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 manual 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.

*Please read and initial each section:

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 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. 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 been paid within 60 days, the claim will be closed on your account and the balance will then be transferred to you. Once you contact your insurance company regarding the claim, we will resubmit accordingly. Initial_____

Accounts:

- Past due balances are subject to additional collections 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 in full is due the day of appointment for all 'self-pay' accounts. Initial_____

Thank you for understanding our Office Policy. Please let us know if you have any questions. "I have read an 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)