Pediatric Dental Care, Inc.
1160 Joliet Street, Suite 102/Dyer, IN 46311
219.322.7610

REGISTRATION

PATIENT INFORMATION

Date: _____/_____/______ email ______________________________________

Patient Name (Last, First) ____

Sex: M F Age _________Birthdate ____/_____/_______Home Phone Number ( ) _______________________

Please give best phone number to reach you ( ) _________________________________

Address: ____

Whom may we thank for referring you? ____

Who is accompanying the child today? ____

Relation to the child: ___________________________________Do you have legal custody of the child? □ Yes □No

*In case of emergency, whom should we contact? ______________________Phone (________) _______________________

GUARDIAN INFORMATION

(Both Parent/Guardian Information required)

Your Name (Last, First)_____________________________	Your Name (Last, First)_____________________________
Date of Birth: ____/_____/______	Date of Birth: ____/_____/______
Single Married Widowed Separated Divorced	Single Married Widowed Separated Divorced
SS#________-__________-__________________________	SS#________-__________-__________________________
Address:____	Address:____
City:________________ State:______ Zip code:__________	City:________________ State:______ Zip code:__________
Home Phone Number: (____) ________________________	Home Phone Number: (____) ________________________
Work Phone (____) ________________________________	Work Phone (____) ________________________________
Cell Number (____) _______________________________	Cell Number (____) _______________________________
Occupation:______________________________________	Occupation:______________________________________
Employer: ____	Employer: ____

INSURANCE INFORMATION

Primary	Secondary
Adult who has insurance for the child______________________	Adult who has insurance for the child______________________
Employer ____	Employer ____
Plan Name ____	Plan Name ____
Phone Number _________________________	Phone Number _________________________
Address ____	Address ____
____	____
ID # ____	ID # ____
Group # ____	Group # ____

*Is your child eligible for Medicaid? yes no

DENTAL/MEDICAL HISTORY

1. Is this your child's first dental visit? □ Yes □No ______________________________ *Previous Dentist's Name*

2. Has your child ever had problems receiving dental care? □ Yes □No ______________________________ *Explain the problem*

3. Is there a particular problem with your child's teeth that prompted you to bring him/her to our office? □ Yes □No ______________________________ *Explain the problem*

4. Does your child brush his/her teeth at home? □ Yes □No ________________ ______________ *Who brushes? How often?*

5. Is the patient receiving fluoride in any form? □ Yes □No ______________________________ *Type of treatment*

Physician's Name ________________________________ Phone (   ) ______________________________________

Address ____

Has your Child ever had any of the following diseases or medical problems? If so please check □

□ Congenital Heart Defect	□ Kidney problems	□ HIV/AIDS	□ Chicken pox
□ Heart Murmur	□ Joint replacement	□ Tuberculosis	□ Anemia
□ Rheumatic Fever	□ Excessive bleeding (Hemophilia)	□ Lung problems	□ Measles
□ Cancer	□ Epilepsy/seizures	□ Asthma	□ Behavioral Issues
□ Diabetes	□ Psychological disorders	□ Sinus problems	□ Cleft lip/ palate
□ Liver problems	□ Nervous system disorders	□ ADHD	□ Mental Retardation
□ Hepatitis	□ Hives/Rashes	□ Spina Bifida	□ Hearing problems
□ Autism	□ Cerebral Palsy	□ Mental Retardation	□ Other________________

Is your child taking any medications? □ Yes □ No if yes, please list? ____
____

***Does your child need antibiotic treatment prior to the dental appointment?** □ Yes □ No
***Is your child allergic to any medications, anesthetic or latex?** □ Yes □ No if yes, please list?
____

Is your child in good health? □ Yes □ No
Is there any condition or problem related to your child's medical history that has not been mentioned?
____

AUTHORIZATIONS with RELEASE AND ASSIGNMENT

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services for my minor/child, including but not limited to x-rays, photos, and the administration of anesthetics which are deemed necessary by the doctor, whether or not I am present at the actual appointment when the treatment is rendered. **I understand that only one parent/guardian is allowed during my child's dental visit.** I also understand that the use of anesthetic agents embodies a certain risk. I also authorize the use of nitrous oxide with my child in cases where the doctor feels would be appropriate or beneficial.

I understand that any balance that is not covered by insurance is due in full at the time of service. This includes co-payments, deductibles, previously owed balances and estimates on treatment. I understand that Pediatric Dental Care, Inc. files my insurance as a courtesy, and any questions I have regarding my insurance and the reimbursement schedule, I should contact the insurance directly. I also understand it is my responsibility to keep current and accurate phone numbers and insurance information up to date by supplying Pediatric Dental Care with any changes in coverage. I understand that I am liable for any charges denied by my insurance plan.

I understand if my insurance does not remit payment to this office within 5(five) business weeks post date of service, a statement for the balance will be sent to me and will be my responsibility. Any insurance payment received in overage from the payment would then be refunded.

I , ____ understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable, at the time services are rendered, and I am liable for all charges whether or not paid by insurance. **Insurance estimates are based on our fees and not what your insurance deems usual and customary** I further understand that a 1.5% finance charge (18% annually) will be added to balances over 60 days. In the event of default, I (we) promise to pay interest on the indebtedness, together with reasonable attorney fees and an additional 50% of balance added for the collection costs as will be required to effect collection of this account. $35 will be charged for collection letters, returned checks, appointment no shows, and/or cancellations under 24 hours per 30 minute of scheduled appointment time. I authorize the doctor to release all information necessary to secure a payment of benefits. I authorize the use of this signature on all my insurance submissions.

____/________/______
Signature of (please circle) parent / guardian   Date

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ACKNOWLEDGEMENT FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES

(You May Refuse to Sign This Acknowledgement)

I, ____, have received or reviewed a copy of the Notice of Privacy Practices.

____

Please Print Patient Name

____

Parent/Guardian Signature

____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (please specify)

____

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OUR OFFICE AND YOUR INSURANCE PLAN: HOW THEY WORK TOGETHER

The staff at Pediatric Dental Care is pleased that you have insurance benefits to help with the cost of your children's dental care. We would like to help you obtain the maximum use of these benefits. With this in mind, please read the information on our insurance claims process, so that we can work together to ensure this benefit.

DO YOU ACCEPT MY INSURANCE? / HOW MUCH WILL THEY PAY?

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 services.) This means that we work with literally thousands of companies. Although we can maintain computerized histories or payment by a given company, they do change. Therefore, it is impossible to give you a guaranteed 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 exact insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. This does delay treatment, but will give you the exact out of pocket figures you may require.

I THOUGHT I PAID MY PORTION BUT I GOT A BILL, WHY?

We base the patient portion of your bill on our most current data, but there are many factors that can affect this estimate. There may be a deductible (individual or family) or you may have received treatment in another office prior to joining Pediatric Dental Care which in not calculated into our database. Sometimes you or your child may need to see a specialist for care, which also uses your annual benefit. Insurance companies do not (and cannot) notify us of changes to your benefits, they only notify you. If these situations apply to you, please let us know when we estimate your treatment plan so we may adjust accordingly.

INSURANCE DIDN'T PAY, NOW WHAT?

We bill your insurance company as a courtesy. If insurance does not pay within 5 weeks post date of service, we reserve the right to request payment in full for services from you and let you collect the insurance funds that are due to 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.

FINANCIAL OPTIONS:

Pediatric Dental Care does request payment in full for your portion at time of service. We accept cash, check, debit, or credit card. If you are in need of an extended finance option, we also work with Care Credit. Just ask one of the patient services staff for an application, or we can qualify you online.

We welcome you to our family and look forward to helping your kids get the healthy, beautiful smile they deserve!

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I have read, understand, and accept the terms of the above outline policies for insurance handling and financial commitment that I may incur as a result of treatment at Pediatric Dental Care, Inc.

____________________________________ __________________

Signature of (Please circle): Parent / Guardian Date

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OFFICE FINANCIAL POLICY AND CONDITIONS

**Please read and initial the section that applies to you, then sign below.*

PATIENTS WITHOUT DENTAL INSURANCE

__________Payment in full is expected at the time of treatment. If this is not financially possible for larger amounts, financial arrangements must be made before any treatment is begun. If you feel you need financing, please let us know before treatment begins. We work with Care Credit to make your child's necessary treatment affordable.

PATIENTS WITH DENTAL INSURANCE

__________Pediatric Dental Care, Inc is NOT A NETWORK PROVIDER UNLESS YOU ARE A DELTA DENTAL SUBSCRIBER.

It is important that patients realize that only on **rare** occasions, usually for preventative work, will the insurance company pay 100% of your services. If there is an unmet deductible, which is usually $50; this must be paid at the time of service. In almost all cases for work that is not preventative, you will owe a percentage of the dental service performed. This percentage may vary from 20%-60% or more. We will try our best to estimate your portion of any treatment performed so that you will know your out-of-pocket expenses prior to treatment. Please remember this is an **estimate only**, as there is a wide variance in the amounts different insurance companies pay for different services.

*It is our policy that patients pay any balance that is not covered by insurance in full at the time of service and prior to new treatment. If your insurance company does not remit payment to our office within five (5) weeks post date of service, a statement for the balance will be sent to you and will be your responsibility. Any insurance payment received in overage from your payment would then be refunded.

ALL PATIENTS

__________Our individual scheduling is one of the things that make this practice so unique and special for our patients. Our time is dedicated solely to your child, and you will rarely have to wait. Because of this, however, it is very important that you do not miss your appointments and that you are on time. We request that you call at least 24 hours in advance should you need to reschedule. In keeping with the above, a **$35 broken appointment fee will be charged for each scheduled 30 minute missed appointment**. If you are more than 10 minutes late, we cannot guarantee that you can be seen or, if you are seen, that all of the services can be preformed. $35 charge will be added for preparation letters and returned checks. A $35 late fee will be added for any delinquent accounts that will be settled though legal matters.

Do not hesitate to contact our office if there are any questions about our financial policy.

I hereby acknowledge and agree that I am financially responsible for all services rendered by Dr. Lynn Karr. I understand that I am liable for all charges whether or not paid by insurance. The parent/guardian (signed below) agrees to be fully responsible for the total payment of procedures performed in this office.

____ ____________________

Signature of (Please circle): Parent / Guardian Date