



Child Information

Whom may we thank for referring you? _____

Name of Minor/Child _____ Birth date _____ Date _____

Sex M / F Age _____ Nickname _____ School _____ Grade _____

Home

Address _____

City _____ State _____ Zip _____ Home Phone _____

Parent or Guardian Information:

1) Name: _____ Home _____ Work _____ Cell _____

2) Name: _____ Home _____ Work _____ Cell _____

Insurance Information

Father's/Guardians Name _____ Employer _____ Occupation _____

Address (if different from child) _____ City _____ State _____ Zip _____

Father's Birth date _____ Soc. Sec. # _____ Email _____

Mother's/Guardians Name _____ Employer _____ Occupation _____

Address (if different from child) _____ City _____ State _____ Zip _____

Mother's Birth date _____ Soc. Sec. # _____ Email _____

Do you have dental insurance for minor/child? Yes _____ No _____ Policy holder _____

Company _____ Phone Number _____

Address _____ City _____ State _____ Zip _____

Group # _____ Policy # _____

Child Dental History

Date of last dental visit _____ for what services? _____

Chief Dental Concern or Purpose for Today's Visit: _____

Has child complained about dental problems? Yes _____ No _____

Does child have any mouth habits- thumb sucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc?

Yes _____ No _____

Please list _____

Does child brush teeth daily? Yes _____ No _____

Does child use floss every day? Yes _____ No _____

Is fluoride taken in any form? Yes _____ No _____

Any injuries to mouth, teeth, head? Yes _____ No _____

Has child experienced any unhappy dental visits? Yes _____ No _____

Please explain: _____



Child Medical History

Child's Physician _____ City/State _____ Phone _____

Date of last physical examination _____ Results _____

Is your child under care of a physician now? Yes _____ No _____

Are Immunizations current? Yes _____ No _____

Is your child taking any medications? Yes _____ No _____

Please List _____

Is your child allergic to any medications? Yes _____ No _____

Please List: _____

Any Surgeries? Yes _____ No _____

Hospitalization Yes _____ No _____

Excessive bleeding when cut? Yes _____ No _____

Please describe: _____

Has child had any history of or difficulty with any of the following? *If yes please check if YES:*

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

In the case of an emergency, whom may we contact?

Name _____ Relationship _____ Phone _____

Minor/Child Consent

I am the parent, guardian, or personal representative of _____ and 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 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 my insurance with _____ and assign benefits, if any, to be directly paid to North Stapley Dental Care 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 entity may use my child's health care information and may disclose such information to the above-name 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.

Parent/Guardian signature _____ Date _____

Print Parent/ Guardian name _____ Relationship _____



ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION

HIPAA. I acknowledge that I have received a copy of North Stapley Dental Care Notice of Privacy Practices, containing a complete description of the uses and disclosures of my health information. This is simply an acknowledgement of receipt, and nothing more.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

APPOINTMENTS AND FINANCIAL POLICY. I acknowledge that I have received a copy of North Stapley Dental Care Appointments and Financial Policy. I have read, understand, and agree to the policy.

Signature of Responsible Party _____

Date _____

ASSIGNMENT OF BENEFIT. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with my dental claims. **I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to North Stapley Dental Care.**

Signature of Responsible Party _____

Date _____



OFFICE POLICY

Welcome to North Stapley Dental Care! Our interest is to provide our patients with the finest possible dental care. As your provider, we advise treatment that is in the best interest of your medical and dental health. Be aware, often, insurance companies select the dental procedures that they will and will not cover without regard to your personal situation, health, and dental needs. Following is an overview of our office financial policy we provide to you as a courtesy.

Insurance: Dental Insurance rarely pays for 100% of all dental services. *As a courtesy*, we will bill your dental insurance for your care, providing you give us the needed information for claim submission. Your estimated co-pays are due at time of service and any balance unpaid after the claim settles is due within 14 days of receipt of statement. Initials_____

Payment from the insurance company is expected within thirty (30) days. If your insurance company has not responded within a sixty (60) days grace period from the date of service, the remaining balance in full is your responsibility. At the time of service, we will request from you an initial payment; this is an estimated portion of the charges which insurance may not cover, including all applicable deductibles and co-pays. Initials_____

Copyright: Any comment posted online in any way relating to North Stapley Dental Care, doctors or employees will be the sole right and property of North Stapley Dental Care P.C. and the copyright of the content of the comment, rating, or review is hereby assigned to North Stapley Dental Care P.C. to utilize at our discretion in order to protect the practice and our patient's anonymity and privacy. Initials_____

Payment: Payment in full is required at the time of service. For your convenience, we accept cash, checks, debit, and credit cards, including Visa, MasterCard, Discover, and American Express. Our office also offers No Interest and Extended Payment Plans, upon approved credit, through CareCredit. Initials_____

Estimates: Before treatment, we will perform a diagnosis and provide you with an estimate of the charges involved. As treatment progresses, it is possible that additional circumstances not be apparent at the initial exam, may be encountered. In this event, we will discuss options with you and proceed as necessary. Initials_____

Aged Account: The total balance on your account, after claim settlement, is due upon receipt of statement. Failure to keep this account current may result in North Stapley Dental Care being unable to provide additional dental services. In the event of a default, I agree that any information collected can be used to collect on my account, and I agree to pay all costs incurred in the attempt to collect on this account, including late fees of 10% or \$30 (whichever is greater), finance charges, service and/or collection agency fees, attorney's fees and court costs. Initials_____

Appointments: If you are unable to keep a scheduled appointment, we ask that you provide us with 48 hours notice as a courtesy. Notice of less than 48 hours may result in a minimum charge of \$50.00 per hour. Initials_____

Assignment of Benefit: I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with my dental claims. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to North Stapley Dental Care.

I have read, understand, and agree to the above.

Signature of Person Responsible for Account

Printed Name of Person Responsible for Account

Date