Meridian Pediatric Dentistry

TOBY MERRIMAN, DMD

PATIENT INFORMATION

Name of Minor/Child_____ SSN_____
Sex: M_____F_____ Age_____Birthdate_____Nickname_____
Mailing Address_____
City, State, Zip_____
Physical Address_____
City, State, Zip_____
Home Phone _____Work_____Cell_____
Email Address_____
Dad's Name _____SSN_____ DOB_____
Mom's Name _____SSN_____ DOB_____

Who is responsible for this account_____Relationship to patient_____

How did you hear about us (referral, facebook, etc.)?_____

INSURANCE

Does your child have dental insurance? Yes / No
Name of Insurance Co._____
Subscriber Name & Employer_____
Subscriber's Social Security #_____Date of Birth_____
Insurance Company Address_____
_____
Phone #_____ID#_____

Does your child have secondary dental insurance? Yes / No
Name of Insurance Co._____
Subscriber Name & Employer_____
Subscriber's Social Security #_____Date of Birth_____
Insurance Company Address_____
_____
Phone #_____Group#_____

Assignment and Release

I, the undersigned certify that I (or my dependent) have the above insurance coverage and assign directly to Dr. Merriman otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature | Relationship to patient | Date

EMERGENCY CONTACT

In the event of an emergency, whom may we contact? (someone not living with you)
Name_____Relationship_____Phone_____

Dental History

Date of last visit to the dentist_____service done_____
Has child complained of dental pain_____
Does child brush and floss daily_____
Is fluoride taken in any form_____
Any injuries to mouth, teeth or head_____
Any unhappy dental experiences_____
_____
Any mouth habits - thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc._____

Medical History

Child's Physician_____
Date of last physical exam_____
Ever been hospitalized or had any surgeries_____
_____

Current Medications_____
_____
Allergies_____
_____

Has child had any difficulty or history of any of the following: **YES / NO**
Please circle any that apply and explain below:

AIDS/HIV	Chicken Pox	Hearing problems	Mononucleosis
Anemia	Convulsions	Heart problems	Rheumatic Fever
Asthma	Diabetes	Hepatitis	Sinus problems
Bladder problems	Drug/Alcohol Abuse	Kidney Disease	Thyroid Disease
Cancer	Epilepsy	Liver Disease	Tuberculosis
Cerebral Palsy	Fainting	Measles/Mumps	Eye problems

Other_____
Explanation _____

Authorization

I understand I am responsible for my account regardless of my insurance. I also understand that my insurance is an agreement between me and my insurance company.

I understand that I may be charged a 1.5% finance charge per month (18% annually) if my balance goes beyond 90 days.

I give permission for my dentist and clinical team to take any necessary radiographs, study models, and photographs to make a complete diagnosis of my dental needs. I also give permission for my dentist and dental team to use my photographs for in-office patient education.

I consent to the use and disclosure of my protected health information to obtain payment information in connection with my dental claims.

The information I have provided is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services for my child.

_____
Signature of parent/guardian Date

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Financial Policy

For your convenience we offer several options of payment: cash, check, and debit or credit card. We also have companies willing to finance dental treatment with no money down. Payment arrangements must be agreed upon before procedures are initiated. If you have dental insurance, we will gladly file your claim for you; however**, you are responsible for your account**. We can provide you with an estimate of co-pays and deductibles; however, this is only an estimate. **We are not responsible for amounts not paid by the insurance company.** We cannot guarantee what insurance will or will not pay. If your insurance company neglects to pay within 60 days, the balance on the account becomes your responsibility, and is due in full. If full payment is not received immediately, a monthly interest charge at the rate of 1.5% will begin to accrue on the unpaid balance. If your account becomes delinquent it can be turned over to a local collection agency and you will incur any collection costs and any related attorney's fees. If you do not have dental insurance, we do have other payment options that you may discuss with our financial coordinator.

As our patient, we ask that you keep your account current to allow us to continue providing our highest level of care for you, your family, and friends. Your account will be charged a return check fee in the amount of $35.00 for any check returned unpaid.

We are committed to superior service and reserve time for you and your child's individual needs. We ask that if you need to cancel an appointment that you give us at least 24 hours notice.

Please read carefully before signing and dating this agreement.

Date

_____

Signature

_____

AUTHORIZATION TO CONSENT TO TREATMENT

Dear Parents:

If an adult other than your child's parent or legal guardian accompanies him/her to office visits, we will be unable to provide treatment without your written authorization, except in emergency situations.

To authorize an adult other than your child's parent or legal guardian to consent to medical treatment for your child, please complete the sections below. By completing this authorization, you consent to the sharing of your child's protected health information with this individual as outlined in Meridian Pediatric Dentistry's Notice of Privacy Practices.

AUTHORIZATION

I , _____authorize the following individual(s),
(Name of Parent or Legal Guardian)

Name: _____ Relationship to child: _____

Name: _____ Relationship to child: _____

to consent to medical treatment for my minor child/children listed below:

Name: _____ Date of birth: _____
Name: _____ Date of birth: _____
Name: _____ Date of birth: _____
Name: _____ Date of birth: _____
Name: _____ Date of birth: _____
Name: _____ Date of birth: _____
Name: _____ Date of birth: _____
Name: _____ Date of birth: _____

LIMITATIONS

Identify any limitation on the kinds of dental services for which this authorization is given. If none are specified, no limitations will be applied.

_____
_____

Identify any limitations on the time frame for which this authorization is given. If none are specified, no limitations will be applied.

_____
_____

_____ _____
Signature of Parent or Legal Guardian Date

Updated August 2013

Meridian Pediatric Dentistry *Dr. Toby Merriman* *208-288-2719*
1550 E. Heritage Park #150 *Meridian, Idaho 83646*

General Consent Form

Patient's Name: _____

Please read and initial the items listed below, then read and sign at the bottom of this form

1.Diagnosis (Initials_____ Date_____)

I understand that during any appointment, through standard procedures conducted during an office visit, I may obtain recommendations, advice, referrals, receive instructions regarding any home-care regimen, be asked for information as it relates to the patient's status or condition, undergo clinical observations, diagnostic testing, obtain a personal treatment plan including possible treatment options, and be provided the opportunity to access treatment costs, and make financial arrangements for necessary services.

2.Radiographs (x-rays) (Initials_____ Date_____)

I understand that the dentists, administering hygienists, and assistants, may advise, request/administer radiograph x-rays in order to provide more thorough and accurate diagnosis.

3.Drugs and Medications (Initials_____ Date_____)

I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). It is my responsibility to let the office know which medications are currently being taken and if there have been any allergic reactions to medications in the past.

4.Changes in Treatment Plan (Initials_____ Date_____)

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during the examination; the most common being pulp therapy following routine restorative procedures. I give permission to the dentist to make any/all changes and additions as necessary.

5.Nitrous Oxide (Initials_____ Date_____)

I understand that the dentist will routinely use nitrous oxide to calm/relax my child during restorative procedures. Oxygen will be administered at the end of the procedure to eliminate the nitrous oxide.

6.Anesthetic (Initials_____ Date_____)

I understand that use of local anesthetic can cause hematoma (bruising), swelling, soreness and/or parasthesia (prolonged numbness).

7.Fillings (Initials_____ Date_____)

I understand that the dentist will primarily place a composite (tooth colored) filling. There may be circumstances when behavior, isolation or conditions may require an amalgam (silver) filling to be used. I also understand that my insurance may require that I pay the difference in allowable fees when composite fillings are used. I understand that sensitivity is a common after-effect of a newly placed filling.

8.Removal of Teeth (Initials_____ Date_____)

I understand that alternatives to the removal of certain teeth exist (pulpotomy, crowns, etc.). I understand removing teeth does not always remove all of the infection, if present, and it may be necessary to render further treatment. I understand the risks involved with having teeth removed, some of which are: pain, swelling, spread of infection, dry socket, loss of feeling in teeth, lips, tongue, and surrounding tissue (Parasthesia) that can last for an indefinite period of time, or fractured jaw. I understand the patient may require further treatment from a specialist, or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

9.Space Maintenance (Initials_____ Date_____)

I understand that space maintainers are used to hold adequate space for permanent teeth. The use of space maintainers does not replace the need for possible future orthodontic needs.

10.Therapeutic Pulpotomy (Initials_____ Date_____)

I understand that the goal of a therapeutic pulpotomy is to retain a tooth that may otherwise require extraction. Although pulp treatment usually has a high degree of clinical success, it is a dental-biological procedure, where results cannot be guaranteed. Occasionally, therapeutic pulpotomy treatment may fail, with resulting tooth loss. A permanent restoration covering the outside of the tooth such as a stainless steel crown will be needed to protect the tooth from fracture.

11.Crowns (Initials_____ Date_____)

I understand crowns are a treatment option to restore teeth with cavities. I understand that posterior (back) teeth will have stainless steel (silver) crowns and anterior (front) teeth will have stainless steel crowns with a resin (white) facing. Occasionally, crown treatment may fail, with resulting tooth loss.

I understand that dentistry deals with multiple biological facets and therefore, reputable practitioners cannot fully guarantee results. I also understand behavior dictates treatment options and results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Parent/Guardian:_____ Today's Date:_____