SmArt Pediatric Dentistry

Patient Information:

Child's Name _____ Today's Date _____
Address _____ Preferred Name _____
City _____ State _____ Zip _____ Sex _____M _____F
Child's Date of Birth _____Age_____ Grade _____ Home Phone _____
Who was your child's previous dentist? _____ When was their last cleaning and exam? _____

Responsible Party Information

Legal Guardian/Parent of a minor child is responsible for the account.
Parent's marital status: Single ____ Married ____ Widowed ____ Separated ____ Divorced ____

Mother's Information:

Name _____ Cell Phone _____
Address _____ Work Phone _____
City _____ State _____ Zip _____ Home Phone _____
Employer _____ Occupation _____
Date of Birth _____ SS# _____
Email Address_____ Appointment confirmation by Text__ Email __Phone call__

Father's Information:

Name _____ Cell Phone _____
Address _____ Work Phone _____
City _____ State _____ Zip _____ Home Phone _____
Employer _____ Occupation _____
Date of Birth _____ SS# _____
Email Address_____ Appointment confirmation by Text__ Email __Phone call__

Insurance Information:

Primary Insured Information:

Name _____ Relationship to Patient _____
Employer _____ Group/Plan Number _____
Dental Ins. Co. _____ Phone Number _____
Insured S.S. # _____

Secondary Insured Information:

Name _____ Relationship to Patient _____
Employer _____ Group/Plan Number _____
Dental Ins. Co. _____ Phone Number _____
Insured S.S. # _____

Person to contact in case of emergency:

Name _____ Relationship _____ Phone _____

Whom may we thank for referring to you? _____

Medical and Dental History Form

Child's name: _____ **Date of birth:** _____ **Gender:** □ Female □ Male

Please complete the following form so we may better serve your child:
What is the main reason you brought your child to us? (Chief complaint) _____

Has your child ever had any of the following:	Yes	No	Comments
Heart Murmur			
Congenital heart disease			
Asthma, Cystic Fibrosis, Respiratory Disease (please state)			
Diabetes, Thyroid, Glandular, or other endocrine disease			
Liver Disease/Hepatitis/Jaundice (please state)			
Kidney Disease			
Skin, Bone, Muscle, or Joint Disease			
Seizures/Convulsions/Loss of Consciousness			
Cerebral Palsy or Neurological Disease			
Sexually Transmitted Disease or HIV			
Anemia, Hemophilia, other Blood Disorders			
Sickle Cell Disease or Trait			
Cancer			
Speech disorder			
Hearing disorder			
Sight or eye disorder			
Frequent Headaches			
Mental, Emotional, or Developmental delays			
Autism, ADHD, Genetic Disorder/ Syndrome (please state)			
Frequent infections			
Has your child ever received blood/blood products?			
Has your child ever been hospitalized?			
Has your child ever been seriously ill?			
Has your child ever had a significant injury?			
Has your child ever had surgery?			
Does your child take any medicine?			
If so, what medicine?			
Is your child allergic to any foods, environmental pollutants, animals, or medicines?			
If so, what foods, pollutants, animals, or medicines			

Are there any other diseases or medical conditions that we should know about in order to care for your child? □ No □ Yes, please list_____

What is the name and phone number of your child's Primary Physician? _____
_____

Has your child had any of the following:	Yes	No	Comments
Pain in the teeth			
Swelling of the mouth and face			
Injury to the face or teeth			
A bad dental experience			
Does your water have fluoride			
Does your child thumb suck, or other oral habit			
Does your child have any other dental condition			

Which of the following categories best describes your child's learning abilities? □ Delayed □ Normal □ Advanced

How do you think your child will cooperate for this appointment? □ Well-behaved □ Unsure □ Uncooperative

_____ _____ _____ _____

Date Parent/Guardian Reviewed By Date

FEES, INSURANCE COVERAGE, AND PAYMENT POLICY

Payment of Service: I **understand payment is required at the time of service, whether I have insurance or not. Smart Pediatric Dentistry will *assist* me in filing any claims, but I am the one responsible for the bill. If I have insurance, I will make the full payment of the estimated out-of-pocket portion. It is possible that my insurance company may provide Smart Pediatric Dentistry with inaccurate information. This can lead to an inaccurate estimate of my responsible portion. However, I understand that I am still responsible for the balance. Once the claim is filed, my insurance company will provide an Explanation of Benefits (EOB) that will finalize my responsible portion of the claim. My insurance company does not provide this prior to receiving services. Smart Pediatric Dentistry encouraged me to verify my plan's benefits directly with my insurance company prior to initiating treatment. If my Explanation of Benefits indicates an overpayment has been made by me, Smart Pediatric Dentistry will mail me a refund.**

24 Hour Cancellation Policy: We value your time and strive to make appointments as timely as possible. We require 24-hour notice if you need to reschedule any appointments. Failure to give notice will result in a $25 missed appointment fee for routine visits and $100 missed appt fee for sedation visits.

Method of Payment: Smart Pediatric Dentistry does not provide a payment plan. However, I have options for payment including cash, MasterCard, VISA, Discover, American Express, and any other finance institutions with whom Smart Pediatric is connected.

Insurance:

- **Verification and estimation of benefits**: As a courtesy to me, Smart Pediatric Dentistry will verify my insurance benefits and give me an estimate of my out-of-pocket expenditure. This is NOT a guarantee that my insurance will pay exactly as estimated. Even though Smart Pediatric Dentistry will give me this estimate, I understand it is my insurance company that determines the amount paid and may provide Smart Pediatric Dentistry with inaccurate information on the initial estimate. As dictated by law and my insurance plan, if I have reached my maximum benefit of the plan, the insurance fee schedule will no longer apply, and the Smart Pediatric Dentistry fee schedule will be used to calculate charges on additional services.
- **Payment responsibility**: I understand I am responsible for payment of estimated co-insurance, deductible, co-pay, or non-covered services at the time of service. ***I am responsible for payment whether or not my insurance pays. Any discrepancies between Smart Pediatric Dentistry's initial estimate and final amount due, based on the Explanation of Benefits as set by my insurance company, are also my responsibility.***
- **Insurance Information: I** verify that all insurance information I have provided is correct and current. It is my responsibility to verify that Smart Pediatric Dentistry is a participant in my plan.

Collection Fees: If it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal charges incurred. In the event that any amount(s) is/are referred to a third-party debt collection agency, I agree that in addition to any other amount(s) allowed for by law, (such as interest, court costs, reasonable attorney's fees, etc.) I will also be responsible for a collection fee of up to 40% of the principal amount(s) owing as allowed by Utah Code Annotated, sec. 12-1-11 and further agree to pay all other costs of collection (whether incurred by Smart Pediatric Dentistry or its assigns) including but not limited to court costs, reasonable attorney fees, and interest (both pre-and post-judgement) at the rate of 1.5% per month (18% annum). If it becomes necessary for our office to enlist a collection service and our legal assistance, you will be responsible for any collection and/or legal charges incurred.

Minor Patients: The parent or guardian accompanying the minor is responsible for the payment of services. Regardless of insurance coverage, young adults (age 18 and over) are legally responsible for their accounts unless a parent accompanies them to the initial appointment and signs the financial agreement.

Divorced/Separated Parents: The parent who brings the child for an appointment or visit will be responsible for payment of any sums due at the time of the encounter, regardless of which parent is providing the insurance coverage, if any, for the child. Smart Pediatric Dentistry is not a party to nor bound by any divorce decree, court order or other agreement concerning responsibility for costs associated with the child's medical care. Should any divorced or separated parent believe the other parent is responsible for payment or reimbursement, that parent will need to address those concerns with the other parent, their counsel, or the court. Smart Pediatric Dentistry will not become involved in any such disputes between parents.

Phone Contact: I hereby consent to being contacted by telephone at any telephone number (including but not limited to wireless/cellular phone numbers) provided by me or anyone associated with me or acting on my behalf to Smart Pediatric Dentistry or anyone acting on its behalf. I understand and agree that such calls may be initiated by a collection company or any of its affiliates, agents, contractors or assigns, including but not limited to billing companies and/or third-party collection agency(ices), and that the methods of contact may include using pre-recorded/artificial voice messages and/or the use of an automated dialing device and/or the use of text messages-some or all of which may result in data charges. I also consent to receiving emails at any e-mail address provided by me or anyone associated with me or acting on my behalf.

_____ _____

Signature of Patient or Parent/Guardian Date

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUAL/FAMILY MEMBERS

In accordance with Federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPAA), in order for your healthcare provider or staff of Smart Pediatric Dentistry to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

_____ I **do not authorize** Smart Pediatric Dentistry to release any or all information concerning medical care to any individual except for as set above.

_____ I **do authorize** Smart Pediatric Dentistry to verbally release any or all information concerning my medical to the following individuals:

_____

Name Relationship to Patient

_____

Name Relationship to Patient

_____

Name Relationship to Patient

_____

Patient Signature -Parent

_____

Print Patient Name - List all children

_____ Date