We Care Dental Care
Benjamin Burkitt, D.M.D.

Patient Information:
Name_____Nickname_____
Gender_____Date of Birth_____
Home
Address_____City_____State_____Zip_____

E-mail address_____

Parent/Guardian information:
Father's name _____DOB _____Phone _____
Home address
If different City _____State _____Zip_____
Employed by_____
Address _____Phone _____
Social Security Number _____
Mother's name _____DOB_____Phone _____
Home address
If different: City _____State _____Zip _____
Employed by_____
Social Security Number _____
Address _____Phone _____

General Health Information:
Child's Physician_____Phone_____
Does our office have permission to contact your child's Physician if needed
Yes _____ No _____
Is your child in good health _____, if not briefly describe

Conditions_____

Has your child ever been hospitalized?_____
When, where and for what reason _____

For reason did you schedule this appointment _____

Whom may we thank for referring you? _____

Medical History **Circle all that apply**

Allergies

Food Drug Other

Medical Conditions

Measles (Rubella)	Mumps	Tuberculosis
Hepatitis	Cold Sores	Chicken Pox
Bladder	Kidney	Learning
Immunological Disorder	Bleeding Disorder	Asthma
Cystic Fibrosis	Gastro Intestinal	Diabetes
Jaundice	Emotional Disorder	Anxiety
Drug reactions	Seizures	

Heart Disease: Rheumatic Congenita Murmur

List any surgeries your child has had _____

Is your child presently on any medication _____

If so describe_____

AUTHORIZATION TO TREAT

Acknowledgement of Receipt of Notice of Privacy Polices

List people authorized to bring child to dental appointments other than parent/guardian

1. _____
2. _____
3. _____

Parent/Guardian Signature _____

Date _____

WE CARE DENTAL CARE FINANCIAL POLICY

Assignment and Release
I the undersigned, have insurance with _____, and assign directly We Care Dental Care all 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.

Date: _____ Signature: _____
Signature of patient/parent/legal guardian

Patient Agreement and Financial Policy
I hereby agree to be responsible for the costs of care provided by We Care Dental Care and/or the dental team for myself or my dependent(s). These include any deductibles and amounts not covered by insurance. **I also understand that it is my responsibility to be aware of any limitations, and benefits of my insurance policy.** Payment to this office is my responsibility and I am aware that if the insurance company does not reimburse the doctor, I am responsible for the total amount(s).

This office does not accept personal checks.
We do accept Visa, Mastercard, Discover, American Express and Care Credit

I understand that because appointments are not double-booked, I must provide notice of cancellation at least 48 hours prior to my scheduled appointment time. A $50 cancellation fee may apply if I do not provide notice of cancellation at least 48 hours prior to my scheduled appointment time.

We make every effort to schedule appointments that are most convenient for you and that fit your personal schedule. Because we do not schedule several patients at the same time, all appointments are reserved exclusively for you. In return, we ask that you make every effort not to change your reserved dental appointment.

I understand that payment in full is due at the time of service. I understand that after 90 days, any unpaid balance will incur a $30 billing fee. I understand that failure to pay amounts due to this office will result in my account being placed with a collection agency. In the event that my account is further referred to an attorney, I agree to pay all collection and attorney fees.

Date: _____ Signature: _____
Signature of patient/parent/legal guardian

Minor/Child Consent
I, being the parent or legal guardian of _____, do here, by request and authorize the dental staff to perform necessary services for my child, including but not limited to radiographs (x-rays) and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered. I also understand that the parent or guardian who brings my child in for treatment will be responsible for payment. A receipt will be provided so I may seek reimbursement.

Date: _____ Signature: _____
Signature of patient/parent/legal guardian

We Care Dental Care

Your Privacy Is Important to Us

Acknowledgement of Receipt of Notice of Privacy Policies

I have received a copy of the Notice of Privacy Practices of We Care Dental Care. I hereby authorize, as indicated by my signature below, We Care Dental Care to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

_____ _____

Print Name Address

_____ _____

Signature Date

Please check your preferred means of communication:

☐ You may contact me at my home telephone number _____

☐ You may contact me on my mobile telephone number _____

☐ You may contact me on my work telephone number _____

☐ You may send me an unencrypted email/text message at: _____

☐ Other _____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. _____ Date Added / Removed:_____

2. _____ Date Added / Removed: _____

3. _____ Date Added / Removed: _____

4. _____ Date Added / Removed: _____

* * *

For Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining the acknowledgement

☐ Other (Please Specify) _____

Staff Person Initials _____