DENTISTRY "4" CHILDREN PLLC

Jeremy Wiggins, DDS

PATIENT INFORMATION

Full name_____ Preferred name_____ Sex **M F** Birth date_____
First MI Last

Address_____ City, State, Zip_____ Phone_____

Who does child live with? ☐ Both Parents ☐ Mother ☐ Father ☐ Other: _____

Child's Parents Marital Status ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Separated** ☐ **Divorced**

How did you hear about us?_____ How do you prefer we contact you regarding appointments? ☐ Phone ☐ E-mail ☐ Text ☐ Postcard

PARENT/GUARDIAN INFORMATION

☐ **MOTHER** ☐ STEP ☐ GUARDIAN Marital Status **S M W Sep Div**

First and Last Name_____ Date of Birth_____ SSN_____

Address _____ City _____ State _____ Zip _____

Home # _____ Cell#_____ Work #_____

Employer_____ E-mail address: _____

☐ **FATHER** ☐ STEP ☐ GUARDIAN Marital Status **S M W Sep Div**

First and Last Name_____ Date of Birth_____ SSN_____

Address _____ City _____ State _____ Zip _____

Home # _____ Cell#_____ Work #_____

Employer_____ E-mail address: _____

INSURANCE INFORMATION

Name of Insured: _____ Birth date_____ ID#_____ Group # _____

Insured's Address:_____ Insured's Employer Name _____

Patient's Relationship to Insured: Self ____ Child ____ Other _____ Insurance Plan Name & Address:_____

If patient is covered by additional insurance, please complete below

Name of Insured: _____ Birth date_____ ID#_____ Group # _____

Insured's Address:_____ Insured's Employer Name _____

Patient's Relationship to Insured: Self ____ Child ____ Other _____ Insurance Plan Name & Address:_____

EMERGENCY CONTACT NAME (other than parent): _____ Relationship to Child _____

Home Phone # _____ Cell Phone# _____ Work Phone # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s) have the above named insurance coverage and assign directly to Dentistry "4" Children all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Dentistry "4" Children may use my healthcare information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payments for services and determining insurance benefits or the benefits payable for related services. This consent will remain valid unless revoked in writing.

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO PROVIDE AND INFORM THIS OFFICE WITH ANY PERSONAL CHANGES AND INSURANCE CHANGES.

_____ _____

Signature of Parent or Guardian **Date**

DENTAL HISTORY

Patient Name_____ **Date of Birth**_____

Is this your child's first dental visit? Y N If no, date of last dental exam_____

Were x-rays taken? Y N Dentist's name_____

Reason for today's visit_____

Do you think your child will be a cooperative patient? Y N

Please indicate if your child has had any of the following:

	YES	NO
Toothaches		
Clenching or grinding teeth		
Lip sucking		
Cold sores (fever blisters)		
Mouth breathing		
Tooth abscess (gum boil)		
Stained teeth		
Bad breath		
Gum swelling or tenderness		
Bleeding gums		
Clicking/popping/pain in jaw		
Frequent sore throat		
Finger/thumb habit		
Pacifier use		
Sleeps with a bottle		
Presently nursing or drinking from a bottle		

If not, when did your child stop nursing or drinking from a bottle? _____

If nursing or drinking from a bottle, what are the usual contents? _____

	YES	NO
Frequent snacking (1-3 times daily) between meals		
Drinks acidic beverages (Gatorade, Soda-Pop, Juice)		
Chews gum with sugar		
Use of Xylitol gum or products containing Xylitol		
Use of an electronic toothbrush (Sonicare or Oral-B)		
Child has an adult help with dental home care (brushing & flossing)		
Mother/Father or primary caregiver has had a cavity in the past 12 months		
Is your child on a special diet?		

Does your child use a fluoridated rinse (ACT, Carifree)? Yes _____ No _____ Not sure _____

Does your child live on Well Water _____

How often does your child brush? 1 time per day _____ 2 times per day _____ other (please specify) _____

Parent or Guardian Signature:_____ **Date:**_____

MEDICAL HEALTH HISTORY

Patient Name_____ **Date of Birth**_____

Name of Child's Physician _____

ALLERGIES

Please indicate if your child is allergic to or had an unfavorable reaction to any of the following:

- ☐ None
- ☐ Penicillin
- ☐ Amoxicillin
- ☐ Sulfa
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Other known allergies to food or drugs_____

DOES YOUR CHILD REQUIRE PRE-MEDICATION? YES _____ NO _____

Please indicate if your child has had any of the following health problems:

	YES	NO
MRSA		
Autism		
Asthma		
Hay fever		
Blood disorder		
Hemophilia		
Kidney problems		
Liver problems		
Growth problems		
Rheumatic Fever		
Mental/emotional problems		
ADHD/ADD		
Heart murmur		
Heart problems		

	YES	NO
Artificial heart valve(s)		
Sickle cell anemia		
Diabetes		
Breathing/lung problems		
Deafness/hearing loss		
Blindness/loss of sight		
Convulsions/ seizures/ epilepsy		
Tumors/ cancer/ leukemia		
Car/motion sickness		
Problems w/concentrating		
Problems w/learning		
Problems w/speech		
Problems w/cooperating		
Problems w/understanding		

Other : _____

If needed, please explain health problems:_____

_____

MEDICATIONS

Please list any drugs or medications your child is taking at this time:_____

_____

VITAMINS

Please list any vitamins your child is taking at this time: _____

My signature below indicates that I understand and have answered all questions to the best of my knowledge. I request and consent to the performance of any tests or procedures which are deemed necessary after a complete clinical examination. I understand it is my responsibility to provide and inform you with any insurance or health changes.

Parent or Guardian Signature: _____ Date_____

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Financial Policy

We find that our patients appreciate knowing in advance what is expected of them financially and what terms and conditions are available. Please read the following information carefully. We are committed to providing your child with the highest standard of dental care. We welcome your child and family into our practice and we will strive to make your child's dental experience positive and pleasant. In order to achieve these goals, and focus on caring for your child, we need your assistance and understanding of our financial policy.

Fees incurred are due and payable at the time of service (for insurance coverage read below). Understand that filing a claim with your insurance company does not relieve you from your responsibility for the payment of all charges. We gladly accept cash, personal checks, and VISA/Mastercard and Discover® for payment of your account. We offer a 5% cash discount if paid by paper check or cash. For your convenience, we also work with CareCredit® & Citi HealthCard®, who offer "no interest" payment plans. Please ask our business office for information on this outsourced financial plan. **Please be aware that the parent bringing the child to our office is responsible for payment of all charges.** You give us permission to check your credit and employment history and to answer questions about your credit experience with us.

If we have received **all** of your insurance information **on the day of the appointment**, we will be happy to file your claim for you. In order to provide this service, we will need your **updated insurance information before each appointment.** Remember it is your responsibility to give accurate insurance information so that this can be done in a timely manner. We accept assignment of benefits on most major insurance policies and will also prepare and file your claim as a courtesy to you. We ask that **you pay your deductible, co-payment, and non-covered portions at the time of your visit**. You must be familiar with your insurance benefits, as we will collect from you the **estimated amount** insurance is expected to not pay. At your child's evaluation appointment, we will provide a written estimate of your out of pocket expenses for services and the **estimated** portion due for each treatment appointment. We can only assist you in **estimating** your portion of the cost of treatment. We at no time guarantee what your insurance will or will not do with each claim. **We have absolutely no control over the reimbursement process or determination of eligibility.** If your insurance company fails to pay our office within 30 days, then you are responsible for the balance. All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance is a contract between you, your employer, and the insurance company. We will be glad to send a refund to you if your insurance pays us and it creates a credit on your account. We will make every effort to assure you receive maximum benefits.

You are responsible for any balance on your account, whether insurance has paid or not. A finance charge of 1.5% per month or an annual percentage rate of 18% may be added to your account, with a minimum finance charge of $1.99. If your account becomes past due, we may assign the account to our collection agency (American Credit Bureau) for further collection actions and report the status of your account. You agree to pay all collection costs incurred. Should your account balance go to collections, it is our policy to not reschedule appointments for your family in our office. **We reserve the right to cancel your privileges to make "charges" against your account at any time, or require a larger co-pay be made at the time of service. Returned checks will be charged $20 for any check returned by the bank.**
Orthodontic payment is handled on a case by case basis.

Transferring of records

You will need to request in writing if you want to have copies of your records sent to another doctor or organization (we reserve the right to request a copying fee of up to $25). You authorize us to include all relevant information, including your payment history.

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Appointment Commitment

To best meet the needs of our patients and their families, Dentistry "4" Children makes every attempt to remain on schedule throughout the day. When we schedule an appointment for your child, two events occur: 1) we will hold that appointment time for your child in our appointment book and, 2) we trust you will arrive on time for that appointment. As a courtesy, our office will attempt to contact you for confirmation 1 – 2 days before your appointment. However, we do ask that patients/parents assume responsibility for their appointment time/date. If you are late for an appointment, we will do our best to fit you in our schedule, however, it may be necessary for us to reschedule your appointment. Please note that **repeated late appointments or cancellations with less than a 24 hour notice may result in you being charged a $30 fee or being "Dismissed". Not showing for 2 appointments may result in the family being "Dismissed" from the practice.**

How Are Appointments Scheduled?

The office attempts to schedule appointments at your convenience and when time is available. Preschool children should be seen in the morning because they tend to be more cooperative at that time and we can work more slowly with the child for their comfort. School children with a lot of work to be done should be seen in the morning for the same reason. We know that you don't like missing school or work for appointments. Because of the nature of our practice, it is impossible to accommodate everyone for these sought-after appointment times. To make our schedule run smoothly and to benefit our patients, there are certain times of day that certain procedures are performed. Dental appointments are an excused absence. We appreciate your understanding in this matter. Since appointment times are reserved exclusively for each patient we ask that you **please notify our office 24 hours in advance of your scheduled appointment if you are unable to keep your appointment**. Another child who needs our care could be scheduled if we have sufficient time to notify them. We realize that unexpected things can happen, but we ask for your assistance in this regard. Please **plan to arrive 5 minutes** or more before your scheduled appointment. This will allow time for you to complete any additional paperwork and for us to see your child on time. If you have to wait more than 15 minutes, please advise our front office staff. **A parent or legal guardian (with official documentation) must be present in the office during the initial examination and/or any restoration appointments**.

_____ _____

Signature of Parent/Legal Guardian Date

HIPAA (Acknowledgement of receipt of Notice of Privacy Practices)

These Health Information Privacy Policies & Procedures implement our obligations to protect the privacy of individually identifiable health information that we create, receive, or maintain as a healthcare provider.

We implement these procedures as a matter of sound business practice; to protect the interests of our patients; and to fulfill our legal obligations under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), its implementing regulations at 45 CFR Parts 160 and 164 (65 Fed. Reg 82462 (Dec. 28, 2000)) ("Privacy Rules"), as amended (67 Fed Reg 53182 (Aug. 14, 2002)), and state law that provides greater protection or rights to patients than the Privacy Rules.

These Policies & Procedures address the basics of HIPAA and the Privacy Rules that apply in our dental practice. They do not attempt to cover everything in the Privacy Rules. The Policies & Procedures sometimes refer to forms we use to help implement the policies and to the Privacy Rules themselves when added detail may be needed.

Please note that while the Privacy Rules speak in terms of "individual" rights and actions, these Policies & Procedures use the more familiar word "patient" instead; "patient" should be read broadly to include prospective patients, patients of record, former patients, their authorized representatives, and any other "individuals" contemplated in the Privacy Rules.

If you have questions or doubts about any use or disclosure of individually identifiable health information or about your other obligations under these Health Information Privacy Policies & Procedures, the Privacy Rules or other federal or state law, consult our business manager at (208) 743-2505 before you act.

_____ _____

Signature of Parent/Legal Guardian Date