Dr. Doug's Pediatric Dentistry Registration

Please list your child(ren)'s First Name, Last Name, & D.O.B.

_____ _____

_____ _____

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_____ _____

PARENT/GUARDIAN INFORMATION

*We can only bill ONE Responsible Party for a patient/family. The Responsible Party is the parent/guardian that will receive appointment reminders, bills, updates, & any other communication(s) from our office. **He/She agrees to pay all fees related to the patient's care.**
(The Responsible Party does not have to be the insurance policy holder.)
Please use the box next to either Mother or Father to indicate who is signing as the Responsible Party for this Account.*

☐ Mother		☐ Father	
Name		Name	
DOB		DOB	
Phone		Phone	
SSN		SSN	
Address		Address	
City, State, Zip		City, State, Zip	
Marital Status	☐ Single ☐ Married ☐ Divorced ☐ Other:		
If divorced, custody status:			
Is anyone NOT allowed access to patient(s) dental records?	☐ Yes ☐ No		
Name:		Relationship to Patient:	

Insurance information must be filled out at time of service, or you will be asked to pay for your visit in full. We do not accept medical insurance.

DENTAL INSURANCE

Policy Holder: _____ DOB: _____
SSN (required by most insurances): _____
Relationship to Patient: _____ Phone: _____
Employer that insurance is provided by:_____
Dental Insurance Company:_____
Insurance Address: _____ Insurance Phone: _____
City/State/ZIP: _____
ID #: _____ Group #: _____

*If you have a secondary insurance, please request a *Secondary Insurance Sheet* from the front desk.*

MEDICAID INSURANCE

Patient Name(s) as listed on the Medicaid Card: ID #

_____ _____

_____ _____

_____ _____

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_____ _____

(Continue to Sign)

Dr. Doug's Pediatric Dentistry Policies

Insurance

Your coverage is based on a contract between you & your insurance company. It is your responsibility to know what your insurance covers. We do NOT work for your insurance and are not privy to the "fine print" of your policy. We are here to provide the best dental care to your child, regardless of insurance policies.

- You are responsible for providing current insurance information, including a card, at the time of your appointment. If you are unable to provide the necessary information, you will be charged a late claim-filing fee of $15.
- All quotes given by our office for Restorative treatment are **estimates**. We recommend you contact your insurance directly for exact coverage details, including deductibles, copays, limitations, exclusions, frequencies, etc. before every appointment. **Fees estimated to not be covered by insurance will be due in full at the time of service.**
- As a courtesy we will file claims on your behalf. However, **if we do not receive payment from your insurance company within 60 days of submission, the claim(s) will be closed, and you will be billed the full amount.**

Responsible Party

We can only bill ONE Responsible Party' for a patient/family. The Responsible Party is the parent/guardian that will receive appointment reminders, bills, updates, & any other communication(s) from our office. He/She agrees to pay all fees related to the patient's care. The Responsible Party does not have to be the insurance policy holder.

We understand that in some cases billing responsibilities are shared. In an effort to be helpful, we can provide copies of receipt(s) for payments made in full. Because payment is due *at the time of service*, payments from multiple parties can be taken over the phone before or on the day of service as well.

Adult Supervision

All children under the age of 16 must have an adult with them unless arrangements have been made with our office before the appointment.

Missed, Canceled, or Changed appointments

To make visits pleasant for your child(ren) Dr. Doug works extremely fast & keeps appointments as short as possible. Patients arriving 10 minutes late will be considered missed and rescheduled for a later date. We require a 24-hour notice of cancellation/reschedule requests; otherwise a $15 missed appointment fee will be charged, which will need to be paid before rescheduling.

'Standard of Care' for Routine 6 Month Cleanings

Our office strives to give every patient the same Standard of Care recommended by the American Dental Association, which includes: Prophylaxis (cleaning), Exam, and Topical Fluoride. Recommended Annual X-rays: Bitewings (1-4), & Intraoral Periapicals (1-2). A Panoramic image is recommended every 3 years starting at 6-7 years old.

Your insurance may not cover these services at the same frequency as the ADA recommends. If you ever want to opt out of preventive services at your regular cleaning appointments, you will need to notify the front desk before being seen.

Any services not covered are your responsibility.

Payments

In consideration for the professional services to be rendered to me, or at my request, to my minor child or ward by the dentist, I agree to pay the fees charges for the dental services provided to the dentist or his/her assignee at the time the services are rendered, or within (5) days of billing if credit should be extended. I agree to pay the remaining balance along with a collection agency commission. Should your account be turned over for collection, the undersigned agrees to pay all costs to collect the debt, including, but not limited to, interest in the amount of 18% per annum, attorney's fees, court costs, and collection fees in the amount of 40%. The obligation to pay the collection fees shall be imposed at the time of assignment of the debt to a third-party debt collection agency. *The undersigned certifies that he/she has read and understands the foregoing disclosure.*

Your Rights Regarding Your Health Information

A copy of your privacy rights is available at the counter. If you would like a copy to take with you, please ask and we would be happy to get you a copy. I acknowledge that I have been offered or received a copy of Dr. Doug's Notice of Privacy Practices.

I give consent for this patient to receive treatment in an oral exam today and any possible treatment that might be proposed in the future by the office of Dr. Doug's Pediatric Dentistry. I give consent for the use and disclosure of any protected health information that may be used to carry out treatment, payment activities, and healthcare operations. I have read and understand all the above information.

Parent/Guardian Signature:_____ Date: _____