

We are pleased to welcome you and your child to our practice. Our goal is to educate, motivate, and promote good oral health that will last a lifetime. Please take a few minutes to fill out this form completely. Please mark "SAME" or "N/A" where appropriate.



1. Patient Information

Child's Name:

_____ Nickname _____

Male / Female

Physical Address: _____ City _____

State _____ Zip _____

Mailing Address: _____ City _____

State _____ Zip _____

Phone: (____) _____ SSN: _____

Child's Birth Date: ____/____/____ Age: ____ Grade: ____

School: _____ Special interests/Pets _____

Emergency Contact(other than parent): _____

Phone #: (____) _____

2. Parent/Guardian Information

Name: _____

Relation to child: _____

Address: _____ City _____

State _____ Zip _____

Phone: (____) _____ Work #: (____) _____ Ext: ____

Cell #: (____) _____

Birth date: ____/____/____ SSN: _____ DL#: _____

Email: _____

Employer: _____ Occupation: _____

Marital Status: Married Single Divorced Separated Widowed

Are you the legal guardian of this child? **Yes / No**

Are you the person responsible for the account? **Yes / No**

If no, please name the legal guardian / responsible

party: _____

Name: _____ **Relation to child** _____

Address: _____ City _____

State _____ Zip _____

Phone: (____) _____ Work #: (____) _____ Ext: ____

Cell #: (____) _____ Birth date: ____/____/____

SSN: _____ DL#: _____

Email: _____

Employer: _____ Occupation: _____

Marital Status: Married Single Divorced Separated Widowed

Are you the legal guardian of this child? **Yes / No**

Are you the person responsible for the account? **Yes / No**

If no, please name the legal guardian / responsible

party: _____

How did you hear about us? _____

3. Child's Dental History

Why did you bring your child to the dentist today?

Is your child having dental problems at this time? If so, explain _____

Has your child had any unfavorable dental experiences? If so, explain _____

Date of last dental visit: _____

Previous dentist's name: _____

Is your child's drinking water fluoridated? **Yes / No**

Is your child taking fluoride supplements? **Yes / No**

How often do your child's teeth get brushed? _____

How often do they get flossed? _____

Does your child have any of the following dental habits?

Y N Thumb/ finger sucking **Y N** Nursing/ bottle habits **Y N** Bites/ chews objects

Y N Mouth breather **Y N** Pacifier **Y N** Grinds/ clenches teeth **Y N** Tongue thrusting

Y N Pain in jaw (TMJ)

4. Child's Medical History

Has your child ever had any of the following medical problems?

Y N Asthma **Y N** Behavioral problems **Y N** Diabetes **Y N** HIV / AIDS

Y N Heart Murmurs **Y N** Cancer **Y N** Hepatitis **Y N** Nervous disorders

Y N Abnormal Bleeding **Y N** Congenital Heart Defect **Y N** Handicaps/ Disability

Y N Rheumatic Fever **Y N** ADD/ ADHD **Y N** Convulsions / Epilepsy

Y N Hearing Impairments **Y N** Speech delays **Y N** Any hospital stays

Y N Developmental/ Learning delays

Y N Hemophilia

Y N Tuberculosis (TB)

Please discuss any medical problems that your child has had:

Child's physician: _____ Phone #: (____) _____

Last Visit: _____ Child's pharmacy: _____

Phone #: (____) _____

Please list any drugs your child is currently taking:

Please list any drugs / materials that your child is allergic to: penicillin, latex, anesthetics, codeine, metals, Other:

5. Insurance Information

() **Please see copy of insurance card(s) provided**

Policy Holder's Name: _____ **Birthdate:** ____/____/____

SS#: _____ **Insurance Name:** _____

Ins. Phone: (____) _____ **Ins. Address:** _____

Policy ID#: _____ **Group #:** _____

Policy Holder's Employer: _____

6. Acknowledgement

I attest that the information that I have given is accurate to the best of my knowledge. It is my responsibility to inform the office of any changes in my child's health or other information.

Signature of parent or guardian

Date

THANK YOU

Beech Lake Pediatric Dentistry

Your Privacy Is Important to Us

Acknowledgement of Receipt of Notice of Privacy Policies (Minor)

I have received a copy of the Notice of Privacy Practices of Beech Lake Pediatric Dentistry. I hereby authorize, as indicated by my signature below, Beech Lake Pediatric Dentistry to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

Print Name

Address

Signature

Date

Please check your preferred means of communication:

- You may contact me at my home telephone number _____
- You may contact me on my mobile telephone number _____
- You may contact me on my work telephone number _____
- You may send me an email at: _____
- Other _____

* * *

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
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining the acknowledgement
- Other (Please Specify) _____

Staff Person Initials _____

PATIENT CONSENT (MINOR)

Clinical

1. As the parent/legal guardian of _____ (“Patient”), I authorize Beech Lake Pediatric Dentistry to perform all recommended treatment on the Patient.
2. I authorize the Practice to take radiographs, study models, photos, and other diagnostic aids or materials (collectively, “Diagnostic Material”) as needed to make a thorough diagnosis. I authorize that such Diagnostic Material may be released to third-party payors and/or other health professionals.
3. I authorize the use of anesthetics, sedatives, and other medication, as needed, and am fully aware that using anesthetic agents involves certain risks, including but not limited to redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest, drowsiness, and/or lack of coordination.
4. I authorize the following individual(s) the authority to transport and/or accompany my child to their dental appointments in my absence. I furthermore agree that the individuals listed below have my full authority to authorize changes in my child’s dental treatment. I further authorize the discussion of the patients Protected Health Information (PHI) to the below listed persons. This includes, but is not limited to, medical information/conditions, different filling types, extraction of teeth, conscious sedation, and all other forms of dental treatment. I understand that any changes made to my child’s treatment plan can result in changes to the amount of money owed to the dental office, and I agree to be fully responsible for any additional fees incurred. I understand that I can revoke this permission at any time, but this must be done by WRITTEN notification.

Individual’s Name

Individual’s Phone Number

Date authorized

Individual’s Name

Individual’s Phone Number

Date authorized

Parent/Guardian Name (Print)

Parent/Guardian Signature

Date

5. I understand that Dr. Burke and his staff might use behavior management techniques such as praise, child appropriate language, demonstration of procedures and instruments, and variable voice tone to aid in cooperation during dental treatment.

Financial

6. **I am responsible for payment for all services rendered on behalf of the Patient.** I understand that payment is due when services are rendered. I am aware that a 1.5% MPR or 18% APR is automatically tabulated into my account if my balance is 60 days old or older. Balances over 90 days will be turned over to a collection agency; Should my account become delinquent, **I will be responsible for all additional collection costs including reasonable attorney fees.**
7. **We accept cash, checks, debit cards, Visa, and MasterCard.**
8. If a check is returned NSF, there will be a **\$25.00 check return fee**; from that point on, checks will not be accepted. A drivers license number will be required on all checks.
9. We also offer financing through a separate company (CitiHealth and CareCredit). This, however, requires credit approval from an outside agency and minimal monthly payments. If you are interested in this program, ask one of our front office staff for more information.
10. I am aware that to hold down operating costs, 24 hours notice of cancellation is required. A missed appointment charge of \$50.00 may be applied to your account if less than a 24 hour notice is given.

Insurance

11. I authorize the Practice to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, any and all information, records, and radiographs about the Patient's medical history, services rendered, or recommended treatment.
12. I authorize the Practice to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company, on my behalf or on Patient's behalf and in my name listed as "signature on file" and assign to the Practice the insurance benefits providing assignment is accepted. **I am responsible for payment regardless of the coverage provided.**
13. **Patient's portion of payment is due at the time of service.** We will gladly submit your insurance claim for you; however, we do require any deductibles, co-payments, and "estimated" patient portions be paid at the time of service. **PLEASE UNDERSTAND** that we file dental insurance as a courtesy to our patients. We do not have a contract with your insurance company, only you do. We are not responsible for how your insurance company handles its claims or for what benefits they pay on a claim. 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 ALSO CANNOT BE RESPONSIBLE FOR ANY ERRORS IN FILING YOUR INSURANCE.** Once again, we file claims as a courtesy to you.
14. I understand that my dental insurance plan is designed to only **share** in my dental costs, usually covering **50-80%** of the total dental bill. I understand that some dental services may **not** be covered by my insurance plan. I understand the amount of dental benefits I receive is determined by my employer or my insurance company, **not by the dental clinic.** I understand it is my responsibility to review my insurance policy and to understand my specific dental benefits.

