SHALIMAR
FAMILY DENTISTRY

Child Information

Whom may we thank for referring you? _____

Name of Minor/Child_____ Birth date_____ 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_____

Insurance Information

Father's/Guardians Name _____Employer _____Occupation_____
Address (if different from child) _____City_____State_____Zip_____
Birth date _____Soc. Sec. # _____Email_____

Mother's/Guardians Name _____Home Phone_____ Cell Phone_____
Address (if different from child) _____City_____State_____Zip_____
Birth date _____Soc. Sec. # _____Email_____

Do you have dental insurance for minor/child? Yes___ No___ Policy holder_____
Plan Name_____ Phone Number_____
Address_____City_____State _____Zip_____
Group #_____Policy #_____

Child Dental History

Date of last dental visit _____ for what services? _____

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 child under care of a physician now? **Yes**___ **No**___
Is child taking any medications? **Yes**___ **No**___
Please List_____
Surgeries? **Yes**___ **No**___ Hospitalization? **Yes**___ **No**___ Excessive bleeding when cut? **Yes**___ **No**___

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. ____ Cerebral Palsy ___ Epilepsy ___ Kidney Disease___ Rheumatic Fever____
Anemia____ Chicken Pox ___ Fainting ___ Liver Disease ___ Sinus Problems ___ Asthma ___ Cancer___
Bladder problems ___ Convulsions ___ Hearing Problems ___ Measles ___ Thyroid Problems ___
Diabetes ___ Drug/ Alcohol Abuse ___ Heart Problems ___ Mononucleosis ___ Tuberculosis ___
Hepatitis ___ Mumps ___ Other _____
Drug Allergies: Please list_____
Are Immunizations current? **Yes** ___ **No** ___
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-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_____

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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 _____

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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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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.

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

_____
Signature of Person Responsible for Account

_____ _____
Printed Name of Person Responsible for Account Date