LAKEFRONT
FAMILY DENTISTRY

PATIENT & FAMILY INFORMATION

Child's Name:______________________ DOB: __________ Male_____/Female_____
Home Address: ______________________
City: ______________________ State: __________ Zip: __________
School: ______________________ Grade:__________
Responsible Party: ______________________ **Relationship to Child:** __________
Name of Mother/Guardian: ______________________DOB: __________
Cell/Home Phone#: ______________________ SS #: __________
Employer: ______________________ **Primary Insurance Subscriber Y/N**
Secondary Insurance Subscriber Y/N
Name of Father/Guardian: ______________________DOB: __________
Cell/Home Phone#: ______________________ SS #: __________
Employer: ______________________ **Primary Insurance Subscriber Y/N**
Secondary Insurance Subscriber Y/N

CHILD'S DENTAL HISTORY

Former Dentist: ______________________ Office Phone:__________
Address: ______________________ City:__________ State:__________
Date of last dental visit: ______________________
How often does your child brush? Morning ___Y/N___ Mid-Day ___Y/N___ Night ___Y/N___
How often does your child floss? Morning ___Y/N___ Mid-Day ___Y/N___ Night ___Y/N___
Please check all that apply:
____Thumb/Finger Sucking
____Lip of Cheek Biting
____Fingernail Biting
____Jaw Difficulty: Clicking and/or Pain
____Grinding Teeth

INSURANCE INFORMATION

Primary Insurance Name: ______________________ Phone Number: __________
Member/Subscriber ID#: ______________________ Group #: __________
Subscriber Name: ______________________ Relation to Patient: __________

Secondary Insurance Name: ______________________ Phone Number: __________
Member/Subscriber ID#: ______________________ Group #: __________
Subscriber Name: ______________________ Subscriber DOB: __________ Relation to Patient: __________

MEDICAL HISTORY

Child's Physician: ______________________ City/State: ______________________

Phone #: ______________________ Last Visit: ______________________

Is minor/child under care of physician now? ___Y/N___ Allergies: ______________________

Currently taking medication? ___Y/N___ Medications: ______________________

Ever been hospitalized? ___Y/N___ If yes, describe: ______________________

Ever had surgery? ___Y/N___ If yes, describe: ______________________

Is there excessive bleeding when cut? ___Y/N___

Has minor/child had any history of or difficulty with any of the following? If yes, please check (√)

___ A.I.D.S. / H.I.V	___ Convulsions	___ Hepatitis	___ Sinus Problems
___ Anemia	___ Diabetes	___ Kidney Disease	___ Thyroid Disease
___ Asthma	___ Drug/Alcohol Abuse	___ Liver Disease	___ Tuberculosis
___ Bladder Problems	___ Epilepsy	___ Measles	___ Other
___ Cancer	___ Fainting	___ Mononucleosis	
___ Cerebral Palsy	___ Hearing Problems	___ Mumps	
___ Chicken Pox	___ Heart Problems	___ Rheumatic Fever	

AUTHORIZATIONS

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

MINOR/CHILD CONSENT:

I am the parent, guardian, or personal representative of

______________________ (Print Name of Minor/Child)

and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for he child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

INSURANCE ASSIGNMENT AND RELEASE:

I certify that my dependent(s) is covered by insurance with

______________________ (Name of Insurance Company(ies))

and assign directly to **Dr. Nicole Bellingham D.D.S.** 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 authorize the use of my signature on all insurance submissions.

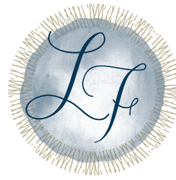
The above-named doctor may use my minor/child's health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below. .

______________________ ______________

Signature of Parent, Guardian or Personal Representative — Date

______________________ ______________

Please print name of Parent, Guardian or Personal Representative — Date



LAKEFRONT
FAMILY DENTISTRY
NICOLE BELLINGHAM, D.D.S.

TO ALL OUR PATIENTS

IN EFFORT TO KEEP DENTAL COSTS DOWN WHILE MAINTAINING A HIGH LEVEL OF PROFESSIONAL CARE, WE HAVE ESTABLISHED THE FOLLOWING INFORMED CONSENT FOR OUR PATIENTS. WE ENCOURAGE OUR PATIENTS TO DISCUSS ANY QUESTIONS THEY MAY HAVE REGARDING OUR POLICIES

FINANCIAL POLICY:

1. Payment in FULL at the time of visit is due.
2. We accept cash, Care Credit and all major credit cards ONLY.
3. If you have dental insurance, which provides coverage for this provider, we will be happy to help determine the coverage you have available.
4. Keep in mind however: your insurance policy is a contract between you and your insurance company. We, therefore, cannot guaranty payment of your claims or accept responsibility of negotiation with insurance companies or other persons.
5. If your insurance has not paid or denied your claim in 45 days, you are responsible for full payment of all unpaid claims.
6. For any balances over 60 days, interest will accumulate at the rate of 1% per month.

YOUR PAYMENT IS TO BE PAID IN FULL AT THE TIME OF EACH SERVICE, FEES ARE SUBJECT TO CHANGE EVERY YEAR.

DELINQUENT ACCOUNTS will be referred for collections after 30 days and subject to credit reporting. You will be responsible for the collection fees / attorney's fees.

NO SHOW AND CANCELLATION POLICY:

Your visit has been reserved for you, the dentist and/or hygienist. A 24- hour notice is required in advance for cancellations in order to allow all our patients to receive the bets possible dental care (4 p.m. Thursday for a Monday appointment).

I hereby authorize the release of any dental information necessary to process claims. I authorize the payment of benefits to the dentist described herein for services rendered.

STATEMENT OF UNDERSTANDING:

I HAVE READ AND UNDERSTAND THIS INFORMATION SHEET AND INFORMED CONSENT

Signature ______________________ Date ______________

Printed Name ______________________