1400 Hwy. 78 West • Suite 300
Jasper, Alabama 35501

Infants, Children, Teenagers, Handicapped

Phone (205) 384-9104
Fax (205) 384-9102

TO OUR NEW PATIENT

If you have any records at another dental office (mainly x-rays) you will need to bring them. Your previous dentist may make a copy for you to bring. Also, please bring your insurance card.

A NOTE TO PARENTS:

As with most offices that specialize in dentistry for kids, we will ask that you remain in the reception area if your child has reached school age. We must develop a trusting relationship with you and your child in order to deliver the best care possible. Frequently this relationship is not achieved if the child's focus is on the parent rather than on the dental experience. More times than not, when the parent is out of sight, the child will become engrossed in all the activity and visual stimulation and, before they know it, they are done and on their way home.

If your child is pre-school age, we will allow one parent to accompany the child on the initial visit. After the first visit, you should send them back on their own. This gives them a great sense of accomplishment and independence.

Once your child's visit is complete, the doctor or helper will go over all findings and recommendations with you and answer any questions that you might have.

Please do your part in preparing your child for visits. Be relaxed and at ease. Any anxiety on your part will be sensed by your child. We have developed a vocabulary that will fully explain our procedures without using words that are frightening, such as "shot", "drill", or "hurt". We will help you with wording that is appropriate. We hope dentistry will always be seen as positive to your child.

Jasper Pediatric Dentistry, L.L.C.

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Our office is committed to your child's dental treatment. Please understand that payment of your bill is considered part of the treatment. We make every effort to keep down the cost of your child's dental care. You can help by following our office guidelines. We ask that you read and sign this agreement prior to treatment.

PAYMENTS

- We accept cash, checks, VISA and Mastercard
- Full payment is due at time of service
- Insurance deductibles and co-payments are due in full at time of service
- Payment arrangements may be offered prior to treatment

Because of the difficulty of third party billing, in the event of divorce or separation, the parent who brings the child in for his/her care will be financially responsible for treatment costs.

INSURANCE INFORMATION

As a courtesy to our patients, we accept assignment on most dental insurances. <u>We would need all of your insurance information prior to the visit</u>. We will verify coverage and inform you of the estimated balance due. In the event we cannot get this detailed information, we would require payment in full and a statement of actual services will be provided to you so that you can be directly reimbursed by your insurance carrier. If your carrier has not made payment in 60 days, your outstanding insurance balance will be your responsibility.

Due to the many different insurance policies and frequent changes in coverage, it is impossible for us to know them all. Please familiarize yourself with your dental coverage. We recommend that you contact your insurance carrier to understand your benefits. Please know your insurance policy is contract between you and the carrier. We are not a party to that contract, therefore it is important for you to be involved to help assure timely payments on your account.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best dental care for your child. We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Our fees are based on the treatment selected, the time needed to provide your child with necessary dental care and the overhead involved in our practice.

MISSED APPOINTMENTS

Charges will not be made for broken appointments and canceled appointments with a 24 hour notice. <u>We do reserve the right to terminate our professional relationships if you fail to keep two appointments.</u> Please help us serve your better by keeping your scheduled appointments.

FINANCIAL

Any expense incurred for returned checks, legal fees and collection agency fees will become your responsibility and will be added to your account balance.

We know questions can arise on billing matters. We encourage you to discuss any financial concerns that you may have so that we may assist you in the effective management of your account.

I authorize you to release information acquired in the course of treatment and examination for insurance requirements or dental care purposes. I understand I will be responsible for any charges not paid by insurance company. In the event of default, I agree to pay all costs of collection including but not limited to reasonable attorney fees and cost. I waive exemption rights under the state of Alabama. I authorize verification of employment or insurance benefits to you or your agents.

I have read, understand and agree to the financial policy described above.

Signature____ Date__________________________

Welcome

Infants, Children, Teenagers, Handicapped

4330 Hwy. 78 East • Suite 121
Jasper, Alabama 35501
Phone: (205) 384-9104
Fax: (205) 384-9102

① About Your Child

Today's Date: ______/______/______

Child's Name:

Last First MI

Child's Nickname: ____________________ ○ Boy ○ Girl

Child's Social Security # ____________________

Child's Birth Date: _____/_____/_____ Age______

School: ____________________ Grade: ________

Child's Home Phone #: (____)____________________

Child's Address: ____________________

City State Zip

Referred By:____________________

② Child's Family Information

Who is accompanying this child today?

Full Name (If Other than Parent) Relation to Child

Mother's Name:____________________

○Stepmother ○ Guardian

Home Address/City/State/Zip

(____)______________ (___)______________

Home Phone # Work Phone #

Mother's SS # Date of Birth Driver's License #

Employer's Name ____________________

****

Father's Name:____________________

○ Stepfather ○ Guardian

Home Address/City/State/Zip

Father's SS# Date of Birth Driver's License #

Employer's Name

③ Insurance Information

Primary Dental Insurance

Co. Name: ____________________

Insured's SS#: ____________________

Insured's Name: ____________________

Relation: ______________ Date of Birth: __________

Insured's Employer: ____________________

Secondary Dental Insurance

Co. Name: ____________________

Insured's SS#:____________________

Insured's Name: ____________________

Relation: ______________ Date of Birth: ______

Insured's Employer: ____________________

④ Permanent Account Information

Permanent Contact Telephone # ____________________

)Method of Payment: (Copy of Insurance Card Required

Private Insurance ____________________

Medicaid # ____________________

Self Payment ____________________

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

Initials __________

⑤ Child's Dental Information

Why did you bring the child to the dentist today?

Previous Dentist: ______

City State

⑥ Child's Medical Information

Please list all drugs that the child is currently taking______

Is child allergic to any medications or materials?

Please describe the child's current physical health:

❍ Good ❍ Fair ❍ Poor

Child's Primary Physician:

Approximate Date of Last Medical Exam: ______

⑥

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform any necessary services needed during diagnosis and treatment.

THE PARENT OR GUARDIAN WHO ACCOMPANIES THE CHILD IS RESPONSIBLE FOR PAYMENT AT THE TIME OF SERVICE.

I HAVE RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES.

Signature of Parent or Guardian Date

⑦ Child's Medical History

Does child have or ever had any of the following diseases, medical conditions or procedures?

Y	N	Heart Murmur
Y	N	Requires Antibiotic Pre-med
Y	N	Rheumatic Fever
Y	N	Artificial Heart Valves
Y	N	Congenital Heart Defect
Y	N	Scarlet Fever
Y	N	Surgeries/Operations
Y	N	Cancer/Tumors
Y	N	Chemotherapy
Y	N	Hearing Problems
Y	N	Asthma/Difficulty Breathing
Y	N	Leukemia/Anemia
Y	N	Diabetes/Hypoglycemia
Y	N	Hemophilia
Y	N	Abnormal Bleeding
Y	N	Cleft Lip/Palate
Y	N	High/Low Blood Pressure
Y	N	Hepatitis
Y	N	Artificial Bones/Joints/Implants
Y	N	Liver/Kidney/Organ Problems
Y	N	HIV+/AIDS/ARC
Y	N	Tuberculosis TB
Y	N	Psychiatric Problems
Y	N	Hyper Active/ADD
Y	N	Fainting/Seizures/Epilepsy
Y	N	Cerebral Palsy

Please list any other medical condition(s) child has or ever had: ______

Office Use Only

I have reviewed the medical/dental information with the parent/guardian and patient named herein ______

Initials Date

Medical History Update

Initials Date Comments

Initials Date Comments