CHILD PAPERWORK

Getting to know you and your child				
Child's name		Age M ☐ F ☐		Birthdate / /
Home address		City, State, Zip		Child's Home Phone
Who will normally accompany your child to the appointment?		Phone		
Father's Name	Phone	Mother's name	Phone	Cell Phone
Email Address		Email Address		

Do you have...	Dental benefits Yes☐ No☐	Dual benefit Yes☐ No☐

Person responsible for paying services		
Name	Home phone	Birthdate / /
Home Address	City, State, Zip	Cellphone
Email Address	Gender: M ☐ F ☐ Others ☐	Driver's license
Marital status Single ☐ Married ☐ Separated ☐ Divorced ☐	Social Security Number	Work phone
Responsible Person's Employer		Occupation
Business Address		City,State, Zip

Spouse's name	Spouse's Social Security Number	Birthdate / /
Spouse's Employer	Spouse's Occupation	Spouse's Work Phone
Spouse's Business Address		City, State, Zip

HOW DID YOU HEAR ABOUT THIS OFFICE?(CHECK ONLY ONE)

☐Referred by a friend. ☐Online (directory or advertisement) ☐Insurance plan.

☐Health Fair/Community Event. ☐Drive by/Signage ☐Other

If you were referred, whom may we thank for referring you? _____

TERMS & CONDITIONS

This office depends upon reimbursement from the patient for the costs incurred in their care. The financial responsibility of each patient must be determined before treatment.As a condition of treatment by this office, I understand financial arrangements must be made in advance. All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for at the time services are performed. I understand that the dental services furnished to me are charged directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office can not render services on the assumption that changes will be paid by an insurance company.

ASSIGNMENT OF INSURANCE: I hereby authorize release of any information needed and also authorize my insurance company to pay directly to This Office benefits accruing to me under my policy. I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient's examination.

I agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred, including reasonable attorney's fees.

I grant my permission to you, or your assigns, to telephone me at home or at my work to discuss matters related to this form.I have read the above conditions and agree to their consent.

Signature _____ Date / /

CHILD'S DENTAL HEALTH

Why have you brought your child to visit us today ?_____ Is this your child's first visit to the dentist ?_____Has your child ever had a serious problem with a previous dental treatment? _____(If so, pleaseexplain)_____

Please circle Y for Yes and N for No

Does your child suck his/her thumb or pacifier?	Yes☐ No☐
Does your child take fluoride drops, tablets, or rinse?	Yes☐ No☐

CHILD'S MEDICAL HEALTH

Why have you brought your child to visit us today ?_____Is this your child's first visit to the dentist ?_____

Has your child ever had a serious problem with a previous dental treatment?(If so, please explain)_____

CHILD'S MEDICAL HEALTH

Your child's Physician _____ Phone _____

Has your child ever been hospitalized? (If so, please give reason) _____

Please circle Y for Yes and N for No.

Is your child allergic to:		**Has your child ever been treated for:**			
Local Injected anesthetics (Novocaine)	Y☐ N☐	Asthma	Y☐ N☐	Fainting spells	Y☐ N☐
Penicilin	Y☐ N☐	Bleeding disorder	Y☐ N☐	Prolonged bleeding	Y☐ N☐
Latex, Metals, Plastics	Y☐ N☐	Diabetes	Y☐ N☐	Hepatitis	Y☐ N☐
Aspirin	Y☐ N☐	Arthritis	Y☐ N☐	Emotional problems	Y☐ N☐
Codeine	Y☐ N☐	Hearing loss	Y☐ N☐	Rheumatic Fever	Y☐ N☐
Sulfites/Sulfides	Y☐ N☐	Heart disease	Y☐ N☐	Seizures	Y☐ N☐
Other _____	Y☐ N☐	Heart murmur	Y☐ N☐	Lung Disease/TB	Y☐ N☐
		Joint replacement or artificial prosthesis	Y☐ N☐	Other _____	Y☐ N☐

Has your child had any serious illness not listed above? Y or N If yes, please explain _____

Is there anything else you would like us to know about your child? _____

MEDICATIONS

Does your child usually take an antibiotic prior to dental treatment? Y N

List all medications your child is currently taking (or has recently taken) and the condition for which they are prescribed:

Medication: _____ Dosage: _____ Condition: _____

Medication: _____ Dosage: _____ Condition: _____

Medication: _____ Dosage: _____ Condition: _____

IN THE EVENT OF AN EMERGENCY, PLEASE CONTACT

Name _____ Relationship _____ Phone _____

Name of nearest relative not living with child _____ Phone _____

Medical health reviewed by:

_____
Doctor's Signature

_____
Doctor's Signature

_____
Doctor's Signature

If Patient is a minor:

_____
Parent/Guardian's Signature

_____
Parent/Guardian's Signature

_____
Parent/Guardian's Signature

POWER OF ATTORNEY

I, the undersigned, hereby authorize _____

to bring in _____ to receive dental treatment.

Signature of Parent or Guardian _____ Date _____

I give my permission for this Office to administer any necessary treatment in an event of a medical emergency.

Signature of Parent or Guardian _____ Date _____

WELCOME TO OUR OFFICE

We would like to welcome you as a patient. Your initial visit to our office will consist of obtaining a thorough Medical/Dental history, a full oral examination, and necessary X-rays. A description of treatment needed for your best dental care will be discussed, as well as a prognosis, estimated fee, and treatment time. Our staff is here to work with you as a team to ensure you receive the best dental care possible.

FEES AND PAYMENTS

WE OFFER THE FOLLOWING PAYMENT OPTIONS:

- CASH
- CHECK
- CREDIT CARD (Visa, MasterCard, Discover, or American Express)
- CARE CREDIT (Please ask our staff for application process)
- All payments require a valid picture ID in order to process your payment.

MISSED APPOINTMENTS

24 HOUR NOTICE IS REQUIRED IN ORDER TO CANCEL OR RESCHEDULE ANY APPOINTMENT

Although the dental office makes every effort to confirm appointments the day before it is your responsibility to keep track of your appointments. By scheduling and missing an appointment, you are preventing other patients from being seen by the dentist. If you fail to provide the dental office with 24 hour notice, a $25.00 charge will be posted to your account. By signing this document, you agree to pay this charge and understand that further services will be provided when your balance is paid in full.

INSURANCE

ALL DEDUCTIBLES AND CO-PAYS ARE DUE AT THE TIME OF SERVICE

Please be aware that your insurance company may not cover all services offered by this office. Most companies pay fixed portions of the charges, and it is your responsibility to pay the deductible, co-insurance, and other balances not paid by your insurance. If your insurance company has not paid your account in full within 45 days of billing, the balance is your responsibility.

- By signing this form I have read, understood, and agreed the above mentioned offices polices.

Patient or Parent/Guardian Signature _____ **Date** / /

ELITE DENTAL
FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. The following is our Financial Policy. If you have any questions or concerns about our payment policies, please do not hesitate to ask our office.

PLEASE BE AWARE OF THE FOLLOWING:

- Payment for services is due at the time services are rendered. We accept cash, checks, care credit, and major credit cards.
- If your insurance coverage changes, it is your responsibility to inform our office immediately.
- Your insurance policy is a contract between you and the insurance company. We are not a party to that contract. Our relationship is with you, not your insurance company. We submit claims as a courtesy. However, we do our best to accurately estimate your out of pocket expense.
- All charges are your responsibility whether your insurance company pays or not. We CANNOT guarantee the exact amount your insurance company will pay on services rendered. Not all services are covered under your policy and the insurance chooses the procedures they cover. Fees for these services, along with unpaid deductibles and co-payments are due at the time of treatment. You are responsible for these amounts.
- Returned checks are subject to a $25.00 returned check fee.
- Patient balances over 60 days old will be the patient's responsibility and may be subject to an interest charge if arrangement for payment has not been made.
- You are responsible for knowing your insurance benefits. We will make every effort to provide you with information about the benefits you have used at our office. It is your responsibility however, to keep track of your maximum allowable benefits for your plan year.

I understand that I am financially responsible for charges not paid by my insurance. I understand that reasonable collection charges may be applied in order to collect any unpaid charges in which I will be responsible for.

_____ _____

Responsible Party Signature **Date**

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any dental or medical information necessary to process claims, and I authorize payment of dental benefits to Elite Dental for services rendered.

_____ _____

Responsible Party Signature **Date**

NOTICE OF PRIVACY PRACTICES

I acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have in regard to this Notice.

_____ _____

Responsible Party Signature **Date**

INFORMED CONSENT

I understand that by signing and initialing any of the following items, I am requesting and authorizing the procedure(s) to be performed and I have read and understood the risks and complications of the procedure(s).

1. X-rays and Examination: Initials_____

I understand that I will be receiving a dental examination from a state licensed dental practitioner. I understand that while X-rays are taken of my teeth, I will be exposed to a minimal amount of radiation as part of the necessary requirements to complete a thorough and comprehensive examination. I also understand that if I am pregnant, radiation exposure poses a serious threat to the life and health of my unborn child. Pregnant woman are required to have a medical release from their Medical Doctor prior to X-rays and Dental Treatment.

2. Changes in Treatment Plan: Initials_____

I understand that during treatment it may be necessary to change procedures or add procedures because of conditions discovered while working on the teeth that were not found during examination. I understand there may be unforeseen changes that can occur during treatment. I understand that whenever possible, I will be informed of any treatment changes in advance. As the patient, I will also be informed of the changes in price, if necessary price changes are needed. I give permission to the dentist to make any and/or all changes and additions as necessary.

3. Drugs and Medications: Initials_____

I understand that antibiotics, analgesics, and other medications can cause allergic reactions. The reactions can include: redness and swelling of tissues, pain, itching, nausea, vomiting, trouble breathing, and/or anaphylactic shock. It is my responsibility as the patient to inform the dentist of any allergies in advance before treatment to minimize the chances of these side effects.

4. Fillings Initials_____

I understand that care must be exercised in chewing with filling, especially during the first 24 hours, to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after-effect of a newly placed filling. If sensitivity continues, I understand that a root canal may be needed, Even though the tooth may not have hurt prior to the filling being placed.

I understand that there has been no guarantee or assurance made by anyone in regards to the dental treatment I have authorized. I also acknowledge that I am ultimately responsible for all dental fee payments regardless of any dental insurance coverage.

_____ _____

Patient or Parent/Guardian Signatur **Date**

_____ _____

Doctor Signature **Date**