

**PATIENT INFORMATION**

**DATE** \_\_\_\_\_

**CHILD'S NAME(S):** \_\_\_\_\_ Date of Birth: \_\_\_\_\_

\_\_\_\_\_ Date of Birth: \_\_\_\_\_

\_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Whom may we thank for referring you to our practice? (Please be specific)** \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION**

**Who is responsible for this account?** \_\_\_\_\_

**MOTHER NAME** \_\_\_\_\_ Marital status: \_\_\_\_\_  
Last First Initial

Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Employer \_\_\_\_\_ Work phone \_\_\_\_\_

**Would you be interested in receiving email reminders for upcoming or unscheduled appointments? YES NO**

**Email** \_\_\_\_\_

**FATHER NAME** \_\_\_\_\_ Marital status: \_\_\_\_\_  
Last First Initial

Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Employer \_\_\_\_\_ Work phone \_\_\_\_\_

**Would you be interested in receiving email reminders for upcoming or unscheduled appointments? YES NO**

**Email** \_\_\_\_\_

**Relative not living with you:**

Name: \_\_\_\_\_ Relation to patient \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

**PRIMARY DENTAL INSURANCE INFORMATION**

Name of Subscriber \_\_\_\_\_  
Last First Initial

Insurance Co. Name: \_\_\_\_\_

Subscriber's Birth Date \_\_\_\_\_ ID # \_\_\_\_\_

SS# \_\_\_\_\_ Group # \_\_\_\_\_

**SECONDARY DENTAL INSURANCE INFORMATION (IF APPLICABLE)**

Name of Subscriber \_\_\_\_\_  
Last First Initial

Insurance Co. Name: \_\_\_\_\_

Subscriber's Birth Date \_\_\_\_\_ ID # \_\_\_\_\_

SS# \_\_\_\_\_ Group # \_\_\_\_\_

**UNDERSTANDING YOUR DENTAL INSURANCE**

Dental Insurance is designed to help pay part of the cost of dental treatment. Dental insurance is not designed to pay all of the cost of treatment; it is more like a benefit towards the total costs.

We do our best to retrieve your child's dental benefits prior to their scheduled appointments. The information that we receive is not a guarantee of payment from your insurance company. They will only consider payment when a claim is received. The benefit information that we receive from them is very basic, meaning that the information that we provide to you is *only an estimate* based on the information provided to us. Since there is no guarantee that we will receive full payment from your insurance company, it is best to understand that ultimately you are responsible for your child's bill.

**Initial** \_\_\_\_\_

**FINANCIAL CONSENT**

I acknowledge that I have read and agree with the office financial policy. ***I understand that any estimate of my insurance benefits is solely an estimate and not a guarantee of payment.*** I understand this office bills my insurance as a courtesy and is not required to file my claims either legally or contractually. I am ultimately responsible for knowing the benefits and limitations of my plan. I understand this office may place composite (tooth-colored) fillings and I may have a higher copay if my insurance only covers amalgam (silver) fillings for back teeth. I also understand other charges such as (but not limited to) nitrous oxide (laughing gas) and fluoride may not be covered by insurance and will be my financial responsibility.

**Initial:** \_\_\_\_\_

I certify that I have given the correct insurance information to the office and will notify the office of any changes in insurance company or coverage. I also understand that fees and treatment needs are subject to change and previous estimates are not to be considered a guarantee.

**Initial:** \_\_\_\_\_

I acknowledge that payment in full is expected in cases of no insurance unless extended financing has been obtained.

**Initial:** \_\_\_\_\_

Name of Parent/Guardian \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**GENERAL CONSENT**

I request and authorize Bittner Dentistry for Kids, to perform examination, cleaning, radiographs (x-rays), photographs, and fluoride for my child as necessary. I understand that any treatment needs will be explained to me prior to treatment and will require additional consent.

I state that I am the child's legal guardian and that I have read and agree to follow all office policies stated on the website and available within the office. This consent will remain in effect unless canceled in writing.

I agree to notify this office of any change in my child's health, including any allergies or current medications/supplements. And any changes in contact and insurance information.

I authorize Bittner Dentistry for Kids, to release any information necessary for the processing of dental insurance claims and authorize direct payment from the insurance company to Bittner Dentistry for Kids.

Child(s) name(s) \_\_\_\_\_  
\_\_\_\_\_

Name of Parent/Guardian \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES  
\*\*YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT\*\***

I HAVE RECEIVED A COPY OF BITTNER DENTISTRY FOR KIDS NOTICE OF PRIVACY PRACTICES.

\_\_\_\_\_  
(PLEASE PRINT NAME)

\_\_\_\_\_  
(PARENT GUARDIAN SIGNATURE)

\_\_\_\_\_  
(DATE)

---

**OFFICE USE ONLY**

---

WE ATTEMPTED TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES, BUT ACKNOWLEDGEMENT COULD NOT BE OBTAINED BECAUSE:

INDIVIDUAL REFUSED TO SIGN

COMMUNICATION BARRIERS PROHIBITED OBTAINING ACKNOWLEDGEMENT

AN EMERGENCY SITUATION PREVENTED US FROM OBTAINING ACKNOWLEDGEMENT

OTHER \_\_\_\_\_