



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#: _____ Email: _____

SS #: _____ Employer: _____

Primary Insurance Subscriber Y/N

Secondary Insurance Subscriber Y/N

Name of Father/Guardian: _____ DOB: _____

Cell/Home Phone#: _____ Email: _____

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 N Mid-Day Y/N N Night Y/N N

How often does your child floss? Morning Y/N N Mid-Day Y/N N Night Y/N N

Please check all that apply:

Thumb/Finger Sucking

Jaw Difficulty: Clicking and/or Pain

Lip or Cheek Biting

Grinding Teeth

Fingernail Biting

Pain on Eating/Drinking/Sweets

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 (✓)

<input type="checkbox"/> A.I.D.S. / H.I.V	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> Drug/Alcohol Abuse	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Bladder Problems	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Measles	<input type="checkbox"/> Other
<input type="checkbox"/> Cancer	<input type="checkbox"/> Fainting	<input type="checkbox"/> Mononucleosis	
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Hearing Problems	<input type="checkbox"/> Mumps	
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> 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, being the patient or parent/guardian (of the named minor/child) hereby request and authorize the dental staff to perform necessary dental services for the 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. .

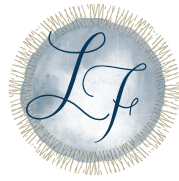
Signature of Parent, Guardian or Personal Representative

Date

Please print name of Parent, Guardian or
Personal Representative

Date





L A K E F R O N T
F A M I L Y D E N T I S T R Y
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. Keep in mind however: your insurance policy is a contract between you and your insurance company. We, therefore, cannot guarantee payment of your claims or accept responsibility of negotiation with insurance companies or other persons.
4. If your insurance has not paid or denied your claim in 45 days, you are responsible for full payment of all unpaid claims.
5. 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 with 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 best possible dental care (and by 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