To help us better serve you, please complete the following forms to the best of your ability. If you have questions, do not hesitate to let us know. Thank you for choosing our office

Child's Name: ____________________ DOB (MM/DD/YY) ____________________

Nickname: ____________________ Age: __________ Social Security #: ____________________

Ethnicity: ☐Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Declined Gender: ☐ Male ☐ Female

Race: ☐ White ☐ Hispanic ☐ Black/African American ☐ Asian ☐ Other ☐ Declined

Home Address: ____________________

City/State/Zip: ____________________ Phone Number ____________________

Who can we thank for referring you to us? ____________________

How have you heard about us? (Please Check all that apply)

☐ Social Media ☐ Google/Website ☐ Insurance Directory ☐ Drive By/Signage ☐ Billboard ☐ Radio

☐ Referral, Who can we thank for referring you to us: ____________________

☐ Other (please specify): ____________________

DENTAL HISTORY:

Please select all that apply:

☐ First Dental Visit ☐ Child loves dental visits ☐ Child dislikes dental visits

Please describe your child's dental history:

☐ Never had a cavity ☐ Untreated cavities ☐ Dental treatment in office ☐ Dental Treatment while asleep

Please select all that apply:

☐ Parents assists brushing ☐ Child Brushes alone ☐ Brushes 2x a day ☐ Brush 1x a day ☐ Flosses daily

Please check which foods your child consumes each on an average day:

Drinks: ☐ water ☐ juice ☐ milk ☐ soda ☐ Gatorade ☐ other (please specify):____________________

Snacks: ☐ crackers ☐ fruit snacks ☐ fruit ☐ veggies ☐ pouches ☐ yogurt

☐ other (please specify)____________________

INFORMATION: Parent 1

Name: ______________________________ Relationship: ______________

DOB: __________ Social Security #: __________ Phone Number ______________

Email Address: ______________________________

Home Address (If different than child): ______________________________

INFORMATION: Parent 2

Name: ______________________________ Relationship: ______________

DOB: __________ Social Security #: __________ Phone Number ______________

Email Address: ______________________________

Home Address (If different than child): ______________________________

Primary Dental Insurance:

Insurance Company: ____________________ Insured's Name______________

Relationship to Patient: __________________ DOB: __________ SSN: __________

Employer: ________________ Subscriber ID: ____________Group #:__________

Employer Address: ______________________________

Employer Phone: ____________________

Secondary Dental Insurance (If Applicable):

Insurance Company: ____________________ Insured's Name______________

Relationship to Patient: __________________ DOB: __________ SSN: __________

Employer: ________________ Subscriber ID: ____________Group #:__________

Employer Address: ______________________________

Employer Phone: ____________________

Emergency Contact Information (Please select a local friend or relative now living in the same residence)

Name: ________________________ Phone Number:__________________

Relationship to Patient: __________________

HIPPA NOTICE OF PRIVACY PRACTICE

I have been given a copy of the HIPPA NOTICE OF PRIVACY PRACTICE:

X ____ __________________

Patient/ Guardian Signature Date

CONSENT FOR TREATMENT:

I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my child's dental needs. Upon diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives, and other medication as necessary. I understand I can ask for a complete recital of any possible risk of complications.

X ____ __________________

Patient/ Guardian Signature Date

FINANCIAL INFORMATION

"I agree to pay my account in full at the time of services, unless Idaho Falls Pediatric Dentistry agrees to other payment arrangements. I understand that Idaho Falls Pediatric Dentistry will submit insurance benefits for payment only as a courtesy to me. If my account is assigned to a collection agency that sues to recover payment, I agree to pay a reasonable attorney's fee in the event default is entered 35% of the principal and interest on my account balance or $400.00, whichever is greater. If I consent entry of default, I agree that the court may award a reasonable attorney's fee under Idaho law that this award may exceed the amount of the attorney's fees otherwise awarded in the event of default. I further agree to pay reasonable costs of suit. I also agree to pay a $20 processing fee if my account is assigned to a collection agency."

I accept responsibility for payment to Idaho Falls Pediatric Dentistry for any portion of the account that the insurance carrier does not pay. In the event that I do have dental insurance, I agree to accept responsibility for payment. All balances over 90 days with an interest rate of 1.5% per month (18% A.R.P.).

A $25 fee will be charged to the account for all returned checks. I have read and understand all stated financial policy for this office.

X ____ __________________

Patient/ Guardian Signature Date

The above information is true to the best of knowledge. I authorize my insurance benefits be paid directly to the dentist. I understand that I am financially responsible for any balance. I also authorize Idaho Falls Pediatric Dentistry or insurance company release any information required to process my claims.

X____ ___________________________ __________

Patients/ Guardian Signature Printed Name Date

PATIENT:_______________

MEDICAL HISTORY FORM

Pediatrician Name: ______________________________ Phone: ______________

Preferred Pharmacy: ______________________________ Phone: ______________

Does your child see any specialists? ☐ NO ☐ YES (if yes please complete the lines below)

Name: ____________________ Specialty: ______________ Phone:: ______________

Name: ____________________ Specialty: ______________ Phone:: ______________

Reason seen by Specialist: ______________________________ Date last seen: ____________

Has your child ever been hospitalized? ☐ No ☐ Yes, details______________________________

Has your child ever had surgery? ☐ No ☐ Yes, details ______________________________

Has your child ever needed antibiotic prophylaxis for any conditions? ☐ No ☐ Yes

Does your child have limitations in: ☐ Hearing ☐ Speech ☐ Vision ☐ Mobility ☐ None

Allergies : ☐ None ☐ Yes, (please list allergies and reactions)______________________________

____

Does your child have any medical conditions? ☐ No ☐ Yes (please complete below)

☐ Blood Disorder	☐ Seizures	☐ Heart Problems	☐ Breathing Problems (asthma, etc)
☐ Acid Reflux	☐ Diabetes	☐ Endocrine Disorder	☐ Skin Problem (Eczema, Psoriasis, etc)
☐ Premature Birth	☐ Cancer	☐ Chromosomal Disorder	☐ Gastrointestinal Disorder
☐ Congenital Anomaly	☐ Autism	☐ ADHD	☐ Mental Health Disorder

Please specify exact diagnosis/more details or other conditions: ______________________________

____

Additional Comments: (Please use this space to describe any medical conditions or details not included above):

____

____

____

THE ABOVE INFORMATION IS ACCURATE TO THE BEST OF MY KNOWLEDGE.

Parent Signature: ______________________________ Date: ____________________

IDAHO FALLS PEDIATRIC DENTISTRY FINANCIAL POLICY

It is our intent to fully explain and inform you of all procedures, options, and fees prior to treatment. Insurance quotes are an estimate only and not a guarantee. During the course of treatment, due to the complexity of the mouth, treatment plans may change according to unexpected oral conditions.

Payment is required at time of service. If you are not able to pay in full, we may be able to offer payment plans after you have paid (at minimum) half of treatment done on each date of service.

Patients who carry insurance should understand that services rendered are charged to the patient, not the insurance company. We are happy to file claims with your insurance carrier, however, all charges are your responsibility. Any estimates by this office regarding insurance benefits are only a guideline based on the information provided to us by your insurance carrier. This office makes no guarantee of an insurance payment. If after 6 months your insurance has not paid their portion, it is the patient's responsibility to pay the account in full.

Payment Options

Deductibles, co-payments, and any position not covered by your insurance is due at the time of your visit. If you are unable to pay in full at time of your visit, please speak with our staff to see if the office can offer a payment plan prior to completing treatment.

We accept cash, check, Visa, MasterCard, Discover, AMEX, CareCredit.

Due to insurance restrictions, discounts cannot be offered to patients with dental insurance.

Cash or check payments for the full account balance without insurance are eligible for a 10% cash discount.

Payment of half-down on each date of service is required if the office is able to arrange a payment plan, and the plan must be updated if further treatment is completed.

Idaho Falls Pediatric Dentistry will apply finance charges monthly at 1.5% (18% A.P.R.) if balances are not paid within 90 days, or within the guidelines that have been set for payment plans.

If a planned payment is delinquent, payment must be made within 30 days, and the remainder of the payment plan will continue as outlined. If payment is not received within 30 days, the payment plan will terminate, and the account balance will be sent to our collection agency.

Financing Options

1: Care Credit

Applications for Care Credit are available at our office. We would be happy to assist you with your application.

2: In-office payment plans

A recurring payment plan can be created after payment of half-down is made at time of service. Please ask front office for details, and to set up a plan.

Idaho Falls Pediatric Dentistry reserves the right to update and revise this policy as needed.

Patient Signature ______________________________ Date ________________