have been made with the business office.

Insurance

OUR PRACTICE IS COMMITED TO YOU by providing you with the best quality of dental care available. Our fees are determined upon the usual and customary rates for our area, regardless of an insurance company's arbitrary determination of usual and customary rates.
AS A BENEFIT TO YOU we submit all insurance claims and obtain the dental benefits you and your family are eligible to receive through your insurance carrier. However, this is only an ESTIMATE of coverage. Your insurance policy is a contract between you and your insurance company. **We are not a party to that contract therefore; the balance of our account is your responsibility regardless of what your insurance company reimburses for services rendered.**

Co-pays

We REQUIRE your deductible and estimated co-pay be paid at the time of service.
We cannot bill an insurance company for any claim unless all information to file claims is received from the patient.
We request a copy of an original insurance card ANNUALY.
If your insurance company has not paid its portion in 60 days after services have been rendered. The amount outstanding to insurance will be transferred to your account and will be your sole responsibility.

IF SUFFICIENT INSURANCE INFORMATION IS NOT RECEIVED THE ENTIRE FEE FOR SERVICE IS DUE AT THE TIME OF THE APPOINTMENT.

Broken Appointments

We understand that occasionally situations may arise to warrant a broken appointment; however, this does leave a serious void in our schedule. We request 48 hours notice of cancellations be given so that this time can be used for another patient in need of care. **Therefore, we reserve the right to charge for an appointment cancelled or broken without 48 hours advance notice.**

<u>There will be a $60 cancellation fee for missed appointments without 48 hour notice.</u>

Our goal is to make your dental appointments as comfortable and as pleasant as possible. If you have any questions or concerns please feel free to discuss them with our staff.

"I understand and agree that regardless of my insurance status or state of coverage I am ultimately responsible for the balance on my account. In the event that the account would be sent to a collection agency or attorney, due to non-payment on the account. I am responsible for all collection fees or charges."

_____

Signature of Responsible Party Date

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Contact Information

Patient(s) Name(s): _____

_____

_____

_____

_____

Father's Full Name: _____

Father's Work # : _____

Company and/or department _____

Father's Cell # : _____

Email Address: _____

Mother's Full Name: _____

Mother's Work # : _____

Company and/or department _____

Mother's Cell # : _____

Email Address: _____

In Case of Emergency

Name and Phone Number (other than Guardian)

_____

Pediatric DENTAL CENTER

HIPAA

Protecting Your Privacy

At Pediatric Dental Center we understand how important it is to our patients and their families that their private information would be kept confidential. We are committed to protecting and managing your information as explained in our privacy policy. We would like to take this opportunity to describe how Pediatric Dental Center gathers, retains, and protects the security of your information.

Gathering and Maintaining your Information

In order to assist you with your financial needs and provide excellent service, it is often necessary to collect and maintain certain types of personal information. We may collect or retain nonpublic personal information about you from the following sources.

Patient history forms that you provide to us with information such as your name, address, social security number, work information, and insurance data. Information about our transactions with us such as payment history and account balances.

Sharing Information Outside Pediatric Dental Center

Our practice does not disclose nonpublic information about our patients or former patients to nonaffiliated third parties, except permitted by law. This action may result in the disclosure of patient information in certain situations including, but not limited to:

To provide information to assist us in processing your applications for insurance processing or managing your account for credit purposes. To protect the integrity and security of your records including prevention of fraud and unauthorized transactions. To comply with the federal, state, or local laws, rules and other applicable legal requirements (such as subpoena, garnishment, or court order)

In situations where the patient information is shared, we require other parties to treat and maintain the privacy of your personal information to at least the same extent and with the same degree of diligence and careful attention that is required by Pediatric Dental Center.

Accurate Information

Maintaining accurate information is essential to protecting the integrity of our client's records. Pediatric Dental Center takes all precautions, in accordance with the reasonable industry standards, to insure information is current and complete. If you become aware of any inaccurate information, please help us correct it by contacting our office at (859)534-5640 or (859)341-3012.

Security Practices to Protect Your Information

To further safeguard your information, we limit the availability of your information to our employees. Employees may only access your information for legitimate business purposes, and are trained to respect your privacy concerns and to safeguard your personal information. Furthermore, as technology becomes more advanced, Pediatric Dental Center has continuously modified its physical, electronic and procedural safeguards to insure compliance with the state federal standards and to protect your nonpublic personal information.

I have read and fully understand the above policy.

Signature of responsible party Date