Welcome to Pediatric Dentistry of Greenville!

Child's Information

Child's Name(Last, First, Middle Initial)_____

Child's DOB: ____/____/_____Child's Age_____ Nickname: _____ ( ) Male ( ) Female

School : _____ Grade: _____

Child's Home Phone : (____)_____-_____ SS# :____-___-_____

Child's Address: _____ Apt #:_____

City: _____ State:_____ Zip Code: _____

Who is Accompanying The Child Today?

Name:_____ Relation:_____

Email Address: _____

Would you like to receive our monthly newsletter? ( ) Yes ( ) No

Would you like to receive text message reminder? ( ) Yes ( ) No Cell Phone:(____)_____-_____

Whom may we thank for referring you?_____

Other siblings seen by us: _____

Previous Dentist: _____ Last Visit Date: ___/___/_____

Parent's Information

Mother's Name: _____ DOB: ___/___/_____

Work Phone: (____)_____-_____ Ext: _____ Home Phone: (____)_____-_____

Employer: _____ SS#: _____- ____-_____

Father's Name: _____ DOB: ___/___/_____

Work Phone: (____)_____-_____ Ext: _____ Home Phone: (____)_____-_____

Employer: _____ SS#: _____- ____-_____

Person Responsible for Account

Name: _____ Relation: _____

Billing Address: _____ Apt#: _____

City:_____ State:_____ Zip Code: _____

Primary Dental Insurance

Insurance Co Name: _____

Insurance Co Address: _____

Insurance Co Phone Number: (____)_____-_____ Group #: _____

Policy Owner's Name: _____

Relationship to Patient: _____ Policy Owner's DOB: ___/____/_____

Policy Owner's SS#: _____-_____-_____ Policy/Member ID# _____

Policy Owner's Employer: _____

Secondary Dental Insurance

Insurance Co Name: _____

Insurance Co Address: _____

Insurance Co Phone Number: (____)_____-_____ Group #: _____

Policy Owner's Name: _____

Relationship to Patient: _____ Policy Owner's DOB: ___/____/_____

Policy Owner's SS#: _____-_____-_____ Policy/Member ID# _____

Policy Owner's Employer: _____

Medical Problems

Has your child ever had any of the following medical Problems?

Yes	No	Abnormal Bleeding		Yes	No	Allergies to any Drugs
Yes	No	Anemia		Yes	No	Any Hospital Stays
Yes	No	Any Operations		Yes	No	Asthma
Yes	No	Cancer		Yes	No	Chicken Pox
Yes	No	Congenital Heart Defects		Yes	No	Convulsions
Yes	No	Diabetes		Yes	No	Epilepsy
Yes	No	Exposed to HIV, but negative		Yes	No	Handicaps or Disabilities
Yes	No	Hearing Impairments		Yes	No	Heart Murmurs
Yes	No	Hemophilia		Yes	No	Hives
Yes	No	HIV / Aids		Yes	No	Kidney or Liver Problems
Yes	No	Measles		Yes	No	Mononucleosis
Yes	No	Rheumatic / Scarlet Fever		Yes	No	Skin Rash
Yes	No	Tuberculosis (TB)				

Are the Child's Immunizations current? ( ) Yes ( ) No

Please discuss any serious medical problems that the child has:

3)_____ 4)_____

Please list any allergies the child has:

1)_____ 2)_____

3)_____ 4)_____

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest 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.

My method of payment will be: _____

Signature of Parent or Guardian: _____ Date: ____/_____/_____

I certify that my child is covered by _____ Insurance Co and I assign directly to Dr _____ all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary for the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature of Parent or Guardian: _____ Date:____/____/_____

OFFICE USE ONLY **OFFICE USE ONLY** **OFFICE USE ONLY** **OFFICE USE ONLY**

I verbally reviewed the medical / dental information above with the parent / guardian named herein.

Staff Name: _____ Date: _____/_____/_____

Doctor's Initials: _____ Date: _____/_____/_____

Medical Updates:

_____
_____
_____
_____
_____
_____

Payment Information

It is the policy of this office to **request payment at the time of your visit.** You will be provided with an itemized and diagnosed statement that is satisfactory for insurance purposes.

Private insurance is a contract between you and your insurance company. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc., other than to supply factual information as necessary.

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependants during the period of such dental care to third party payors and/ or other health practioners. **I authorize and request my insurance company to pay directly the dentist** or dental group insurance benefits otherwise payable to me:

I understand I am financially responsible for all charges not covered by this assignment.

Signature: _____ Date: ____/____/_____

My method of payment will be : (Please check one of the following options)

- _____Cash
- _____Check
- _____Credit Card

Credit Card # : _____

Expiration Date: _____/_____

Signature of Credit Card Holder: _____

Type of Credit Card:

- _____Visa
- _____Master Card
- _____Discover

If I do not pay the entire new balance within 25 days of monthly billing date, a late charge of 1.5 % on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current, may result in my being unable to receive additional dental service except for dental emergencies or when there is prepayment for additional dental services. In case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

Signature: _____ Date: ____/____/ _____

Our Financial Policy

Thank you for choosing us for your dental care provider. We are committed to your being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy which we require you read and sign prior to any treatment. All patients must complete our information and insurance form before seeing the doctor.

-**Full Payment is due at time of service unless otherwise arranged prior to appointment.**

- We accept Cash, Checks, Visa, Master card, American Express, and Care Credit

Regarding Insurance: **We cannot bill your insurance unless you give us your insurance information or insurance card. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We do require and appropriate co-payment to be paid at the time of services. The balance is your responsibility whether your insurance company pays or not. In the event we do accept assignment of benefits, you must provide a credit card with authorization to bill the account for the balance. To "accept assignment of benefits" means to accept that portion of your responsibility directly from the insurance company. It does not imply that any insurance company that has not paid your account in full within 45days, the balance will automatically be transferred to your credit card, unless other arrangements are made. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not portion of the family account with this office is unpaid, the responsible party and/or insurance policy holder does herby assign any and all insurance benefits directly to the provider.**

Usual and Customary Rates: **Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.**

Minor Patients: **The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan.**

Appointment Cancellations: **Please help us serve you better by keeping scheduled appointments in timely fashion. At least 48 hours advanced notice in canceling appreciated. If proper notice is not given, an office fee will be charged.**

Thank you for understanding our Financial Policy. Please let us know if you have any questions of concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy, which includes direct payment of benefits to the provider.

Signature of Patient or responsible party : _____

Patient's Name : _____

Witness: _____

Date: _____/_____/_____

ACKNOWLEDGEMENT OF RECEIPT OF

NOTICE OF PRIVACY PRACTICES AND

CONSENT OF INFORMATION

You may refuse to sign this acknowledgement and consent form.

I, _____, have received a copy of this office's notice of privacy practices. By this signature, I also consent that this office can use or disclose my health information to a physician or other healthcare provider, providing treatment for me. It also authorizes this office to use and disclose my health information for the purpose of filing insurance claims. It further authorizes this office to contact me via mail, and/or telephone (cell phone or pager) to advise me of appointment times, payment and/or questions regarding treatment. **If there is any part of this consent you do not wish to agree to, please strike through that portion and advise our staff.**

Print Name:
_____

Signature: _____ Date:
_____/_____/_____

-Office use only-

We attempted to obtain written acknowledgement and consent of our notice of privacy practices, but acknowledgement and consent could not be obtained because:

___Individual refused to sign

___Communication barrier prohibited obtaining the acknowledgement and consent

___An emergency situation prevented us from obtaining acknowledgement

___Other (Please Specify)