Welcome to our Pediatric Dental Office. On behalf of everyone here, we would like to thank you for choosing us for your dental needs. I am confident that by working with you, we will be able to meet all of your dental needs and goals, and provide the best care possible for your child(ren).

The single most effective way to maintain the best oral and dental health is by emphasizing preventive dentistry. The recommended preventive care visits are very important. By using cleanings, topical fluoride treatments and a very thorough exam with emphasis on early detection techniques and radiographs when necessary, we can eliminate the need for more extensive dental treatment. When any treatment does become necessary, we then make it as easy as possible.

As a Pediatric Dentist, I am specially trained to provide comprehensive dental care for your children. This is not limited to prevention of tooth decay and gum disease. This also includes early detection and elimination of problems with the bite and alignment of the teeth.

*For our new patient's the legal guardian must accompany the child(ren) to the first visit and must bring: their Drivers License or State ID card for copying purposes, (completed) enclosed new patient paperwork, and the most current copy of your active insurance card in order to be seen for the appointment. If we are not provided with the up to date, active insurance information prior to the appointment's start, this will result in the total balance becoming patient's responsibility, due at the end of the appointment.

*If your child(ren) was referred by another dentist, please bring a copy of the referral, your child's most recent x-rays and any information regarding the treatment needed.

Sincerely,

Dr. Jody & Staff

**Our office does require a 24 hour notice if you are unable to keep this appointment.*

This Appointment is Reserved for:

____

On: ____________________

At: ______________

We look forward to meeting you and your family!

Jody L. Wright, D.D.S.

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Wright Smiles Pediatric Dentistry

Date ______

Patient Information

Name: ______ Nickname: ______
Birth date: ______ Age: ______ Social Security #: ______
☐ Male ☐ Female Hobbies: ______
Home Address: ______ Email: ______
City: ______ State: ______ Zip: ______

Father/Guardian Information

Name: ______ Birth Date: ______
Social Security #: ______ Marital Status: ______
Address (If same as Patient Please Check) ☐ ______
Home #: ______ Cell #: ______ Work #: ______
Employer: ______ Occupation: ______

Mother/Guardian Information

Name: ______ Birth Date: ______
Social Security #: ______ Marital Status: ______
Address (If same as Patient Please Check) ☐ ______
Home #: ______ Cell #: ______ Work #: ______
Employer: ______ Occupation: ______

Referral Information

Whom may we thank for referring you to our office?

☐ Another patient/Friend ☐ Another Dental Office ☐ Yellow Pages ☐ Online

**Please list either the persons name, insurance, other office referring you to our office:

______

Dental Insurance Information

Policy Holders Name: ______ Birth Date: ______
Social Security #: ______ Employer: ______
Insurance Name: ______ Id #: ______
Insurance Address: ______
Insurance #: ______ Group #: ______

I, being the parent or guardian of ______ do hereby request and authorize the dental staff to perform necessary dental services for my child, including but not limited to x-rays, and Fluoride, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

Signature of Responsible Party: ______ Date: ______

Medical Information:

PLEASE respond to every question

Patient's Name: ____________________

Patient's Physician/Pediatrician: ____________________ Phone #: ____________________

Date of last physical examination: ____________________ Results: ____________________

Has this patient had ANY history of difficulty with ANY of the following ? If YES, Please Check!

☐ AIDS/HIV	☐ Cancer	☐ Liver Disease
☐ ADD/ADHD	☐ Cerebral Palsy	☐ Measles/Mumps
☐ Anemia/Blood Disorders	☐ Chicken Pox	☐ Rheumatic Fever
☐ Asthma	☐ Diabetes	☐ Sickle Cell Disease/Trait
☐ Autism	☐ Epilepsy/Seizure's	☐ Sinus Problems
☐ Behavioral/Sensory Issues	☐ Hearing Impaired	☐ Thyroid Disease
☐ Birth Defects	☐ Heart Disease/Heart Murmur	☐ Tuberculosis
☐ Bladder Problems	☐ Hepatitis	☐ Other:
☐ Brain Damage/Developmental Delays	☐ Kidney Disease	____________________

Is patient under care of physician currently?	☐ Yes	☐ No	Explain ____________________
Receiving any medication or drugs?	☐ Yes	☐ No	Explain ____________________
Ever been hospitalized?	☐ Yes	☐ No	Explain ____________________
Ever had surgery?	☐ Yes	☐ No	Explain ____________________
Is there excessive bleeding when cut?	☐ Yes	☐ No	Explain ____________________
Been to the emergency room?	☐ Yes	☐ No	Explain ____________________

Allergies: ____________________

Medications: ____________________

Patient Dental History

Date of last visit to a dentist? ____________________ For What services? ____________________

Any Complained dental problems?	☐ Yes	☐ No
Any injuries to mouth, teeth, head?	☐ Yes	☐ No
Any unfavorable dental experiences?	☐ Yes	☐ No

Brush Daily ☐ Yes ☐ No   Does patient use fluoridated water at home? ☐ Yes ☐ No

Floss Daily ☐ Yes ☐ No   City Water ☐ Yes ☐ No   Fluoride Supplements ☐ Yes ☐ No

Any mouth habits- thumb sucking, nail biting, pacifier, sleeping with a bottle/cup, etc.? ☐ Yes ☐ No

Primary Dental concerns? ____________________

Emergency contact Information

In the event of an emergency, please list contact NOT living with you:

Name: ____________________ Relationship: ____________________ Phone #: ____________________

Name: ____________________ Relationship: ____________________ Phone #: ____________________

I acknowledge that deductibles, co-insurance or full payment is due at the time of service, unless other arrangements are made prior to treatment. I accept full financial responsibility for all charges not covered by insurance. I understand that claims will be released to me for full payment if insurance had not responded with payment within 60 days. I hereby authorize this office to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions, whether manuel or electronic. I certify that I have read the contents of this form and have filled it out to the best of my knowledge.

Signature of Responsible Party: ____________________ Date: ____________________

Office Policy

Thank you for choosing Wright Smiles. We are committed to providing your child with the best dental care. Your clear understanding of our Office Policy is important to our relationship.

Appointments:

- All necessary paperwork must be completed prior to being seen. These include patient charts, health history, consent forms and treatment plans.
- Payment is due in full the day of the appointment. If our estimate is more than what your insurance company originally estimated a refund will promptly be given. If the estimate is less, you will receive a billing statement by mail with your additional responsibility.
- A parent or legal guardian must accompany the patient to their first visit.
- We accept cash, check, Visa, Mastercard, Discover, and Care Credit.
- A 24-hour notice is required to change/cancel appointments to avoid a potential charge on your account.

****If you need to change your appointment date and/or time to avoid a $45.00 charge per hygiene appointment and $75.00 for treatment appointment that is scheduled. You may call and leave a message at our office 24 hours a day.**** **Initial______**

Insurance:

- As the responsible party, it is your responsibility to provide complete and accurate information regarding your policy. This includes the personal information of the policy holder i.e., Name, date of birth, employer, social security number, member ID, network status, and claims address. If you are unable to provide these details at the time of the appointment, you can choose to pay out-of-pocket for the appointment or to reschedule for a later date.
- Your insurance policy is a contract between you and your insurance company. We are not a party to that Contract. If your insurance company has not paid within 60 days, the claim will be closed, and the balance will be transferred to you. Once you contact your insurance company regarding the claim, we will resubmit accordingly.
- We will also expect you to know your maximum's, deductibles, and policy limitations prior to treatment. We cannot accept the responsibility of knowing all the details about your personal policy. Any Amount not paid by your insurance is your responsibility regardless of any estimation of benefits made by our office. **Initial______**

Accounts:

- Past due balances are subject to additional collection fees. Should you allow your account to be turned over to collections you will be responsible for all fees and expenses and will only be seen as a "self-pay" patient for future appointments the same guidelines apply if bankruptcy is filed.
- Payment is due in full the day of the appointment for all "self-pay" accounts.
- Our office does not get involved with 3rd party billing. The legal guardian that brings the child in for a visit is responsible for payment in full that day. **Initial______**

Thank you for understanding our Office Policy. Please let us know if you have any questions. "I have read and understand that regardless of my insurance status, I am ultimately responsible for the balance on my account."

Patient Name:____

Parent/Guardian Signature:__________________________________ **Date:**________________

Wright Smiles Pediatric Dentistry

You may refuse to sign this acknowledgement

I have received a copy of this office's Notice of Privacy Practices

Patient Name: ______________________________

Parent/GuardianSignature: ______________________________

Date: ______________________________

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

___Individual refused to sign

___Communications barriers prohibited obtaining the acknowledgement

___An Emergency situation prevented us from obtaining acknowledgement

___Other (Please Specify)