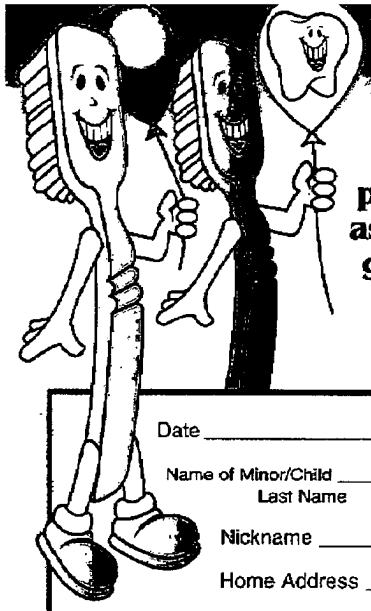
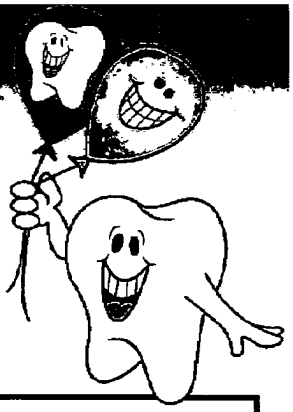


Welcome!



We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.

PATIENT INFORMATION

Date _____ SS/HIC/Patient ID # _____ Birthdate _____

Name of Minor/Child _____ Sex ☐ M ☐ F Age _____
Last Name First Name Middle Initial

Nickname _____ Hobbies _____ Cell Phone (____) _____

Home Address _____
Street City State Zip

Mailing Address _____
Street City State Zip

School Name _____ School Phone (____) _____

Person financially responsible _____ Home Phone (____) _____ Work Phone (____) _____

Whom may we thank for referring you? _____

INSURANCE

Father's/Guardian's Name _____

Address (if different from patient's) _____

Home Phone (____) _____ Work Phone (____) _____
(if different from above) (if different from above)

E-mail _____

Employer _____

Soc. Sec. # _____ Birthdate _____

Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name _____ Phone (____) _____

Address _____

Group # _____ Policy # _____

Mother's/Guardian's Name _____

Address (if different from patient's) _____

Home Phone (____) _____ Work Phone (____) _____
(if different from above) (if different from above)

E-mail _____

Employer _____

Soc. Sec. # _____ Birthdate _____

Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name _____ Phone (____) _____

Address _____

Group # _____ Policy # _____

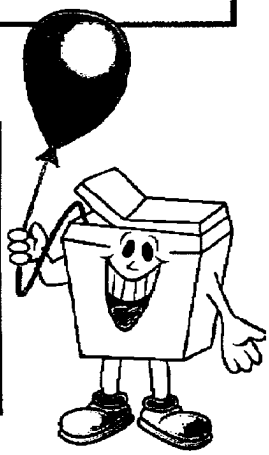
Is your child eligible for treatment under Medical Assistance? ☐ Yes ☐ No Child's Medical Assistance I.D. # _____

DENTAL HISTORY

Date of last visit to a dentist _____ For what service? _____

	YES	NO		YES	NO
Has child complained about dental problems?	☐	☐	Is fluoride taken in any form?	☐	☐
Does child brush teeth daily?	☐	☐	Any injuries to mouth, teeth, head?	☐	☐
Does child use floss every day?	☐	☐	Any unhappy dental experiences?	☐	☐

Any mouth habits - thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc? ☐ ☐



Please Complete Both Sides

Minor/Child's Physician _____ City/State _____ Phone (____) _____

Date of last physical examination _____ Results _____

	YES	NO
Is Minor/Child under care of physician now?	☐	☐
Receiving any medication or drugs?	☐	☐
Ever been hospitalized?	☐	☐
Ever had surgery?	☐	☐
Is there excessive bleeding when cut?	☐	☐

Medications _____

_____

_____

Allergies _____

_____

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

EMERGENCY CONTACT

In the event of an emergency, whom should we contact?

Name _____ Relationship _____ Phone (____) _____

Name _____ Relationship _____ Phone (____) _____

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 _____
Please 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 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

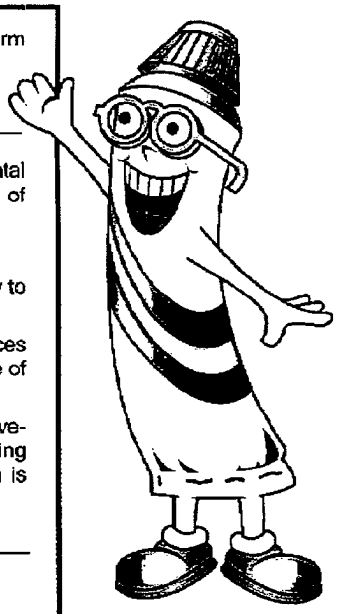
I certify that my dependent(s) is covered by insurance with _____ and assign directly to
Name of Insurance Company(ies)

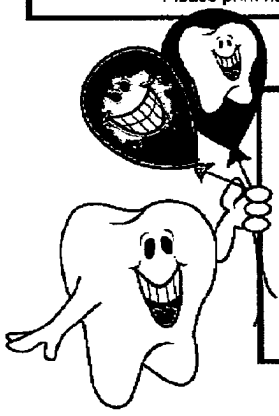
Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

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 — Relationship to Patient





UPDATE

TO BE COMPLETED AT LATER VISIT

Has there been any change in patient's health since last dental appointment? ☐ Yes ☐ No

If yes, please describe _____

Is patient taking any new medications? ☐ Yes ☐ No If yes, please list _____

Date _____ Parent/Guardian Signature _____

Date _____ Dentist Signature _____

Office Policies/Dental Insurance/Private Pay

We are committed to providing you with the best possible care that's why we always try to present you with the best dental solution possible to treat your personal situation. Here are some important things you should know about receiving care at our office:

(Please Initial):

____ A specific amount of time is reserved especially for you, and we strongly encourage all patients to keep their appointments. If you must change your appointment, we **require at least 48 hour notice** to avoid a **$50/hour cancellation fee** (emergencies are an exception). **$100.00 fee for a missed Saturday appointment**.

____ Balances older than **60 days** will be subject to a **monthly $25.00 late fee** until the account balance is brought current.

____ Dr. Gniadek does require payment in full for your portion, including deductible and co-payment at the time your services are rendered unless payment arrangements have been approved in advance by our staff**. We accept cash, check, MasterCard, Visa, and Discover**.

____ Your dental benefits are based upon a contract between your employer and an insurance company. **If you have any questions regarding your dental benefits, please contact your employer or insurance company directly**.

____ We currently accept all private care insurance plans (plans that do not require you to select a dentist from a list, or require our office to accept a reduced fee for service). However, **we may or may not be an in-network provider for your insurance**. Although we can maintain computerized histories of payment by a given company, they do change; therefore it is impossible to give you an absolutely accurate quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is ***ONLY AN ESTIMATE***. (If you would like to know your insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. Keep in mind this is not a guarantee of coverage. This does delay treatment, but will give you a better idea of out-of-pocket expenses).

____ We will bill your insurance company as a courtesy. **If insurance does not pay within 90 days, Dr. Gniadek reserves the right to request payment in full for services from you**, and let you collect the insurance funds that are due you. This is rare, but it is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be a part of that legal contract. Ultimately you are responsible for all charges incurred in our office.

____ In the event of an emergency during regular business hours, a $68.00 emergency fee will be charged in addition to the necessary treatment fees. Established patients will be charged a $150.00 emergency fee for after hour emergencies in addition to the necessary treatment fees.

Situations of Divorce:

____ Divorced parents bringing a child to an appointment are solely responsible for all fees incurred during each visit. Parents will not be billed separately. By initialing, you agree to pay all costs of collection (if necessary) including, but not limited to, reasonable attorney's fee. As painful as divorce is for all parties involved, our office cannot become involved with parents and payment of services rendered.

I acknowledge I have read and understand all the above conditions.

Print Name:_____Date:_____

Patient/Parent Signature: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement.

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operation such as quality assessments and physician certifications.

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions.

Patient Name (Print): _____

Relationship to Patient: _____

Signature: _____ Date: _____

Please list names of persons who we can release your information to:

_____

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Name of Patient: _____ Date of Birth: _____

Address _____

Home #_____	May we leave a message?	Yes____No_____
Work #_____	May we leave a message?	Yes____No_____
Cell #_____	May we leave a message?	Yes____No_____
Email _____	May we leave a message?	Yes____No_____

May we send an appointment reminder text message? Yes____No____
May we leave a message that you need pre-medication? Yes____No ____
May we leave a message that you need a dental appointment? Yes____No ____
I do **NOT** want a reminder left at all_____(initial)
I do **NOT** want a postcard sent_____(initial)

I understand that I <u>will</u> incur a missed appointment fee should I fail to keep my appointment (without 24hr notification). ***_____(signature)***

FOR OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on the *Notice of Privacy Practices*, but was unable to do so as documented below.

Date_____ Reason_____Initials_____