— Quality Dental Care —

WELCOME TO OUR PRACTICE

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out these forms completely:

ABOUT YOUR CHILD

Today's Date _____

Child's Name: _____
LAST FIRST MI

Nickname: _____ ☐ Male ☐ Female

Child's Birthdate: ____/____/____ Age: _____

School: _____ Grade: _____

Child's Home # _____ SS #: _____

Child's Home Address:

_____
APT/CONDO #

_____
CITY STATE ZIP

Parent's Marital Status: ☐ Single ☐ Married ☐ Divorced

Other family members seen by us: _____

_____

Previous/Present Dentist: _____
(Please Circle)

Last Visit Date: _____

How did you hear about our office?

☐ Radio ☐ Mailer ☐ Yellowbook ☐ TV

☐ Google ☐ Sign ☐ Other _____

☐ Patient _____

Have you heard our last radio announcement? ☐ No ☐ Yes

MOTHER'S INFORMATION

(☐ Step Mother ☐ Guardian)

Name: _____

WK #: _____ Ext _____

Cell #: _____ Birthdate: ___/___/___

Employer: _____

SS #: _____ DL #: _____

FATHER'S INFORMATION

(☐ Step Father ☐ Guardian)

Name: _____

WK #: _____ Ext _____

Cell #: _____ Birthdate: ___/___/___

Employer: _____

SS #: _____ DL #: _____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ Relation: _____

Billing Address: _____

_____
CITY STATE ZIP

WK #: _____ Ext _____ Cell #: _____

Employer: _____

SS #: _____ DL #: _____

Email address: _____

Who is responsible for making appointments?

Name: _____

WK #: _____ Ext _____ Cell #: _____

DENTAL INSURANCE

PRIMARY DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____

Relationship to Patient: _____

Insured's Birthdate: ___/___/___ SS #: _____

Insured's Employer: _____

Orthodontic Coverage: ☐ No ☐ Yes

SECONDARY DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____

Relationship to Patient: _____

Insured's Birthdate: ___/___/___ SS #: _____

Insured's Employer: _____

Orthodontic Coverage: ☐ No ☐ Yes

CONTINUED ON BACK OF FORM

WHAT BROUGHT YOU HERE TODAY?

_____

_____

Has the child ever had a serious/difficult problem associated with previous dental work?	☐ No	☐ Yes
Is the child's water fluoridated?	☐ No	☐ Yes
Is the child taking fluoridated supplements?	☐ No	☐ Yes
Has the child ever had any pain / tenderness in their jaw joint (TMJ / TMD)?	☐ No	☐ Yes
Does the child brush their teeth daily?	☐ No	☐ Yes
Floss their teeth daily?	☐ No	☐ Yes

DOES THE CHILD HAVE ANY OF THE FOLLOWING HABITS?

Thumb / Finger Sucking	☐ No	☐ Yes
Lip Sucking / Biting	☐ No	☐ Yes
Nail Biting	☐ No	☐ Yes
Nursing Bottle Habits	☐ No	☐ Yes

Child's Physician: _____

Phone #: _____ Date of Last Visit: _____

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and ADA.

SIGNATURE AUTHORIZATION

**I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment.

**6 month appointments routinely consists of an exam, prophylaxis (cleaning), and a fluoride treatment (for all children under 16 and as recommended by Doctor otherwise). Bitewing x-rays will be taken at least once per year as recommended by Doctor, and a full mouth x-ray will be updated every three years. These are our standards of care to give each patient the best service we can provide. Each employer's policy has different allowances and limitations. Since it is the patient who has the contract with the insurance, it is your responsibility to know your insurance coverage. If you have any questions regarding your treatment, you must ask before treatment is rendered.

**I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with my dental insurance claims.

**I authorize payment of the dental benefits otherwise payable to me directly to Quality Dental Care.

**I understand that all payments at the time of the appointment are estimates only and I am responsible for all charges incurred on my account that are not covered by insurance. I understand that all balances on my account are due in full within 60 days of date of service regardless of insurance payment. A service charge of 1.33% per month, 16% APR, with a minimum of $1.00 will be added to all overdue accounts. A late fee of $20.00 will be added to all accounts unpaid for 90 days. I agree to be liable for all legal and collection fees.

**Since appointment times are reserved just for the patient scheduled, we require 24 hours notice to change appointments without a charge. All appointments changed with less than the required notice are subject to a $50.00 cancellation fee.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**I acknowledge that I have received access to the office's Notice of Privacy Practices.

**I authorize the release of any of my dental information including proposed treatment plans, procedure fees, and dental history to the following individuals:

❖ _____ NAME _____ RELATIONSHIP

❖ _____ NAME _____ RELATIONSHIP

❖ _____ NAME _____ RELATIONSHIP

_____
PRINT PATIENT'S NAME

_____
DATE

_____
SIGNATURE