



*Shalimar*

FAMILY DENTISTRY

*The "red carpet" experience in dental care.*

**CHILD INFORMATION**

Whom may we thank for referring you? \_\_\_\_\_ Date \_\_\_\_\_

Name of Minor/Child \_\_\_\_\_ Birth date \_\_\_\_\_

Sex \_\_\_\_\_ 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 \_\_\_\_\_

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 \_\_\_\_\_

**Insurance Information**

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

Dental Insurance Company \_\_\_\_\_ Phone Number \_\_\_\_\_

Address on card \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Group # \_\_\_\_\_ Subscriber Policy ID # \_\_\_\_\_

**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: \_\_\_\_\_



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**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** \_\_\_ Is your child taking any medications? **Yes** \_\_\_ **No** \_\_\_  
 Please List \_\_\_\_\_

Are Immunizations current? **Yes** \_\_\_ **No** \_\_\_ 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      | _____ |
| Convulsions       | _____ | Diabetes         | _____ | Drug/ Alcohol Abuse | _____ |
| Fainting          | _____ | Hearing Problems | _____ | Hepatitis           | _____ |
| Liver Disease     | _____ | Measles          | _____ | Mononucleosis       | _____ |
| Rheumatic Fever   | _____ | Sinus Problems   | _____ | Thyroid Problems    | _____ |
|                   |       |                  |       | Chicken Pox         | _____ |
|                   |       |                  |       | Epilepsy            | _____ |
|                   |       |                  |       | Kidney Disease      | _____ |
|                   |       |                  |       | Mumps               | _____ |
|                   |       |                  |       | Tuberculosis        | _____ |

Other not listed: \_\_\_\_\_

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 Shalimar Family Dentistry 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-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.

Parent/Guardian signature \_\_\_\_\_ Date \_\_\_\_\_

Print Parent/ Guardian name \_\_\_\_\_ Relationship \_\_\_\_\_



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**ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION**

**HIPAA.**

I acknowledge that I have received a copy of Shalimar Family Dentistry 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 Shalimar Family Dentistry 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 Shalimar Family Dentistry.**

Signature of Responsible Party \_\_\_\_\_ Date \_\_\_\_\_

## OFFICE POLICY

Welcome to Shalimar Family Dentistry! 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\_\_\_\_\_

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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 Shalimar Family Dentistry 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 Shalimar Family Dentistry.

Initials\_\_\_\_\_

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

\_\_\_\_\_  
Signature of Person Responsible for Account

\_\_\_\_\_  
Printed Name of Person Responsible for Account

\_\_\_\_\_  
Date