Patient Information

Child's Name_____
Last Name *First Name* *Middle Initial*

□ **Male**
□ **Female** **Age**_____ **Birthday**___/____/____ **Nickname**_____ **Hobbies**_____

Child's Name_____
Last Name *First Name* *Middle Initial*

□ **Male**
□ **Female** **Age**_____ **Birthday**___/____/____ **Nickname**_____ **Hobbies**_____

Child's Name_____
Last Name *First Name* *Middle Initial*

□ **Male**
□ **Female** **Age**_____ **Birthday**___/____/____ **Nickname**_____ **Hobbies**_____

Home Address_____
Street *Apt #* *City* *State* *Zip Code*

Mailing Address_____
Street *Apt #* *City* *State* *Zip Code*

Home Phone #_____ **Mom Cell#**_____**Dad Cell#**_____

How did you hear about us?_____

Email Address:_____

We remind you about appointments via email, text message and phone calls.

PARENT'S INFORMATION

Circle One:
Father Stepfather Guardian
Name_____
Date of Birth:____/____/_____
Address (if different from patient)
_____
Home Phone_____
(if different from above)
Work Phone_____
(if different from above)
Employer_____
Do you have dental insurance coverage for minor/child? YES NO

Circle One:
Mother Stepmother Guardian
Name_____
Date of Birth:____/____/_____
Address (if different from patient)
_____
Home Phone_____
(if different from above)
Work Phone_____
(if different from above)
Employer_____
Do you have dental insurance coverage for a a minor/child? YES NO

PRIMARY INSURANCE

Subscriber Name:_____
Subscriber SSN#:_____
Subscriber Date of Birth:___/___/_____
Insurance Co._____
Group #_____
Policy/I.D. #_____

SECONDARY INSURANCE

Subscriber Name:_____
Subscriber SSN#:_____
Subscriber Date of Birth:_____/___/_____
Insurance Co. _____
Group #_____
Policy/I.D. #_____

EMERGENCY CONTACT

In the event of an emergency, whom should we contact?_____
Name_____Relationship_____Phone#_____
Name_____Relationship_____Phone#_____

PHOTO CONSENT

I _____, give consent for Tots to Teens Pediatric Dentistry to capture a photographic imagery of my child _____, for their records only. I understand that Tots to Teens Pediatric Dentistry staff will have access to their photo in the dental record.

Patient/Guardian Signature_____ Date_____

SOCIAL MEDIA CONSENT

I _____, give consent for Tots to Teens Pediatric Dentistry to post imagery of my child/children, for social media. I understand that Tots to Teens Pediatric Dentistry staff will utilize the image for social media purposes only.

Patient/Guardian Signature_____ Date_____

CONSENT FOR TREATMENT

The information that I have given is correct and complete to the best of my knowledge. It will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I am the legal guardian of the patient.

I authorize Associate Dentist/Staff to perform the necessary dental procedures: complete dental examination (check-up), prophylaxis (cleaning), fluoride treatment, radiographs (x-rays), sealants, study models, and other diagnostic/preventive aids deemed necessary by the Dentist and the staff to make a thorough diagnosis of my child's dental needs.

I authorize the Dentist and Staff to provide any information to other Doctors (physicians, dentist, etc.) for the purpose of consultation. I understand that prior to providing any treatment I will be advised about such treatment, that I may ask questions concerning the treatment, and that I may revoke this BEFORE treatment is provided. As the parent/legal guardian of the patient, I do hereby grant the dentist and the staff permission to perform any needed treatment(s).

Patient/Guardian Signature_____ Date_____

APPOINTMENT AUTHORIZATIONS

For future appointments, if you are planning to send your child with someone other than a parent/legal guardian, please provide the following information (must be 18yrs or older): Name of authorized person(s) to accompany my child for future treatment visits:

1. **NAME:_____Relationship to Child:_____**
2. **NAME:_____Relationship to Child:_____**

FINANCIAL AGREEMENT

- **Your insurance is a contract between you, your employer, and the insurance company; our relationship is with you, NOT the insurance company. We file your insurance claim as a courtesy to you.**
- ALL charges incurred are charged directly to YOU and you are personally responsible for payment. Deductibles and co-payments are due at the time of treatment. We ESTIMATE your co-payments according to your policy. We DO NOT in any way guarantee that your insurance will pay this amount.
- **If the insurance company doesn't pay within a 60 days, it is required that you pay the balance due**.
- I hereby authorize payment directly to Tots to Teens Pediatric Dentistry P.C., the insurance benefits otherwise payable to me, and authorize release of any information required to process insurance claims.

Patient/Guardian Signature_____ Date_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY

I, _____ have reviewed a copy of Tots to Teens Pediatric Dentistry
(Parent or Legal Guardian's Name) Notice of Privacy Practices regarding my children.

Patient/Guardian Signature_____ Date_____
OFFICE USE ONLY: ___Patient Refused to Sign ___Emergency Situation ___Language Barrier ___Other

Appointment Policy

We reserve time in our schedule especially for your child, and in consideration of others we request at least **48 hours notice prior to cancellation of appointments**. We do understand that there are circumstances that may prevent you from keeping your child's appointment, however, with providing us as much notice as possible we may be able to contact another family who would like that appointment time. Afternoon appointments fill quickly, and canceling with less than 48 hours notice does not allow us enough time to schedule another patient in need of treatment. **After the second missed appointment, you will be asked to pre-pay for your child's appointment before we will reserve time on our schedule.** Patients that are running late are asked to call the office as soon as possible to check with the staff if they will still be able to keep their appointment. Also, cancellations are not accepted if left on the answering service and the appointment will not be considered cancelled unless you call during regular business hours and speak with one of our scheduling coordinators.

Appointments cancelled with less than 48 hours notice on a school holiday, an after school time, or Saturday will not be rescheduled on another school holiday, Saturday or after school appointment time, as they are our most popular appointments.

We greatly appreciate your cooperation in helping us provide you with excellent care for your family. Please sign below that you have read, and acknowledge the above information provided to you. We will provide a copy for your records.

Patient/Guardian Signature_____ Date_____