PEDIATRIC SPECIALISTS

Dentistry FOR CHILDREN

DRS. DILL, VARBLE, WONG & PARKS

ST. CHARLES 636.946.5225

CREVE COEUR 314.567.1122

www.DentistryForChildrenSTL.com

Please note: We DO NOT file Third Insurances

1. TELL US ABOUT YOUR CHILD

CHILD'S LEGAL NAME:

_____
LAST FIRST MI

PREFERRED NAME/PRONOUN: _____

❑ MALE ❑ FEMALE ❑ OTHER

SIBLINGS THAT WE TREAT: _____

CHILD'S BIRTHDATE: _____

BEST CONTACT # _____

ADDITIONAL # _____

CHILD'S HOME ADDRESS: _____

_____

WHO DOES THE CHILD LIVE WITH? _____

EMAIL: _____

2. PARENT/LEGAL GUARDIAN INFORMATION (1)

NAME: _____

❑ MALE ❑ FEMALE ❑ OTHER DOB: _____

EMAIL: _____

HOME ADDRESS (IF DIFFERENT) _____

_____

EMPLOYER: _____

WORK # _____ CELL # _____

SS#: _____

MARITAL STATUS: ❑ SINGLE ❑ MARRIED ❑ DIVORCED

3. PARENT/LEGAL GUARDIAN INFORMATION (2)

NAME: _____

❑ MALE ❑ FEMALE ❑ OTHER DOB: _____

EMAIL: _____

HOME ADDRESS (IF DIFFERENT) _____

_____

EMPLOYER: _____

WORK # _____ CELL # _____

SS#: _____

MARITAL STATUS: ❑ SINGLE ❑ MARRIED ❑ DIVORCED

4. WHO IS ACCOMPANYING THE CHILD TODAY?

NAME: _____

RELATIONSHIP: _____

DO YOU HAVE LEGAL CUSTODY OF THIS CHILD? ❑ YES ❑ NO

The parent or guardian who accompanies the child is deemed responsible for payment at the time of service, regardless of who provides insurance.

Please note: The parent whose birthday falls first in the year (month) is primary, unless there is a divorce decree or legal document.

5. PERSON RESPONSIBLE FOR ACCOUNT

NAME: _____

RELATIONSHIP: _____

BILLING ADDRESS: _____

_____

WORK # _____ CELL # _____

6. PRIMARY DENTAL INSURANCE

INSURANCE CO. NAME: _____

INSURANCE CO. ADDRESS: _____

INSURANCE CO. PHONE # _____

GROUP # (PLAN, LOCAL, OR POLICY #) _____

MEMBER ID # _____

POLICY OWNER'S NAME: _____

RELATIONSHIP TO PATIENT: _____

POLICY OWNER'S BIRTHDATE: _____ SS# _____

POLICY OWNER'S EMPLOYER: _____

7. SECONDARY DENTAL INSURANCE

INSURANCE CO. NAME: _____

INSURANCE CO. ADDRESS: _____

INSURANCE CO. PHONE # _____

GROUP # (PLAN, LOCAL, OR POLICY #) _____

MEMBER ID # _____

POLICY OWNER'S NAME: _____

RELATIONSHIP TO PATIENT: _____

POLICY OWNER'S BIRTHDATE: _____ SS# _____

POLICY OWNER'S EMPLOYER: _____

8. DENTAL HISTORY

IS THIS YOUR CHILD'S FIRST VISIT TO THE DENTIST? ❑ YES ❑ NO

IF NOT, HOW LONG SINCE LAST DENTAL VISIT? _____

PREVIOUS DENTAL OFFICE: _____

WERE ANY X-RAYS TAKEN AT PREVIOUS DENTAL VISITS? ❑ YES ❑ NO

HAVE THERE BEEN ANY INJURIES TO TEETH, FACE, OR MOUTH? ❑ YES ❑ NO

IF YES, PLEASE EXPLAIN: _____

_____

WHY DID YOU BRING THE CHILD TO THE DENTIST TODAY?

_____

_____

DOES THE CHILD HAVE ANY OF THE FOLLOWING HABITS?

- ❑ Y ❑ N LIP SUCKING / BITING
- ❑ Y ❑ N NAIL BITING
- ❑ Y ❑ N NURSING BOTTLE HABITS
- ❑ Y ❑ N THUMB / FINGER SUCKING

HAS THE CHILD EVER HAD A SERIOUS OR DIFFICULT PROBLEM ASSOCIATED WITH PREVIOUS DENTAL WORK? ❑ Y ❑ N

IF YES, PLEASE EXPLAIN: _____

_____

IS THE CHILD'S WATER FLUORIDATED? ❑ Y ❑ N

IS THE CHILD TAKING FLUORIDE SUPPLEMENTS? ❑ Y ❑ N

HAS THE CHILD EVER HAD ANY PAIN OR TENDERNESS IN THEIR JAW/JOINT? (TMJ/TMD)? ❑ Y ❑ N

DOES THE CHILD BRUSH DAILY? ❑ Y ❑ N

DOES THE CHILD FLOSS DAILY? ❑ Y ❑ N

CHILD'S PHYSICIAN: _____

PHONE: _____

IS THE CHILD CURRENTLY UNDER THE CARE OF A PHYSICIAN? ❑ YES ❑ NO

PLEASE DESCRIBE THE CHILD'S CURRENT PHYSICAL HEALTH:

❑ GOOD ❑ FAIR ❑ POOR

9. HEALTH HISTORY

HAS THE CHILD EVER HAD ANY OF THE FOLLOWING PROBLEMS?
(CIRCLE **Y** FOR "YES" OR **N** FOR "NO")

- Y N ABNORMAL BLEEDING
- Y N ALLERGIES TO ANY DRUGS/FOOD (LIST BELOW)
- Y N ACID REFLUX
- Y N ANY HOSPITAL STAYS
- Y N ANY OPERATIONS
- Y N ASTHMA
- Y N CANCER
- Y N CONGENITAL HEART DISEASE
- Y N CONVULSIONS/EPILEPSY
- Y N PREGNANCY
- Y N AUTISM
- Y N DIABETES
- Y N HANDICAPS / DISABILITIES
- Y N HEARING IMPAIRMENT
- Y N HEART MURMUR (DOCTOR LETTER REQUIRED)
- Y N HEMOPHILIA
- Y N HEPATITIS
- Y N HIV + / AIDS
- Y N KIDNEY / LIVER PROBLEMS
- Y N RHEUMATIC / SCARLET FEVER
- Y N ALLERGIES TO LATEX PRODUCT
- Y N ADHD
- Y N OTHER (LIST BELOW)

PLEASE DISCUSS ANY SERIOUS MEDICAL PROBLEMS THE CHILD HAS HAD:

_____

_____

PLEASE LIST ALL MEDICATIONS THE CHILD IS CURRENTLY TAKING:

_____

_____

PLEASE LIST ANY FOOD / DRUG ALLERGIES:

_____

_____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

_____

PARENT ACKNOWLEDGEMENT AND SIGNATURE

I acknowledge that the information provided on this form is accurate and that the person who brings this child to Dentistry for Children is the legal guardian of this child. Whoever accompanies this child on subsequent visits has my express permission to consent to treatment. If this child should come for a subsequent visit, I hereby consent to treatment. I acknowledge that as the legal guardian, I am responsible for full payment of all charges including a broken appointment charge of $40 when appointments are missed without 24 hour notice. I hereby authorize my insurance benefits to be paid to the undersigned dentist. I understand that any balance not paid within 60 days (regardless of outstanding insurance) will become my responsibility. If my account is referred to a collection agency or law firm to collect the unpaid balance, I understand and agree that I will be responsible for paying all collections costs, including but not limited to reasonable attorney fees and court costs. I have received a copy of Dentistry for Children's Notice of Privacy Practices.

As an insurance cardholder, it is important that you as the patient are aware of your insurance benefits. Our office recommends that you confirm your insurance coverage prior to your appointment. This will help eliminate any insurance concerns once treatment has begun. **PLEASE UNDERSTAND** that we file dental insurance as a courtesy to our patients.

By my eSignature verification below, I verify that I understand that electronic signatures are legally binding and have the same meaning as handwritten signatures. Pursuant to section 11.100 of Title 21 of the Code of Federal Regulations, this is to certify that this electronic signature is to be the legally binding equivalent of my handwritten signature and that the data on this form is accurate to the best of my knowledge.

_____ _____

SIGNATURE OF PARENT / LEGAL GUARDIAN | RELATIONSHIP TO PATIENT

_____ _____

PRINTED NAME OF PARENT / LEGAL GUARDIAN | DATE

PEDIATRIC SPECIALISTS
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FINANCIAL POLICY

Welcome to Dentistry for Children. We ask that you read and sign our financial policy prior to any treatment. To avoid misunderstandings, please ask us if you have any questions about our policies.

Payment for Service: Our policy requires payment for services at the time service is provided. If special arrangements are needed, please discuss those arrangements with our front office lead or office manager.

Method of Payment: Our office accepts cash, MasterCard, VISA, Discover, American Express, and CareCredit®

Insurance: As a courtesy to you, we will verify your insurance benefits, estimate your co-insurance (what you owe) at the time of your appointment and file your insurance claims. To do this we must have complete and accurate information from you.

- **Verification of benefits** is not a guarantee of payment by your insurance company; final determination is made by your insurance company at the time the claim is received.
- An **insurance estimate** is not a guarantee that your insurance will pay exactly as estimated. Your insurance company determines the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
- You are responsible for payment of **estimated co-insurance, deductible, co-pay or non-covered services** at the time of service. We will file all claims with your insurance company.
- To determine exactly what amount will be covered by insurance, we will gladly request a predetermination by your carrier. This request may take up to four weeks to be processed by the insurance company.
- **All charges you incur are your responsibility.** Your insurance policy is a contract between you and your insurance company. You are responsible for payment whether or not your insurance pays.
- It is your responsibility to obtain required **authorizations or referrals** from the insurance company or primary care physician for each visit. Failure to have a current authorization could result in rescheduling your appointment or requiring payment in full for all services relating to the appointment.
- We ask that you sign this form and any necessary documents that may be required by your insurance company.
- Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not paid within 60 days, we ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim has been denied, you will be responsible for the full balance at that time.
- We will cooperate fully with your insurance company to assist in the claim being paid.
- **Non-Insured:** If you do not have insurance or our office is not a participating provider with your insurance plan, full payment is due at the time of service.
- **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. A fee will be added should your account be placed in collections. You will also be responsible for any legal fees and costs should the account go to litigation.
- **Minor Patients:** The parent or guardian accompanying a minor is responsible for the payment of services, regardless of insurance coverage.
- **Divorced Parents:** The parent who brings the child to the appointment is deemed responsible for payment, regardless of who provides insurance coverage. Our office will not become involved in disputes over which parent is the responsible billing party.

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my benefits directly to Dentistry for Children.

_____ _____

PRINTED PATIENT NAME DATE

_____

SIGNATURE OF PATIENT OR PARENT / LEGAL GUARDIAN

PATIENT UPDATE

PEDIATRIC SPECIALISTS
Dentistry FOR CHILDREN
DRS. DILL, VARBLE, WONG & PARKS

TELL US ABOUT YOUR CHILD

CHILD'S LEGAL NAME:

_____
LAST FIRST MI

PREFERRED NAME: _____ ❑ MALE ❑ FEMALE ❑ OTHER

SIBLINGS THAT WE TREAT: _____

CHILD'S BIRTHDATE: _____

BEST CONTACT # _____

ADDITIONAL # _____

CHILD'S HOME ADDRESS: _____

_____

WHO DOES THE CHILD LIVE WITH? _____

EMAIL: _____
EMAIL IS USED FOR APPOINTMENT REMINDERS

WHO IS ACCOMPANYING THE CHILD TODAY?

NAME: _____

RELATIONSHIP: _____

DO YOU HAVE LEGAL CUSTODY OF THIS CHILD? ❑ YES ❑ NO

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PLEASE DISCUSS ANY SERIOUS MEDICAL PROBLEMS THE CHILD HAS HAD:

_____

PLEASE LIST ALL MEDICATIONS THE CHILD IS CURRENTLY TAKING:

_____

_____

PLEASE LIST ANY FOOD / DRUG ALLERGIES:

_____

_____

RESPONSIBLE PARTY

NAME: _____

RELATIONSHIP: _____

BILLING ADDRESS: _____

_____

WORK # _____ CELL # _____

PRIMARY DENTAL INSURANCE

INSURANCE CO. NAME: _____

INSURANCE CO. ADDRESS: _____

INSURANCE CO. PHONE # _____

GROUP # (PLAN, LOCAL, OR POLICY #) _____

MEMBER ID # _____

POLICY OWNER'S NAME: _____

RELATIONSHIP TO PATIENT: _____

POLICY OWNER'S BIRTHDATE: _____ SS# _____

POLICY OWNER'S EMPLOYER: _____

SECONDARY DENTAL INSURANCE

INSURANCE CO. NAME: _____

INSURANCE CO. ADDRESS: _____

INSURANCE CO. PHONE # _____

GROUP # (PLAN, LOCAL, OR POLICY #) _____

MEMBER ID # _____

POLICY OWNER'S NAME: _____

RELATIONSHIP TO PATIENT: _____

POLICY OWNER'S BIRTHDATE: _____ SS# _____

POLICY OWNER'S EMPLOYER: _____

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_____ _____
SIGNATURE OF PARENT / LEGAL GUARDIAN RELATIONSHIP TO PATIENT

_____ _____
PRINTED NAME OF PARENT / LEGAL GUARDIAN DATE