Welcome To Family Dentistry!

About Your Child

Name: _____ Date:_____ Age: _____

Birth date: _____ Male Female SS#:_____

About You

Name: _____ Date:_____

Birthdate: _____ Age: _____ Male Female

Home Address:_____

City:_____ Zip:_____ SS#:_____

Home#:_____Cell#:_____W#:_____

E-mail:_____

Employer: _____ Occupation:_____

Spouse's Name:_____ Referred By: _____

_____

Emergency Contact

Name:_____

Phone: _____

Relationship:_____

Preferred Pharmacy

Name: _____

Address:_____

Phone: _____

Insurance Information

Dental Ins Co: _____ Ins Co Phone #: _____

Policy #: _____ Group#:_____

Policy owner's name: _____ Relationship: _____

Policy owner's SS #: _____ Policy owner's birthdate: _____

Policy owner's employer: _____ Occupation: _____

Employer's Address: _____ Phone:_____

*if secondary insurance, please ask for additional form.

How did you hear of us?

- Personal Referral
- Google
- Facebook
- Instagram

Leave us a Google review; receive a free gift at the end of your visit!

Payment & Missed Appointments

Our mission is to deliver the finest, most cost-effective healthcare treatment available today. Following diagnosis, the doctor will advise you of the recommended treatment plan. In addition, we will discuss with you the cost of today's visit and the cost of future treatment.

Payments: for services is due and will be paid at the time that services are rendered. We are sensitive to the fact that some people may not be able to pay cash for their treatment; therefore, we offer several alternative payment programs for your convince. They are:

1. Cash
2. Visa, Master Card, American Express and Discover
3. FSA or HSA
4. Care Credit (Financing) INTEREST FREE (6 and 12 months) alternative

Electronic Statements (e-Statements): By completing this consent agreement, you agree to permit Family Dentistry to make disclosures and provide notices to you in electronic form, including text/email; Instead of providing such notices and disclosures in printed form. You have the right to receive a printed account statement sent to your mailing address of record. By entering into this agreement, you understand that Family Dentistry will cease providing you with a printed statement in the mail, and that all future account statements will be sent by text or email.

Appointments: Times are reserved specifically to meet your needs. If for any reason you are unable to keep your reserved appointment time, a 24-hour advance notice is required by speaking directly with the front office (no texts) to avoid being charged. Since the office is closed on the weekends, all Monday appointments must be canceled by Friday at 2:00. Broken Appointment fees vary between $25.00 to $100.00.

Signature: _____ **Date:** ____/____/_____

Insurance Agreement

To our patients who are requesting that this office carries a balance on their account, to be paid by an insurance company:
This form must be read and signed by the patient or responsible party before we can accept payment directly from an insurance company.

1. I understand and agree that I am responsible for the payment of all treatment fees on my account. If my insurance company fails to pay within 90 days I will be responsible for the full amount.

2. I understand and agree that the amount estimated to remain unpaid by insurance is to be paid by me during treatment.

3. I understand that this office cannot make a totally accurate estimate of all the insurance benefits to be paid for me, since it does not have access to all insurance company records. All fees are only estimated.

4. I understand that after the insurance company pays, there could be a credit remaining to be paid to me.

5. I understand and agree that if upon payment by the insurance company, there is a remaining balance; it is due to be paid in full by me at that time.

6. I understand that after the first 30 days that the balance is not paid there will be finance charges of 3% added at that time. Another 3% finance charge will be added every 30 days there forward that the balance is unpaid.

7. After the office has exhausted the 90 day collection period, if I have not set up and fulfilled a payment plan with the office, I agree to pay a collection fee of 50% times the final balance upon being sent to the collection agency.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (Laminated Sheet on back of clipboard):

Initial: _____

Signature: _____ **Date:** ____/____/_____

Medical History

Does your child brush his/her teeth daily? Y N

Is your child currently under the care of a physician? Y N
Child's Physician: _____
Physician's Phone #: _____

Is your child allergic to any drugs? Y N
If yes, please list: _____

Is your child taking any prescription drugs? Y N
If yes, please list: _____

Does your child need premedication before dental treatment? Y N

Has your child ever had any of the following medical conditions or problems?

Any hospital stays Y N
Operations Y N
Bleeding Problems of Any Kind Y N
Cancer Y N
Convulsions/Epilepsy Y N
Diabetes Y N
Hearing Impairment Y N
Heart Murmur Y N
Heart Problems of Any Kind Y N
Hemophilia Y N
HIV+/ AIDS Y N
Hyperactive Y N
Rheumatic/ Scarlet Fever Y N
Are there any medical conditions or problems relating to your child? Y N
If yes, please list: _____

Update
*Office Use Only

_____ __/__/____
initials date

_____ __/__/____
initials date

_____ __/__/____
initials date

_____ __/__/____
initials date

In the event of an emergency, whom should we contact?

Name: _____ Relationship: _____
Phone: _____ Phone #2: _____

*Please understand that the information that I have given is correct to the best of my knowledge, 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 my child may need.
The parent or guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved

Signature: _____ **Date:**
____/____/_____