Patient Information

Patient's Name: _____Sex: □ M □ F

Age ____ Birthdate ____/_____/____

Address: _____ Apt # _____City_____

State_____ Zip Code_____ Home Phone (____) _____

Mother's Name: _____Cell: (_____) _____

Father's Name: _____Cell: (_____) _____

Patient resides with:_____

How did you hear about us:_____ Phone Number (_____)_____

Emergency Contact Information

Emergency Contact: _____ Relationship: _____

Home Phone (_____) _____ Cell Phone (_____) _____

Primary Insurance

Policy Holder: _____

Relationship: _____ Birthdate: ____/_____/_____

Soc. Sec. #: _____Policy No/Member ID: _____

Insurance Company: _____Phone:(___) _____

Employer: _____

Occupation: _____

Email: _____

Email Address were you would like appointment reminders for your child :_____

(Please continue to the next page)

Patient's Name: _____ **DOB:**_____

Patient's primary caregiver: _____

Preferred Language:_____ **Occupation:**_____

Dental History: **Previous Dentist**: _____ _____**Phone**: (_____) _____
Date of last dental visit: ____/_____/_____

Preferred Pharmacy: **Pharmacy name:**_____ _____ **Phone No: (_____)**_____

PharmacyAddress:_____

Medical History:

Child's Pediatrician: _____**Phone No.**: (____) _____
Are your child's immunizations current? Yes/No
Has your child been hospitalized or has had surgery? Yes/ No
If "yes", when and why? _____
List medications your child is taking:_____
List drug allergies, if any: _____
FEMALES ONLY: Are you pregnant or believe could be? _____

Does your child have health issues? Yes/ No
Has your child had any history of the following:

_____ADHD	_____Autism	_____ Hearing Aids	_____ Bleeding Disorders	
_____Asthma	_____ Heart Disease	_____Chicken Pox	_____ Chronic Sinusitis	
_____Kidney Disease	_____Hepatitis	_____HIV/AIDS	_____Seizure/Epilepsy	
_____Diabetes	_____Liver	_____ Cerebral Palsy	_____Measles	
_____Tuberculosis	_____Fainting	_____Anemia	_____Heart Murmur	
_____ Lungs Disease	_____ Mumps	_____ Tumors	_____Rheumatic Fever	
_____Speech Problems	_____Cleft lip or Palate	_____Cancer	_____GI disorders	____GERD/Acid reflux

Describe in details any of the listed medical issues:

_____

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand this information will be used by the dentist to help determine appropriate dental treatment. If there is any change in my child's medical status, I will inform the dentist. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges not paid by insurance.

Signature _____ **Relationship to Patient:**_____

Date: _____/_____/_____**Providers Signature:** _____

HIPAA Confidentiality Agreement

I do hereby authorize Pediatric Pro Children's Dentistry & Orthodontics and the assistant/s that she may designate to perform the treatment/procedure(s) that are reasonable, necessary, and advisable for the patient I have been informed of the reasons for the treatment/procedure(s), along with the expected benefits, risk, and possible consequences involved. Understanding this, I authorize Pediatric Pro Children's Dentistry & Orthodontics to perform such examinations, treatment, laboratory tests, and to administer such medications as, in his or her opinion, are necessary or advisable for my son/daughter whose name appears above. I understand I may withdraw my consent, at any time, to the extent permitted by law.

INSURANCE AUTHORIZATION

I hereby authorize direct payment of Medical and Dental benefits to Pediatric Pro Children's Dentistry & Orthodontics services rendered by the Dentist in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance, including co-insurance amounts, deductibles and copays.

I certify that the information given by me in applying for payment is correct. I request that payment of authorized benefits be made on my behalf.

CONSENT FOR USE AND DISCLOSURE

I have been offered a copy of and have had full opportunity to read and consider Pediatric Pro Children's Dentistry & Orthodontics Notice of Privacy Practices. This Notice provides a description of our treatment, payment activities and healthcare operation, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information.

I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information as described on the Notice of Privacy to carry out treatment, payment activities and healthcare operations.

Name of who we may disclose your Child's information with: _____

Relationship to child _____ Today's Date: _____

_____ ____/_____/_____

Patient's First & Last Name **DOB**

_____ _____

Parent's / Guardian Signature **DATE**

_____ _____

Witness (staff only) **DATE**

Financial Guidelines

Thank you for choosing us as your child's Dentist. Our main concern is that your child receives the proper and optimal treatments needed to restore his or her dental health. We are committed to providing each patient with quality dental care. If you have any questions or concerns regarding our payment policies, please do not hesitate to ask our Office Manager.

We ask that all patients provide current health history and insurance information on our new patient registration form. Please read and sign our Financial Policy prior to seeing the doctor. We **must** be informed of medical history changes upon arrival at each visit.

Payment is due at the time of service. We accept cash, checks and, for your convenience, MasterCard, Visa, American Express and Discover.

Insurance must be verified prior to your visit .In certain instances we may accept assignment of insurance benefits; however, you must understand that: Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance company. We will not become involved in disputes between you and your insurance company regarding deductibles, non-covered/covered charges, co-insurance, coordination of benefits, or "reasonable an customary" charges other than to provide factual information as necessary. Please understand that our fees are based upon the specific procedure, the time involved, the materials used, and the expertise and knowledge used to place those materials- therefore what insurance deems *usual and customary* specific only to your insurance plan premiums, has no relevance in the determination of fee schedules.

All charges are your responsibility whether your insurance company pays or not. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

Fees for these services, along with unpaid deductibles and co- payments are due at time of treatment.

If the insurance company does not pay your balance in full within 30 days, we ask that you contact the carrier to help speed up the process.

If the insurance company does not pay your balance in full within 90 days, we require you to pay the balance due and resolve any further issues with your contracted insurance carrier.

Returned checks will be subject to a $35 service charge.

Please note that, unless canceled at least 2 business days in advance, **our office reserves the right to charge you** base of our normal office visit fee. Please call if you need to reschedule. We do understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

Again, thank you for choosing our dental office. We appreciate your trust and the opportunity to serve you. Our goal is make dentistry fun for children so that they may establish the lifelong dental habits that are so important in maintaining good dental health.

Patients Name (print name): _____ D.O.B: _____

Parents/Guardian Signature: _____ Date: _____