PATIENT INFORMATION FORM

DATE______________________________

CHILD'S NAME(S): ____ Date of Birth: _______________________

____ Date of Birth: _______________________

____ Date of Birth: _______________________

____ Date of Birth: _______________________

Who should we thank for referring your family to our office? ____

RESPONSIBLE PARTY INFORMATION

Who is responsible for this account? _________________________________

GUARDIAN NAME ____ Relationship to patient: _________________
Last First Initial

Marital Status_________________ Date of Birth_________________ SS# ______________________________________

Street Address____

City_____________________________________ State_____ Zip_________________

Home Phone_________________________ Cell Phone_______________________

Employer____________________________ Work phone_____________________

GUARDIAN NAME ____ Relationship to patient: _________________
Last First Initial

Marital Status_________________ Date of Birth_________________ SS# _______________________________________

Address same as above

Street Address____

City_____________________________________ State_____ Zip_______________

Home Phone__________________________ Cell Phone______________________

Employer____________________________ Work phone_____________________

Our office sends appointment confirmations and other important information pertaining to your account via email and text, please provide us with an email and cell phone number in which you would like the reminders to be sent :

Name__________________________________ **Email** ____ **Cell:**__________________________

For Emergency contact please provide relative not living with you:

Name: ____Relation to patient __________________________Phone: ______________________________

MEDICAL AND DENTAL HISTORY

Child's Name ____ Birthday ____/_____/_____ Male or Female

Primary Care Physician's name, address and phone number:
____

Please check all of the conditions that apply to your child:

( )Anemia	( )Asthma	( )Autism	( )Birth Defects
( )Bleeding Problems	( )Blood Disorders	( )Cancer	( )Cerebral Palsy
( )Diabetes	( )Down Syndrome	( )Epilepsy/Seizures	( )Emotional Problems
( )Heart Condition	( )Heart Murmur	( )Hepatitis	( )HIV/AIDS
( )Liver Disease	( )Learning Disabilities	( )Kidney Disease	( )Hyperactivity/ADHD
( )Intellectual Disability	( )Rheumatic Fever	( )Skin Disorders	( )Psychiatric Problems
( )Sleep Apnea/Snoring	( )Spina Bifida	( )Tuberculosis	( )Speech/Hearing

Please list all other conditions that apply to your child: ____

Has your child ever been hospitalized? (Y/N) Please explain: ____

Please list all medications that your child takes regularly: ____

Please list all allergies and/or drug sensitivities that apply to your child: ________________________________

What is the reason for your child's dental visit today? ____

When was your child's last visit to the dentist (if to a different office)? __________________________________

Prior Dentist's name and phone number: ____

How do you think your child will react to this dental visit? (Circle one) Cooperative/ Uncooperative/ Not sure

How frequently does your child get his/her teeth brushed? (Circle one) 3 x day/ 2 x day/ 1 x day/ Seldom

How frequently does your child get his/her teeth flossed? (Circle one) 1 x day/1 x week/ 1 x month/ Never

Has your child ever injured his/her face/mouth/ teeth? Y/N (Circle one) Please explain: __________________________

Please list some of your child's interests/hobbies ____

Please state any other questions, comments or concerns ____

AUTHORIZATION

I authorize the diagnosis of my child's dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate. I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my child's health. I understand that any change in my child's health or medications requires that an updated medical/dental history form be completed.

____

Parent or Legal Guardian Date

Bittner & Flann Dentistry for Kids Cancelation Policy

To make sure that every patient gets individual attention, we set aside dedicated time for each appointment. Our staff takes the time to prepare for each appointment by sterilizing, organizing, and setting up the room specifically to meet your child's needs prior to your arrival. This ensures that your child receives the highest quality of care that we pride ourselves for.

Running Late:

Coming more than 10 min late for an appointment will require rescheduling. We will do everything we can to accommodate you; however we schedule each appointment according to the time needed to provide quality care for your child. If you are late to your appointment it doesn't allow us to provide the quality of service that we strive for. Please call if you are going to be late. Our office makes every attempt to be on time, but we do run on "kid time". Some children require additional time, and understand that we will do the same for your child as needed.

Cancellations:

Because appointed times are reserved exclusively for each patient we ask that you please notify our office 48 hours in advance if you are unable to keep your appointment. Another patient who needs our care can be scheduled if we have sufficient time to notify them. We realize that unexpected things can happen, but we ask for your cooperation.

No Shows:

If no notice is given and your child no shows to a scheduled appointment, we may ask that your child be seen by another dental office for future appointments.

By signing this policy, I have read and understand the cancellation policy.

Parent/ Guardian Signature

PATIENT INFORMATION FORM

PRIMARY DENTAL INSURANCE INFORMATION
(or you may provide us with a copy of your insurance card)

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___________

PATIENT INFORMATION FORM

GENERAL CONSENT

I request and authorize Bittner & Flann 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 give consent for Bittner & Flann Dentistry for Kids to do recommended treatment as needed.

I state that I am the child's legal guardian and that I have authorization to consent to dental treatment. I 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 & Flann Dentistry for Kids, to release any information necessary to any providers pertaining to my child's dental care and for processing of dental insurance claims and authorize direct payment from the insurance company to Bittner & Flann Dentistry for Kids.

Name of Parent/Guardian____

Signature____ Date____________

BITTNER & FLANN DENTISTRY FOR KIDS CANCELLATION POLICY

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By signing this policy, I have read and understand the cancellation policy.

____

Parent/ Guardian Signature   Date

PATIENT INFORMATION FORM

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

FEDERAL LAW REQUIRES THAT WE PROVIDE YOU WITH A COPY OF OUR PRIVACY NOTICE. THE PRIVACY NOTICE EXPLAINS HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU. WE ASK THAT YOU SIGN THIS FORM FOR OUR RECORDS SO THAT WE MAY DOCUMENT YOUR RECEIPT OF THE NOTICE. IF YOU HAVE QUESTIONS ABOUT THE PRIVACY NOTICE, PLEASE FEEL FREE TO DIRECT THESE TO OUR PRIVACY OFFICER AT ANY TIME. THE NAME AND CONTACT NUMBER OF THE PRIVACY OFFICER IS LISTED ON YOUR COPY OF THE PRIVACY NOTICE.

PATIENT NAME: ____ DOB: ____________________

PATIENT NAME: ____ DOB: ____________________

PATIENT NAME: ____ DOB: ____________________

PATIENT NAME: ____ DOB: ____________________

PATIENT NAME: ____ DOB: ____________________

I HAVE REVIEWED A COPY OF BITTNER & FLANN DENTISTRY FOR KIDS NOTICE OF PRIVACY PRACTICES.

____ _________________________
(PARENT GUARDIAN SIGNATURE) **(DATE)**

OFFICE USE ONLY

(If patient is unable to acknowledge receipt, staff member providing notice to complete this section)

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

___ OTHER____

STAFF MEMBER: ______________________________ TITLE: ____________________

SIGNATURE: ___________________________________ DATE: __________________