Orem Pediatric Dentistry

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442 W 800 N Orem, UT 84057

New Patient Information

Date:

Patient Information

Name: (Child) Last First **Nickname:** **M / F**

Address: Street City State Zip

Birthdate: **Home Phone:**

Where did you hear about us?

(If you were sent by a current patient, please list their name so we can thank them)

Family Information

Name: (Responsible Party) Last First **Relationship:**

Address: Street City State Zip

Birthdate: **Best Email:** (Appointment Reminders & Patient Perks!)

Home Phone: **Cell:** **Work:**

Employer: **Dental Insurance:** (Include ID Number)

SSN #: **Medical Insurance:** (Include ID Number)

Secondary Dental: **Secondary Medical:**

Name: (Addt'l Guardian) Last First **Relationship:**

Address: Street City State Zip

Birthdate: **Best Email:** (Appointment Reminders & Patient Perks!)

Home Phone: **Cell:** **Work:**

Employer: **Dental Insurance:** (Include ID Number)

SSN #: **Medical Insurance:** (Include ID Number)

Secondary Dental: **Secondary Medical:**

Emergency Contact Information

Name: _____ **Relationship:** _____
Last First

Address: _____
Street City State Zip

Phone: _____

Agreement for Extension of Credit

In accordance with the Federal Truth-In-Lending Act, please be advised of the following office policies in connection with the extension of credit. By signing this agreement, the responsible party agrees to:

1) Pay in full each time serviced are rendered. We accept cash, check, or Visa, Discover, and Mastercard.
2) Pay a late fee on any unpaid balance when payment is not received by due date listed on mailed statements.
3) Authorize a credit report to be obtained if necessary.
4) Your insurance is ultimately a contact between you, your employer, and the insurance company. We will assist you in filing your claim but the final responsibility for payment rests with you.

I agree to pay the remaining balance plus all collection/ court costs and fees (a minimum of 50%) if a delinquent balance is placed with a collection agency or attorney.

Name (printed): _____
Circle One: Father / Mother / Guardian

Signature: _____

Medical Information

(Please Answer Every Question)

1. Does your child have a history of health problems from birth or early years? ☐ Y ☐ N

2. Is your child taking any medications at this time? ☐ Y ☐ N

If so, which medications? _____

3. Has your child ever had a reaction to penicillin or other drugs? ☐ Y ☐ N

If so, which drug(s)? _____

4. Does your child have any allergies? _____ ☐ Y ☐ N

5. Is your child presently under treatement for any medical condition? ☐ Y ☐ N

If so, which condition(s)? _____

6. Has your child ever had a history of the following? (circle)

allergies
mental retardation
liver disease
heart problems
heart murmur
sinusitis
epilepsy
brain damage

rheumatic fever
hay fever
mental/ emotional problems
breathing problems
endocrine problems
tonsil/ adenoid problems
kidney/ bladder problems
diabetes

cancer/ leukemia
tuberculosis
blood disorder
earaches
headaches
cerebral palsy
arthritis
abnormal bruising

asthma
stroke
hepatitis
anemia
HIV/ AIDS
pregnancy
venereal disease
other: _____

7. Has your child ever had an unfavorable experience in a dental or medical office? ☐ Y ☐ N

8. Has your child had a toothache recently? ☐ Y ☐ N

9. Date an place of last dental exam: _____

10. Is your child required to take antibiotic premedication? ☐ Y ☐ N

11. Does your child have a history of thumb sucking, lip or nail biting? ☐ Y ☐ N

12. Has your child had any teeth extracted? ☐ Y ☐ N

13. Has your child ever been on a respirator? ☐ Y ☐ N

14. How is the general health of parents and siblings? _____

_____

_____ I hereby certify that the answers to the foregoing questions are accurate to the best of my ability. Since a change in my medical condition or in medications I can take affect dental treatment, I understand the importance of this information and agree to take responsibility to notify the dentist of any changes at subsequent appointments.

Consent for Dental Treatment

I understand the above information is correct and necessary to provide my child with dental care in a safe and efficient manner. I request and consent to all procedures my child's dental condition may require, including administration of any sedative, analgesic, therapeutic and/ or other pharmaceutical agents including those related to restorative, palliative, therapeutic, or surgical treatments. I understand that procedures in dental surgery, diagnosis, and treatment are not an exact science and no guarantees as tot he outcome of his/ her treatments will be offered. I understand that as a part of dental treatment, teeth may remain sensitive or even painful during and after completion of treatment. Jaw muscles, gums, and surrounding tissue may also be sensitive, sore, and tender. Although rare, it is possible for the tongue, cheek, and oral tissues to be inadvertently abraded or lacerated during routine dental procedures. In some case, sutures or additional treatment may be required. I also understand that as part of dental treatment, in rare cases, small instruments or components may be aspirated or swallowed. This unusual situation may require x-rays and other procedures to ensure safe removal. Adverse reaction to materials, medicines, anesthetics, and procedures are possible in dentistry, possibly resulting in, but not limited to, pupal irritation, root canal treatment,. loss of teeth, necrosis, infection, pain, anaphylactic shock, and intestinal or systemic upset. I voluntarily assume the possible risks. I accept Dr. Howell as my child's dentist and understand he will exercise all of his professional care and knowledge to the best of his ability.

Parent/ Guardian Signature: _____ **Date:** _____

Privacy Practices Agreement

Orem Pediatric Dentistry

As part of the HIPPA practices of this office, no information about patients or patient's family members will be discussed outside of the dental setting. The dental setting includes and is limited to the dental office and the surgical location for patients who go to surgery. Information can be discussed on the phone with the dentist, with another practitioner, with the insurance company for the patient and with the parent of the patient. Information will be disclosed as required by law. Information will only be discussed on a need-to-know basis. Staff members not directly concerned with a case will not be involved in discussion about a patient or a patient's family member. Every effort shall be made to keep discussions and phone conversations private.

Our examination rooms are an open bay area with the possibility of multiple patients being present at one time. If there are health issues of a sensitive nature that you do not wish to discuss in front of others, we are happy to provide a private area for discussion upon your request.

Cases may be used by the dentist for instructional purposes when all identifying information is omitted. Our patients' privacy is of our utmost concern.

I have read and understand the privacy practices of Orem Pediatric Dentistry, and I acknowledge that I have had the opportunity to seek further clarification from the staff before signing. I agree that the doctor or his staff can discuss my child's health history and treatment options at the exam chair unless I request a private area. I agree to the privacy policy and agree to take responsibility for my own due diligence when it comes to privacy.

Patient Name(s) _____ **DOB:** _____

_____ _____

_____ _____

_____ _____

Parent/ Guardian Signature: _____

Date: _____

Financial Policy

Orem Pediatric Dentistry

By executing this agreement, you are agreeing to pay in full for all services received.

Payments: Payment is to be made at the time of service, including insurance co-pays and out-of-pocket portions, and payment in full for charges incurred due to non-insurance.

CareCredit *CareCredit is a line of credit with interest-free options. Approval is easy & can be applied for and approved from your personal device right in our office!*

Contact information and permission to contact: It is your responsibility to make sure that we always have your current mailing address and phone numbers on file. You give us permission to contact you at home or at your workplace to discuss any matters related to your account. You also agree to let this office leave voice messages on voicemail or with a family member at the phone numbers we have on file concerning appointments, results, and/ or any financial information including dollar amounts and current collection information. We are not responsible for any late payments, late fees, or collection actions as a result of your failure to keep current contact information on file with us.

Insurance: We will submit your insurance claims as a courtesy to you. We rely on your up-to-date insurance information, as well as the eligibility and benefit fee schedule provided by your insurance. It is impossible for us to foresee every variable with your individual insurance plan. That is why you will only be given an **estimate** of your out-of-pocket cost, which **is not a guarantee** that your insurance will pay a specific amount. By receiving any patient care, **you are responsible to pay all charges incurred**, regardless of the estimates provided to you by us, and regardless of the final amount your insurance pays.

We usually receive insurance payments within 30 days of submitting a claim. However, in the event that **we have not received payment from your insurance within 60 days**, your **full outstanding balance is due at this time. The responsibility is then yours to collect any remaining payment from the insurance**. In this event, we are happy to provide you with the information you'll need to further resolve coverage with them. If we receive any more payment from the insurance after you have paid in full, we will issue you a refund for that amount.

Appointment Scheduling: A $50 deposit is required to schedule a **treatment**, and will be refunded or credited toward the payment due at the time of your appointment. If less than 24-hour notice of cancellation is given, and we are unable to fill your appointment time slot, we may keep the deposit.

Missed appointment fee: Patients who do not show up for an appointment, or who cancel with less than 24-hour notice, will be charged a $35 fee. This fee must be paid before a new appointment can be scheduled.

Account Statements: If you have a balance on your account, we will send a statement to the address we have on file. It will show the current balance, any new charges to the account, the **estimated** insurance amount pending payment (Dental Insurance Estimate), and any new charges to the account during the month. The Patient Balance on your statement is the amount due, and a late fee of $15 will be applied if not paid by the du date listed on the statement. (That amount does **not** include the Dental Insurance Estimate amount).

At 60 days, you will receive a phone call and a second billing notification, which will show any late fees incurred for the outstanding Patient Balance. If there is any amount remaining in the Dental Insurance Estimate box, both the outstanding Patient Balance and the outstanding Dental Insurance Estimate are your responsibility, and are due in full by the due date on the statement. **At this point, you must call our office to pay in full, as we will no longer attempt to collect the insurance payment**.

At 90 days, you will receive a phone call and your last collection notice. If we do not receive payment in full within 7 days of the collection notice date, the account will automatically be turned over to Bonneville Collections. You agree to pay an additional collection cost of 50% of your balance, and all fees associated with the actions necessary to collect the debt.

It is your responsibility to be familiar with your account. If you expected a bill but didn't receive one, or have any other questions, a phone call to our office is **vital** to keep your account in good standing. That is, by far, the best way to avoid incurring late fees.

Financial Policy

Orem Pediatric Dentistry

_____ **Cancellation of privileges:** We shall have the right to cancel your privilege to make charges against your account at any time.

_____ **Waiver of confidentiality:** You understand that if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

_____ **Returned checks and declined card fees:** If a check or credit card information is given to us for any reason (which may include but is not limited to a deposit, automatic withdrawal, or payment), there is an automatic $25 charge if the check is returned or card is declined. You will receive a call and will have 48 hours to return the call and pay off the full balance on the account, regardless of the payment agreement. Failure to do so will result in the account being automatically turned over to Bonneville Collections at that time.

_____ **Credit history:** You give us permission to check your credit and employment history and to answer any questions we may pose about your credit experience. We have the option to report your account status to any credit reporting agency, such as a credit bureau.

_____ **Divorce and assignment of responsibility:** In the case of marital estrangement, separation, or divorce, the parent authorizing treatment (bringing the child in and signing the Treatment Plan Agreement) will be the parent responsible for subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent; they will not be billed separately by Orem Pediatric Dentistry.

_____ **Patient inclusion:** The terms and conditions of this contract are binding and apply to any dependent in your family file on the date signed, and any children who may become part of your family in the future, regardless of whether their name appears below.

I, (print name)_____ agree to all the terms and conditions contained herein, and consider them binding and applicable to my current and future account balance as well as any and all persons in my family file and/ or associated with my account, including any children who may hereafter become part of my family, regardless of any missing or inaccurate information on the Patient Information page, and/ or the Privacy Practice Agreement page, and/ or on this Financial Policy page. Likewise, the terms and conditions remain binding if any information contained on any of these aforementioned documents changes in the future.

Patient Name(s) _____ **DOB:** _____

_____ _____

_____ _____

_____ _____

Parent/ Guardian Signature: _____ **Date:** _____