smile
ORTHODONTICS pediatric dentistry

Today's Date: _____

Tell Us About Your Child(ren)

Patient's Legal Name:_____DOB:_____ Gender: M F
Patient's Legal Name:_____DOB:_____ Gender: M F
Patient's Legal Name:_____DOB:_____ Gender: M F
Patient's Legal Name:_____DOB:_____ Gender: M F
Patient's Legal Name:_____DOB:_____ Gender: M F
School/Schools They Attend:_____

How did you find us?

☐ Friend? Who? _____ ☐ Community Event: _____
☐ Google ☐ Facebook
☐ Insurance Website ☐ Other (please list): _____

Parent/Legal Guardian Information

Legal Name: _____ ☐ Biological ☐ Step ☐ Guardian ☐ Adoptive ☐ Foster
Date of Birth:_____ Employer :_____
Address:_____City_____State_____Zip_____
Home: _____Cell: _____Work: _____
Email: _____

Legal Name: _____ ☐ Biological ☐ Step ☐ Guardian ☐ Adoptive ☐ Foster
Date of Birth:_____ Employer :_____
Address:_____City_____State_____Zip_____
Home: _____Cell: _____Work: _____
Email: _____

***If parents are separated or have a custody agreement, please provide a copy of your parenting plan for proper claims processing and the release of protected health information. Thank you!**

Primary Insurance Information

Subscriber (person that carries the insurance) _____DOB: _____
Optional - Subscriber's Social Security #: _____*Military Rank:* _____
Insurance Company: _____Employer: _____
Group or Plan #: _____ Insurance ID #: _____
Insurance Phone Number: _____

Secondary Insurance Information

Subscriber (person that carries the insurance) _____DOB: _____
Optional - Subscriber's Social Security #: _____*Military Rank:* _____
Insurance Company: _____Employer: _____
Group or Plan #: _____ Insurance ID #: _____
Insurance Phone Number: _____

Medical and Dental History

Child's Name:_____ Date of Birth: _____

Is your child:	Yes	No	Comments/Please Explain/What?
Taking any medication?			
Allergies: Medications/Latex/foods/dyes			
Up to date with immunizations?			

Has your child had any of the following?

	Yes	No		Yes	No
ADD/ADHD/Behavior Problems			Hepatitis/Liver Problems		
Allergies			High Blood Pressure		
Anaphylaxis			HIV+/AIDS		
Asthma			Immune System Problems		
Autism			Kidney/Renal Problems		
Blood/Bleeding Problems			Malignant Hyperthermia		
Cancer/Chemo/Radiation			Organ Transplant		
Convulsions/Epilepsy			Pregnancy		
Diabetes			Rheumatic/Scarlet Fever		
Disabilities/Impairments			Sleep Apnea		
Down Syndrome			Snoring		
Heart Problems			Tuberculosis (TB)		

If you have answered yes to any of the above please explain:_____

_____

Does your child have any other disease/condition or medical problem not listed?(please explain):_____

_____

Physician/Pediatrician Information

Physician/Pediatrician Name:_____Date of last physical:_____

Address:_____City:_____ State:_____ Zip:_____

Phone #:_____

Dental History

Date of last dental visit:_____ Name of Dentist:_____

Do you have any dental concerns?_____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is also my responsibility to inform the office of any changes in my child's medical status.

Signature of Parent/Guardian:_____ Date:_____ Assistant:_____

Office Use Only: Signature of Witness: _____ Scanned in by: _____

smile
ORTHODONTICS pediatric dentistry

FINANCIAL AGREEMENT

Patients Names _____

Payment in full for all charges is required at the time of visit unless prior arrangements have been made.

INSURANCE & FILING YOUR CLAIMS

The parent/legal guardian/patient is ultimately responsible for full charges of their account, not the insurance company.
We Do Not Guarantee Any Insurance Benefits or Payments. _____ Responsible Party Initials.

We do, however, file dental insurance claims as a courtesy to our patients.

We can only make estimates regarding your insurance benefits based on the information provided by you and the insurance company.

In the event your insurance company does not pay as much as expected, the remaining balance is due and payable immediately by you, the patient.

We **are not** HMO or DHMO providers. This means we are out of network with those plan types and out of pocket expenses will be higher and the insurance company may not contribute any benefits or payments on a patient's behalf.

Surprise Billing Law - What are surprise medical bills? If you have health insurance and get care from an out-of-network provider or at an out-of-network facility, your health plan may not cover the entire out-of-network cost. This can leave you with higher costs than if you got care from an in-network provider or facility.

ATTENTION: For those that have, or are in the process of dissolution of marriage, we do not get involved with any personal financial agreements set forth in relation to said matter; that is strictly between you and the other party. We will only work with set insurance guidelines. We will file insurance for you as usual. In any case, where the insurance carrier denied payment because they did not receive information requested from the subscriber, you the responsible party, will be fully responsible for all unpaid balances.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign insurance benefits directly to Erickson Pediatric Dentistry & Orthodontics P.C. dental for all dental work done by any of the doctors and/or his support staff. I further authorize Erickson Pediatric Dentistry & Orthodontics P.C. to release to my insurance company all information relating to the submittal of dental insurance claims. All treatment is just an estimate of benefits, we cannot guarantee or predict how the insurance company will process and finalize your claims.

_____ _____
Responsible Party Signature Date

DELINQUENT ACCOUNTS

All delinquent accounts (30 days or older) may be subject to reasonable service charges and/or legal interest rates. Any delinquent accounts that are sent to collections will incur a $100 charge.

FAILED APPOINTMENTS

Failed appointments (less than 48 hours notice) are a significant contributor to rising dental and health care costs. Individuals who fail to keep their appointments will be charged a **$50 non-negotiable fee**.
In addition, appointments that are missed habitually will result in dismissal from the practice. _____ **Responsible Party Initials**

I have completely read and understand the contents of this agreement. I agree to comply with all policies.

_____ _____
Responsible Party Signature Date

_____ _____
Witness/Title Date

Responsible Party is whomever is filling out this paperwork, makes the appointments, has custody, or is the legal guardian of the patient(s) in question. The responsible party may be mom, dad, stepmom, stepdad or legal guardian. The person who signs the contract is the responsible party, not necessarily the subscriber of an insurance policy if insurance applies.

smile
ORTHODONTICS pediatric dentistry

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I hereby signify I have received a copy of, or been given access to a readable copy of, this office's Notice of Privacy Practices. (HIPAA)

_____ _____

Print Patient's Name Responsible Party Signature

CONSENT FOR DENTAL TREATMENT

Consent for Treatment

I hereby authorize and request the performance of dental services for my minor child. I understand that at the first appointment (examination, necessary x-rays, cleaning, topical fluoride) the doctor will explain my child's treatment needs and the various behavior management approaches. At this appointment the doctor's staff will review any associated fees. I also realize that any restorative treatment will be accomplished at a later date.

I understand that DENTAL TREATMENT is associated with inherent risks, including, but not limited to, the following:

1. Injury to the nerves as a result of local anesthesia: This would include injuries causing numbness of the lips, the tongue, or other tissues of the mouth or face. This numbness is usually of a temporary nature, but permanent numbness is a possibility. If numbness persists more than 24 hours postoperatively, please call our office.

2. Soreness of the gums: Temporary soreness may result from the placement of a rubber dam, or any restoration that extends below the gumline (e.g. stainless steel crowns). This soreness usually goes away within 48 hours.

3. Sensitivity of teeth: Placement of any dental restoration can result in a tooth that is sensitive to hot and/or cold. If these symptoms persist for more than a few weeks, it may be an indication that further treatment is necessary.

4. Breakage, dislodgement, or bond failure: Due to the fact that teeth are subjected to extreme forces from chewing, grinding, and possible trauma, it is possible that bonded restorations (white fillings) or even amalgam restorations (silver fillings) can be fractured or dislodged, resulting in leakage, recurrent decay, or infection. The dentist has no control over the forces to which the tooth/restoration is subjected.

5. Aesthetics: Although dental materials are constantly improving, it is possible that bonded restorations may wear down, lose their luster, or discolor. The dentist has no control over these factors.

6. For dental extractions:

- Bleeding, bruising, or swelling: bleeding may persist for several hours. If profuse, please call our office. Some swelling is normal, but if severe, please call our office. Bruising may persist for some time, but generally heals uneventfully.
- Injury to adjacent teeth or restorations: This is a possibility no matter how carefully the surgery is performed.
- Infection: Due to the non-sterile nature of the mouth, or perhaps due to an existing infection, post-operative infection is a possibility. Some infections can be very serious. If severe swelling occurs, particularly if associated with fever or malaise, please call our office as soon as possible.

7. For endodontically treated teeth:

- Pulpotomies: In a small percentage of cases, the patient's body "rejects" the nerve treatment, resulting in a failed pulpotomy and the need for extraction. The dentist has no control over the body's biological response to treatment.
- Pulpectomies: For teeth requiring a pulpectomy, the long term prognosis is guarded. A significant percentage of pulpectomized primary teeth ("baby teeth") will ultimately need to be extracted. This treatment is generally used when short term retention of a primary tooth is important to long term dental health.

8. IT IS MY RESPONSIBILITY TO SEEK ATTENTION SHOULD ANY COMPLICATIONS OCCUR POSTOPERATIVELY AND I SHALL DILIGENTLY FOLLOW ANY INSTRUCTIONS GIVEN TO ME BY THE DENTIST.

9. For those children receiving nitrous oxide analgesia: Potential side effects include dizziness, nausea, and vomiting. Nitrous oxide should be avoided if your child has just eaten a large meal.

INFORMED CONSENT: I consent for my child(ren) to receive preventative/diagnostic services. I will be given the opportunity to ask questions regarding the proposed treatment and will receive answers to my satisfaction. I will be given alternatives to this treatment, including the option of rendering *no* treatment. I understand and assume any and all risks associated with the procedures, and I understand that no guarantees will be made regarding the outcome of the treatment. By signing this form, I am freely giving my consent to allow and authorize Dr. Josh Erickson or Dr. Lucas Carubia to render treatment, including any anesthetics or medications.

_____

Print Patient's Name Date

_____

Additional patient's names

_____

Parent/Guardian Signature Printed Name Relationship to patient(s)

smile
ORTHODONTICS pediatric dentistry

CANCELLATION, NO SHOW AND LATE POLICY

We understand that illness, emergencies, flat tires, and bad weather do occur. We ask our patients and parents to give us 48 hours' notice if they cannot keep an appointment. This notice allows us time to give that appointment to other patients who need an appointment. Our offices are very busy and appointment times are very valuable to us and all our patients. So, we need your help in making sure these appointment times are used efficiently.

Policy and Fees:

1. Cancellation or rescheduling of an appointment with 48 hours or more notification
    - NO charge

2. Cancellation or rescheduling of an appointment less than 48 hours and up to 24 hours.
    - A charge of $50 (per appointment) will be at our discretion based on the patient's appointment history.
    - If we can successfully fill your appointment time with another patient there will be no charge.

3. Failure to show up for your appointment or the cancelation of an appointment the same day as the appointment:
    - We allow for one (1) No Show or same day Cancelation within a 24 month period.
    - Any additional No Show or same day Cancelation within a 24 month period will be charged a fee: $50

4. Arriving late for an appointment.
    - If you arrive more than 10 minutes past your scheduled appointment time, unfortunately we will not be able to see you and it will be considered a No Show. A No show charge may be applied at our discretion. Please understand some appointments are 30 minutes long and arriving more than 10 minutes late will not allow enough time to provide the proper care that you need.

Definition of a "No Show" is when you or a family member

- Cancel or reschedule an appointment with less than 24 hour notice
- Do not show up for the scheduled appointment
- Arriving more than 10 minutes late for an appointment

Our number one concern is our patient's dental health. Providing services in a timely manner is critical to accomplish that goal. Another concern is to keep the cost of dental services as economical as possible. The appointment you schedule for treatment is reserved for you and your treatment only. We ask our patients and parents to give us 48 hours' notice if they cannot keep an appointment. This notice allows us time to fill our schedule with other patients who need an appointment. When you fail to keep your appointment without providing us adequate notice, this adds to the overall cost of care for you, as our trained professionals and dental facilities are sitting idle and not being utilized. We appreciate your understanding and consideration regarding our appointment policy and if you have any questions or concerns, never hesitate to ask us.

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

_____ _____

Patient signature (Parent or Guardian if minor) Date

Photo / Video Release Form

I, _____(print first and last name) authorize *Smile Orthodontics and Pediatric Dentistry* to take photos and/or videos of myself or my child/children before, during, or after their orthodontic or dentistry experience. I also authorize the use of first names to be used on printed publications, social media outlets, and websites.

I acknowledge that since my participation in printed publications, social media and websites produced by Smile is voluntary, I will receive no financial compensation or right of ownership whatsoever.

I release Smile's contractors and employees from liability for any claims by me or any third party with my participation.

Parent/Guardian Signature:_____ Date: _____

Witness Signature: _____