Child Medical History

Patient Name _____Date of Birth _____Age _____

Name Preference_____ Pediatrician's Name _____

Parent/Guardian Name _____

Address_____Telephone Number_____

Cell Phone Number for Confirmation Text _____

Email address for Confirmation Email _____

Person Responsible for Account_____ Telephone Number_____

Reason for today's visit _____ Date of last dental visit _____

Does your child take daily fluoride tablets? □ Yes □ No
Does your child have behavioral problems? □ Yes □ No
Does your child have any developmental problems? □ Yes □ No

Check all that apply

□ Bleeding Disorder
□ Asthma
□ Cancer Type _____
□ Diabetes
□ Epilepsy
□ Other disease or illness not listed: _____
□ ADHD

Allergies

□ Latex
□ Antibiotics _____
□ Aspirin/Ibuprofen
□ Local anesthetics
□ Other _____

Medications

List any medications that you are currently taking:

_____
_____
_____
_____
_____
_____

I certify that the above medical history is correct to the best of my knowledge:

_____ _____

Parent/Guardian Signature **Date**

HIPPA:

I understand that I have certain rights in privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996. I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment).
- Obtaining payment from third party payers (e.g., my insurance company).
- The day-to-day healthcare operations of your practice.

I have been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

_____ _____

Parent/Guardian Signature **Date**

Insurance and Financial Policy

Thank you for choosing Somers Dentistry, LLC. We are committed to providing you with the best possible care so you can achieve and maintain your optimum dental health in a respectful and caring environment. We thank you for taking the time to read and understand the policy outlined below.

_____Your dental benefits are based upon a contract made between your employer and an insurance company. If you have any questions regarding your dental benefits, please contact your employer or insurance company directly. Dental benefits will almost never pay for completion of your dental care. It is only meant to assist you.

_____We currently process all insurance plans. This means we work with literally hundreds of companies. Although we can maintain computerized histories of payments by a given company, they do change; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is ONLY AN ESTIMATE. If you would like to know your insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. Keep in mind this is still not a guarantee of coverage. This does delay treatment but will give you more accurate ESTIMATE of your financial responsibility.

_____We will bill your insurance as a courtesy. If insurance does not pay within 90 days, we reserve the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare, but it is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

_____A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we ask that you give at least 24 hour notice. Failure to follow this policy or failure to show up for your appointment might result in a $55.00 charge for each hour of a missed appointment. After 2 occurrences, you may be required to pay a deposit in order to schedule further appointments.

_____ Payment is due at the time services are rendered. If we are filing your claim for you, copayment and deductible is due at the time services are rendered. We accept Visa, MasterCard, American Express, Discover, Debit, Cash, Check and CareCredit. For appointments over 90 minutes, if you have insurance, half of your copay is due at the time you schedule, and if you are a cash patient, $200 is due at the time of scheduling. The remainder of the balance is due on the day of service.

I agree with the above conditions.

Print Patient Name: _____ Date: _____

Print Parent Signature: _____

Parent/Guardian Signature: _____