

Child Health/Dental History Form



American Dental Association
www.ada.org

Patient's Name <small>LAST FIRST INITIAL</small>			Nickname	Date of Birth	
Parent's/Guardian's Name			Relationship to Patient		
Address <small>PO OR MAILING ADDRESS CITY STATE ZIP CODE</small>					
Phone <small>Home Work</small>				Sex M <input type="checkbox"/> F <input type="checkbox"/>	
Have you (the parent/guardian) or the patient had any of the following diseases or problems? <input type="checkbox"/> Yes <input type="checkbox"/> No 1. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3. Cough that produces blood? If you answer yes to any of the three items above, please stop and return this form to the receptionist.					
Has the child had any history of, or conditions related to, any of the following:					
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cancer	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> HIV +/-AIDS	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Fainting	<input type="checkbox"/> Immunizations	<input type="checkbox"/> Mumps	<input type="checkbox"/> Tobacco/Drug Use
<input type="checkbox"/> Asthma	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Growth Problems	<input type="checkbox"/> Kidney	<input type="checkbox"/> Pregnancy (teens)	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Bladder	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/> Hearing	<input type="checkbox"/> Latex allergy	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Bleeding disorders	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart	<input type="checkbox"/> Liver	<input type="checkbox"/> Seizures	<input type="checkbox"/> Other _____
<input type="checkbox"/> Bones/Joints	<input type="checkbox"/> Ear Aches	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Measles	<input type="checkbox"/> Sickle cell	
Please list the name and phone number of the child's physician:					
Name of Physician _____			Phone _____		

Child's History

	Yes	No
1. Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? If yes, please list: _____	1. <input type="checkbox"/>	<input type="checkbox"/>
2. Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____	2. <input type="checkbox"/>	<input type="checkbox"/>
3. Is the child allergic to anything else, such as certain foods? If yes, please explain: _____	3. <input type="checkbox"/>	<input type="checkbox"/>
4. How would you describe the child's eating habits? _____		
5. Has the child ever had a serious illness? If yes, when: _____ Please describe: _____	5. <input type="checkbox"/>	<input type="checkbox"/>
6. Has the child ever been hospitalized?	6. <input type="checkbox"/>	<input type="checkbox"/>
7. Does the child have a history of any other illnesses? If yes, please list: _____	7. <input type="checkbox"/>	<input type="checkbox"/>
8. Has the child ever received a general anesthetic?	8. <input type="checkbox"/>	<input type="checkbox"/>
9. Does the child have any inherited problems?.....	9. <input type="checkbox"/>	<input type="checkbox"/>
10. Does the child have any speech difficulties?.....	10. <input type="checkbox"/>	<input type="checkbox"/>
11. Has the child ever had a blood transfusion?.....	11. <input type="checkbox"/>	<input type="checkbox"/>
12. Is the child physically, mentally, or emotionally impaired?.....	12. <input type="checkbox"/>	<input type="checkbox"/>
13. Does the child experience excessive bleeding when cut?	13. <input type="checkbox"/>	<input type="checkbox"/>
14. Is the child currently being treated for any illnesses?	14. <input type="checkbox"/>	<input type="checkbox"/>
15. Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: _____	15. <input type="checkbox"/>	<input type="checkbox"/>
16. Has the child had any problem with dental treatment in the past?	16. <input type="checkbox"/>	<input type="checkbox"/>
17. Has the child ever had dental radiographs (x-rays) exposed?	17. <input type="checkbox"/>	<input type="checkbox"/>
18. Has the child ever suffered any injuries to the mouth, head or teeth?	18. <input type="checkbox"/>	<input type="checkbox"/>
19. Has the child had any problems with the eruption or shedding of teeth?	19. <input type="checkbox"/>	<input type="checkbox"/>
20. Has the child had any orthodontic treatment?	20. <input type="checkbox"/>	<input type="checkbox"/>
21. What type of water does your child drink? <input type="checkbox"/> City water <input type="checkbox"/> Well water <input type="checkbox"/> Bottled water <input type="checkbox"/> Filtered water		
22. Does the child take fluoride supplements?	22. <input type="checkbox"/>	<input type="checkbox"/>
23. Is fluoride toothpaste used?	23. <input type="checkbox"/>	<input type="checkbox"/>
24. How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____	24. <input type="checkbox"/>	<input type="checkbox"/>
25. Does the child suck his/her thumb, fingers or pacifier?.....	25. <input type="checkbox"/>	<input type="checkbox"/>
26. At what age did the child stop bottle feeding? Age _____ Breast feeding? Age _____		
27. Does child participate in active recreational activities?	27. <input type="checkbox"/>	<input type="checkbox"/>

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature _____ Date _____

For completion by dentist Comments _____ _____ _____

For Office Use Only: Medical Alert Premedication Allergies Anesthesia Reviewed by _____
Date _____

WELCOME

EMAIL ADDRESS: _____

PATIENT INFORMATION

Patient Name: _____

Occupation: _____ Marital status: _____

Employer address: _____

Spouse Name _____ Birthdate _____ SS# _____

Whom may we thank for referring you? _____

DENTAL INSURANCE AND/OR ACCOUNT RESPONSIBILITY

Who is responsible for this account? _____

Relationship to patient _____ Ins. Co. _____ Group # _____

Ins. Co address _____

Is patient covered by an additional insurance? Y / N

Subscriber's Name: _____ Birthdate _____ SS# _____

Relationship to Patient _____ Ins. Co. _____ Group # _____

Ins. Co. Address _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____
And assign directly to Dr. Herremans all insurance benefits, if any, otherwise payable to me for
Services rendered. I understand that I am financially responsible for all charges whether or not
paid by insurance. I hereby authorize the doctor to release all information necessary to secure
the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____

Relationship _____

Date _____

PHONE NUMBERS

Cell _____ Home _____ Work _____

Best time and place to reach you _____

Do you prefer to be contacted by: (circle one) email text phone

EMERGENCY CONTACT: Name _____ relationship _____

Phone number: C / H / W _____

Patient Registration Form

Email: _____			Today's Date: _____		
Preferred Name: <input type="checkbox"/> Miss <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.			Referred by: _____		
Name: _____		Home Phone: <i>include area code</i> () ()		Cell Phone: <i>include area code</i> () ()	
Last _____ First _____ Middle _____		City: _____		State: _____ Zip: _____	
Address: _____ <small>Mailing address</small>			SS#: _____		
Date of Birth: _____			Sex: M F		
Employer: _____			Business Phone: <i>include area code</i> () ()		
Emergency Contact: _____		Relationship: _____		Home Phone: <i>include area code</i> () ()	
				Cell Phone: <i>include area code</i> () ()	
College Student Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time			Please provide school info: _____		
Employment Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired			School Name: _____		
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed			Address: _____		
Pref. Pharmacy: _____ Phone: () ()			Address 2: _____		
			City, State, Zip: _____		

Dental Insurance Information

Primary Insurance Information	
Name of Insured: _____	Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Insured Soc. Sec.: _____	Insured Birth Date: _____
Employer: _____	Ins. Company: _____
Address: _____	Address: _____
Address 2: _____	Address 2: _____
City, State, Zip: _____	City, State, Zip: _____
ID#: _____ Gr#: _____	
Secondary Insurance Information	
Name of Insured: _____	Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Insured Soc. Sec.: _____	Insured Birth Date: _____
Employer: _____	Ins. Company: _____
Address: _____	Address: _____
Address 2: _____	Address 2: _____
City, State, Zip: _____	City, State, Zip: _____
ID#: _____ Gr#: _____	

Dental Information

For the following questions, mark (X) your responses to the following questions.

	Yes	No	DK		Yes	No	DK
Do your gums bleed when you brush or floss?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have earaches or neck pains?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to cold, hot, sweets or pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any clicking, popping or discomfort in the jaw?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your mouth dry?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you brux or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any periodontal (gum) treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have sores or ulcers in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had orthodontic (braces) treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear dentures or partials?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any problems associated with previous dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you participate in active recreational activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your home water supply fluoridated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a serious injury to your head or mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink bottled or filtered water?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of your last dental exam: _____			
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY				What was done at that time? _____			
Are you currently experiencing dental pain or discomfort?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of last dental x-rays: _____			
What is the reason for your dental visit today?							
How do you feel about your smile?							

Medical Information Please mark (X) your responses to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question) Yes No DK	Yes No DK
Are you now under the care of a physician? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Physician Name: _____ Phone: include area code (_____) _____ Address/City/State/Zip: _____	Have you had a serious illness, operation or been hospitalized in the past 5 years? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If yes, what was the illness or problem? _____
Are you in good health? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Has there been any change in your general health within the past year? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If yes, what condition was treated? _____	Are you taking or have you recently taken any prescription or over the counter medicine(s)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements: _____ _____
Date of last physical exam: _____	Do you use controlled substances (drugs)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Do you wear contact lenses? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you use tobacco (smoking, snuff, chew, bidis)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If so, how interested are you in stopping? Circle one: VERY / SOMEWHAT / NOT INTERESTED
Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or fen-phen (fenfluramine-phentermine combination)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you drink alcoholic beverages? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If yes, how much alcohol did you drink in the last 24 hours? _____ If yes, how much do you typically drink in a week? _____
Are you taking or scheduled to begin taking either of the medications alendronate (Fosamax®) or risendronate (Actonel®) for osteoporosis or Paget's disease? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	WOMEN ONLY Are you:
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Date Treatment Began: _____	Pregnant? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Number of weeks: _____ Taking birth control pills or hormone replacement? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nursing? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Joint Replacement. Have you had an orthopedic total joint replacement (hip, knee, elbow, finger)?
 Date: _____ If yes, have you had any complications? _____

Allergies - Are you allergic to, or have you had a reaction to: **Yes No DK**
 To all **yes** responses, specify type of reaction.

Local anesthetics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Metals <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Aspirin <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Latex (rubber) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Penicillin or other antibiotics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Iodine <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Barbituates, sedatives, or sleeping pills <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Hay fever / seasonal <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Sulfa drugs <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Animals <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Codeine or other narcotics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Food <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
	Other <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Yes No DK	Yes No DK	Yes No DK	Yes No DK
Heart murmur <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Anemia <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Chest pain upon exertion <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Neurological disorders <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Mitral valve prolapse <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Blood transfusion <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Chronic pain <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	If yes, specify: _____
Artificial heart valves <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	If yes, date: _____	Diabetes Type I or II <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Sleep disorder <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Rheumatic fever <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Hemophilia <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Eating disorder <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Mental health disorders <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Cardiovascular disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	AIDS or HIV infection <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Malnutrition <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	If yes, specify: _____
Angina <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Arthritis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Gastrointestinal disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Recurrent infections <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Arteriosclerosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Autoimmune disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	G.E. Reflux/Persistent heartburn <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Type of infection: _____
Congestive heart failure <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Rheumatoid arthritis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Ulcers <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Kidney problems <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Coronary artery disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Systemic lupus erythematosus <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Thyroid problems <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Night sweats <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Damaged heart valves <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Asthma <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Stroke <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Osteoporosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Heart attack <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Bronchitis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Glaucoma <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Persistent swollen glands in neck <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Low blood pressure <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Emphysema <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Hepatitis, jaundice or liver disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Severe headaches/ Migraines <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
High blood pressure <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Sinus trouble <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Epilepsy <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Severe or rapid weight loss <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Congenital heart defects <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Tuberculosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Fainting spells or seizures <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Sexually transmitted disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Pacemaker <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Cancer/Chemotherapy/ Radiation treatment <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Excessive urination <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Rheumatic heart disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Abnormal bleeding <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?
 Name of physician or dentist making recommendation: _____ Phone: (_____) _____
 Do you have any disease, condition, or problem not listed above that you think I should know about?
 Please explain: _____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
 I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.
 Signature of Patient/Legal Guardian: _____ Date: _____

**TRUTH IN LENDING
EXPLANATION OF INTEREST RATES, INTEREST CHARGES AND FEES**

INTEREST RATES AND INTEREST CHARGES	
Annual Percentage Rate (APR) for Purchases	15.00%
Paying Interest	A finance charge is imposed on those charges not paid in full within 30/60/90/120 days (as shown on the front of your billing statement) of the date you were first billed for the charges. The balance on which any finance charge is computed is determined by totaling the charges not paid within the time period shown on the front of your billing statement and then by multiplying the balance by the periodic rate shown.
Minimum Interest Charge	If you are charged interest, the charge will be no less than \$1.00

FEES	
Late Charge	\$1.00 or 5% of the past due minimum payment, whichever is greater, with a maximum of \$5.00
Non-Sufficient Funds (NSF) Fee	\$25.00 per payment

YOUR BILLING RIGHTS UNDER THE FAIR CREDIT BILLING ACT

If you think you have been billed incorrectly, or if you need more information about a transaction on your bill, write to us on a separate sheet at First Pacific Corporation, PO Box 3000, Salem, OR 97302. We must hear from you no later than 60 days after we have sent you the first bill on which the error or problem appeared. You may telephone us at 1-800-574-7064, but doing so will not preserve your rights. In your letter, please include the following information:

- Your name and account number.
- The dollar amount of the suspected error.
- Describe the error and explain why you believe there is an error. If you need more information, describe the item you are not sure about.

YOUR RIGHTS AND OUR RESPONSIBILITIES AFTER WE RECEIVE YOUR WRITTEN NOTICE

- We must acknowledge your letter within 30 days, unless we have corrected the error by then. Within 90 days, we must either correct or explain why we believe the error was correct.
- After we receive your letter, we cannot try to collect any amount you question, or report you as delinquent. We can continue to bill you for the amount in question, including finance charges and we can apply any amount against your credit limit. You do not have to pay any questioned amount while we are investigating, but you are still obligated to pay the parts of your bill that are not in question.
- If we find that we made a mistake on your bill, you will not have to pay any finance charges related to any questioned amount. If we didn't make a mistake, you may have to pay finance charges, and you will have to make up any missed payments on the questioned amount. In either case, we will send you a statement of the amount you owe and the date that it is due.
- If you fail to pay the amount that we think you owe, we may report you as delinquent. However, if our explanation does not satisfy you and you write to us within 10 days telling us that you still refuse to pay, we must tell anyone we report you to that you have a question about your bill and we must tell you the name of anyone we reported you to. When the matter is finally settled between us, we must tell anyone we report you to that it has been settled.
- If we don't follow these rules, we can't collect the first \$50.00 of the questioned amount even if your bill was correct.
- Your continued use of this account constitutes your acceptance of the above stated conditions.

I agree to be responsible for all charges for dental services and material not paid by my dental benefits plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to any insurance claims.

I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

Dental Entity Name

Signature

Date

Account Name

Address

A photocopy of this document may act as an original

Form 05304CO (7-1-17)

GENERAL CONSENT FOR TREATMENT

I _____, understand that this treatment plan is based on the current knowledge of my clinical conditions. I understand that during the course of treatment clinical conditions may change necessitating a change in the treatment plan and that I will be fully informed of any changes. I have been provided an opportunity to ask any questions regarding my treatment including the risks and benefits of care or not receiving care and I have had them addressed satisfactorily. I understand that some of my dental needs cannot be treated at this office and that those items have been identified. I further understand that this treatment plan and estimate has been created without considering insurance limits and deductibles, as these amounts may change prior to the completion of treatment. The patient estimated amounts have not been verified with my insurance carrier. The total cost of treatment is my responsibility. Estimated patient amounts, co-pays, and deductibles must be paid on the date of service, unless alternate arrangements have been made prior to treatment. An insurance claim will then be submitted to my insurance carrier. When payments are received from the insurance carrier any amounts not covered will be billed to me and I will receive a statement. I have read, understand and now give my permission for treatment at Dedicated Dentistry for myself or the minor patient named above.

Patient Signature

Date

Provider

OFFICE POLICIES

Welcome to the office of Tavi Henry D.D.S, P.C. We feel it is important to inform you of our policies prior to you seeing the Doctor.

We will bill all insurance claims as a courtesy to our patients. Any claims not paid by insurance within 90 days will be turned over to patient for reimbursement. The ultimate responsibility for payment of charges is the patient's, regardless of the type of insurance a patient has. Insurance reimbursement is a contract between the patient and the insurance carrier.

We request you pay your copay and non-covered charges at the time of service unless previous arrangements have been made. We accept cash, checks, Visa, MasterCard, American Express and Discover. Any balances not paid by insurance will be assessed an interest charge after 60 days. Any delinquent accounts older than 90 days will be turned over to collection.

Once a patient is sent to collections, they will be asked to choose another Dentist.

We will attempt to give our patients a reminder call the business day prior to their appointment. We request that if you have to change your appointment you do so 24 hours in advance as a courtesy to us and other patients who want to be seen. Leaving a message on the answering service does not constitute notice when we do not have time to fill the appointment. ***Patients who do not cancel or reschedule at least 24 hours in advance will be charged \$45/hour scheduled, there will also be a \$45 charge for patient who no-show for an appointment.*** Patient who no-show or cancel 3 times will be asked to seek care elsewhere.

Patient's requesting a copy of their records must do so in writing. There will be a nominal charge to copy the records, based on the size of the patient's file.

Patients will be seen for the type of treatment and diagnostic appointment scheduled only. If additional treatment and/or diagnostics are required, the patient may be requested to return for another visit.

We ask that all paperwork required be filled out prior to seeing the Doctor. The patient must have a current ID card complete with claim mailing address. Please verify that Dr. Henry is listed as a provider of that you are able to go out of network. If Dr. Henry is not listed as a provider, the patient is responsible for payment at the time of service.

IT IS THE PATIENT'S RESPONSIBILITY TO KNOW THEIR INSURANCE BENEFITS