pediatric dental care

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Today's Date: _____/_____/_____ Office Location ☐ Fairfax ☐ Springfield

Patient Information

Child's Name: _____ Nickname: _____
Last First MI

Age: _____ Date of Birth: _____ Gender: _____

Mailing Address: _____ City: _____State: _____Zip: _____

Home Phone: _____ Parent's Mobile Phone_____

Parent's Email (s): _____

Responsible Party: ☐ Patient's Both Parents ☐ Patient's Mother ☐ Patient's Father ☐ Patient's Guardian

Mother's Name: _____ Social Security #_____ Date of Birth_____

Occupation: _____ Employer: _____ Work Phone_____

Address: _____

Father's Name: _____ Social Security #_____ Date of Birth_____

Occupation: _____ Employer: _____ Work Phone_____

Address: _____

Guardian's Name: _____ Social Security #_____ Date of Birth_____

Occupation: _____ Employer: _____ Work Phone_____

Address: _____

Parents' Address or Guardian's Address (if not living at above) _____

Whom may we contact in case of emergency? _____ Relationship: _____ Phone: _____

Insurance Information

Primary Insurance

Plan Name_____ Insured's name _____

Insured's Social Security # _____-_____-_____ Insured's Date of Birth_____

Policy/ ID #_____ Group#_____ Effective Date_____

Claim Address: _____ Phone: _____

Secondary Insurance

Plan Name_____ Insured's name _____

Insured's Social Security # _____-_____-_____ Insured's Date of Birth_____

Policy/ ID #_____ Group#_____ Effective Date_____

Claim Address: _____ Phone: _____

Child's Name: _____ **Date of Birth** _____

Referral Information

- ☐ Dentist Office/Name: _____ and/ or Group Name: _____
  Address: _____ Phone_____
- ☐ Pediatrician Office/Name: _____ and/ or Group Name: _____
  Address:_____ Phone:_____
- ☐ Family/Friend Name: _____ Address: _____Phone:_____
- ☐ Insurance Company: _____
- ☐ Yellowbook/ Magazines/Newspaper: _____
- ☐ Other: _____

Consent for Dental Treatment

I am the parent, guardian, or personal representative of the patient and there are no court orders now in effect that prevent me from signing this consent. I do hereby request and authorize the dentist(s) and the staff to perform any necessary dental services including but not limited to a comprehensive examination, cleanings, any necessary dental treatment for my child's teeth, X-rays as necessary to diagnose and/ or treat my child's dental problem, and administration of anesthetics that are deemed advisable by the dentist(s), whether or not I am present when the treatment is rendered. I understand that the dentist(s) will provide an environment that will help my child learn to cooperate during treatment including praise, explanations, and demonstrations of procedures and instruments, and using variable voice tones. I will be responsible for any charge incurred for my child for dental treatment.

Signature: _____ **Date:** _____

_____

Please print name of Patient, Parent, Guardian, or Personal Representative **Relationship to Patient**

Child's Name: _____ **Date of Birth** _____

Financial Agreement

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. Pediatric Dental Care (PDC) will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. PDC may assist you in identifying your insurance benefits, but the ultimate decision is made by your insurance company on whether services are a covered benefit and how much to pay. It is your responsibility to verify insurance coverage and benefits with your insurance company prior to the time that services are rendered by our office. The office makes no representations regarding whether your insurance will cover any services we provide.

A service charge of 1.5% per month on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

A $50 fee will be charged for each check returned by the bank.

A $10 fee will be charged for duplication of radiographs and treatment notes which is due at the time of the request.

The patient/parent/undersigned is responsible for costs and attorney fees (35%) if this account is sent to collection.

We require that at least 24-hour notice be given, as a courtesy to us and to other patients, if your schedule time is inconvenient. **The Broken Appointment fee will be $100, unless otherwise noted. `**

The responsible party have received, read, and understand the financial agreement and broken appointment policies. The responsible party hereby agrees to pay all charges submitted by PDC during the course of treatment for the patient. If the patient has insurance coverage with whom PDC has a contracted agreement, the responsible party agrees to pay all applicable co-payments and deductibles which arise during the course of treatment for the patient. The responsible party also agrees to pay for treatment rendered to the patient which is not considered to be covered service by insurance.

I understand that the fee estimate listed for this dental care can only be extended for a period of three (3) months from the date of the patient examination.

In consideration for the professional services rendered to the patient, or at my request, by the Dentist, I agree to pay therefore the reasonable value of said services to said Dentist, or his/ her assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition, and I further agree to pay all costs of collections and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at my mobile, home or at my work to discuss matters related to this form.

This is the entire agreement of the parties and supersedes any prior written or oral representations or agreements concerning payment for services rendered.

I agree and authorize that balances over 30 days may be applied to my credit card and that I will be responsible for obtaining insurance reimbursement for and outstanding claims. This consent will remain in effect unless canceled in writing.

Name of parent(s)/ guardian: _____

Signature: _____ Date: _____

Credit Card Number: _____ VISA / MC/_____

Name of Credit Card: _____ Expiration Date: _____

Office Witness Signature: _____ Date: _____