Form 10

Patient Number

Rev. 2

Patient's Name _____
Last First Initial Date of Birth

Dental History

Whom may we thank for referring you? _____

Date of last dental visit _____ For what services? _____

	Yes	No		Yes	No
Has child complained about dental problems?	☐	☐	Is fluoride taken in any form?	☐	☐
Does child brush teeth daily?	☐	☐	Any injuries to mouth, teeth, or head?	☐	☐
Does child floss teeth daily?	☐	☐	Any unhappy dental experiences?	☐	☐
TMJ/Joint problems?	☐	☐			

Any mouth habits- thumb sucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc.? _____

Any specific concerns? _____

Medical History

Child's Physician _____ City/State _____ Phone _____

Date of last physical _____ Results _____

	Yes	No	
Is child under care of physician?	☐	☐	Explain _____
Receiving any medication or drugs?	☐	☐	Please list _____
Does child have any allergies?	☐	☐	Please list _____
Ever been hospitalized?	☐	☐	Explain _____
Ever had surgery?	☐	☐	Explain _____
Is there excessive bleeding when cut?	☐	☐	Explain _____

Has child had any history of or difficulty with any of the following?

☐ AIDS/HIV	☐ Cerebral Palsy	☐ Epilepsy	☐ Hepatitis	☐ Mumps
☐ Anemia	☐ Chicken Pox	☐ Fainting	☐ Kidney Disease	☐ Rheumatic Fever
☐ Asthma/Respiratory	☐ Convulsions	☐ Frequent Headaches	☐ Learning Problems	☐ Seizures
☐ Behavioral problems	☐ Diabetes	☐ Hearing Problems	☐ Liver disease	☐ Sinus Problems
☐ Bladder problems	☐ Dizziness	☐ Heart Problems	☐ Measles	☐ Thyroid Disease
☐ Cancer	☐ Drug/Alcohol abuse	☐ Heart Murmur	☐ Mononucleosis	☐ Other

If any of the above were checked, please explain. _____

I ATTEST THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE:

Parent/Guardian Signature _____ Date _____

CHILD HEALTH HISTORY

Patient Information

Patient Name _____ Date _____
Last First Middle

Home Address _____
Street City State Zip

Home Phone _____ Date of Birth _____ Age _____ Male ❑ Female ❑

Email Address _____

Parent/Legal Guardians Information

1st Parent Name: _____ Marital Status: _____
Social Security #: _____ Date of Birth: _____ Relationship to Patient: _____
Mailing Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Employer: _____

2nd Parent Name: _____ Marital Status: _____
Social Security #: _____ Date of Birth: _____ Relationship to Patient: _____
Mailing Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Employer: _____

Insurance Information

Insured's Name _____ Insured's ID Number _____
Social Security # _____ Date of Birth _____ Relationship to Patient _____
Employer _____ Occupation _____ No. Years Employed _____
Insurance Company _____ Group No. _____ Phone No. _____
Insurance Company Address _____
Street City State Zip

Secondary Insurance:
Insured's Name _____ Insured's ID Number _____
Social Security # _____ Date of Birth _____ Relationship to Patient _____
Employer _____ Occupation _____ No. Years Employed _____
Insurance Company _____ Group No. _____ Phone No. _____
Insurance Company Address _____
Street City State Zip

Emergency Information

Nearest relative not living with you: _____
Address _____
Street City State Zip
Phone _____ Relationship _____

Consent

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to Sugar Bugs Pediatric Dentistry use and disclosure of my records or my child's records to carry out treatment, to obtain payment, and for anything related to treatment or payment. My consent to disclosure of records shall be effective until I revoke it in writing.

I understand that where appropriate, credit bureau reports may be obtained.

I authorize payment directly to Sugar Bugs Pediatric Dentistry of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor.

I attest to the accuracy of the information on this page.

Parent/Guardian Signature_____**Date**_____
My relationship to child(ren) is:_____**, and I have the authority to make financial agreements and consent to treat.**

Form 12

Patient Number

Rev. 1

Patient's Name _____
Last **First** **Initial** **Date of Birth**

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day to day healthcare operations of your practice

I understand that you reserve the right to change the terms of this notice from time to time. I also understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

I am aware of and understand the HIPAA Privacy Act.

Patients Name: _____
Relationship to Patient: _____ Date: _____
Signature: _____

I also give consent to the following to discuss and make decisions about my child's dental care with the Sugar Bugs staff

Name: _____ *Relation:* _____

Name: _____ *Relation:* _____

Name: _____ *Relation:* _____

Name: _____ *Relation:* _____

Form 09B

Patient Number

Rev. 4

Patient's Name _____
Last First Initial Date of Birth

SUGAR BUGS FINANCIAL ARRANGEMENT GUIDELINES

At Sugar Bugs Pediatric Dentistry, we use an accounting method known as Zero Balance Accounting. This reduces the number of personnel hours, paper, postage costs, and phone calls related to billing services. Payments for services rendered are expected at the time services are rendered, unless prior arrangements have been made.

Payment Options:
Cash, Check, Debit Card, or Credit Card
Financing Available:
Care Credit
Auto bank withdraw

Insurance:

- ☐ As a courtesy, we presently bill your insurance for you. It is your responsibility to make certain that the information that we have regarding your child(s)'dental insurance is correct including the name of your insurance company, policy number, personal ID number, phone number, address and your child/children's name(s) and ID number if appropriate.
- ☐ **Deductible** and **Patient Portion** are due at the time of service. If these amounts are not known, we expect you to make a minimum payment of $25.00. Any patient portion not paid on date of service must have arrangements made before visit.
- ☐ If your Insurance or other institution fails to honor our request for payment, you are ultimately responsible for any unpaid balance.
- ☐ If you are considering seeking coverage through Medicaid now or at any time in the future, please be aware that in this office **we do not back bill Medicaid** for prior dental costs incurred by you; these are your responsibility.
- ☐ Please remember that we can provide you with an **estimate only,** it is never a guarantee of payment.

Billing Fee: I, the undersigned, agree to all terms in the promissory note. I further agree that in the event of default, I will pay interest at a rate of twenty one percent (21%) per annum or 1.75% /month, reasonable attorney fees, court costs, and fee of thirty five percent (35%) of the unpaid balance of this note in the event my account is turned to a third party collections agency.
Divorced and Custody Situations: The responsibility for payment of services rendered to dependent children whose parents are divorced or in custody disputes rests with the parent seeking treatment for the child/children. A court ordered judgment must be settled between the individuals and is not the responsibility of Sugar Bugs Pediatric Dentistry.
Missed Appointments: We expect the courtesy of a phone call 24 hours in advance if you are not able to keep an appointment that has been scheduled for your child(ren). If we have not received a courtesy phone call 24 hours in advance of the scheduled appointment we shall consider this to mean that you are no longer in need of dental service for your child to be provided by us and we will no longer schedule any dental appointments for them .
Late Arrivals: Any patient arriving up to15 minutes late for an appointment may have treatment plans changed, or minimized to fit the time remaining on the schedule. If more than 15 minutes late we may need to reschedule your appointment.

I have read and agreed to abide by the Sugar Bugs Pediatric Dentistry Financial Policy

Parent/Guardian Name: _____ Date: _____

Parent/Guardian Signature: _____

Late and Missed Appointment Policy

At Sugar Bugs, we put our faith in you to keep your appointment. When we set up an appointment, a specific amount of time is reserved especially for you. If for any reason you must cancel or change your appointment, it is important that you give our office **at least 24 hours'** notice so we can offer that spot to someone else.

***1st missed appointment:** If an appointment is missed or cancelled within the 24 hour window, a letter will be sent to your home reminding you of our policy and the effects of your missed appointment. In order to reschedule the appointment(s) you will need to understand the importance of keeping that appointment.

***2nd missed appointment:** After the second missed appointment, we will send a letter to your home letting you know that you have been dismissed from the practice due to appointment noncompliance.

FOR ALL HYGIENE/PREVENTATIVE APPOINTMENTS AFTER 1st MISSED APPOINTMENT: The patient will be placed on a short notice list and will be notified when there is a cancellation or opening in the schedule. No hygiene appointments can be scheduled ahead of time until the account is back in good standing. The decision to place the patients account back in good standing lies at the discretion of the dentist or front desk staff.

We understand that true emergencies happen. If this is the case, please provide us with your doctor's note or other adequate proof and the missed appointment will be removed from your accounts record.

LATE ARRIVAL: When we reserve time for you, we require all of that time to provide you with the best quality work possible. When you are late it decreases our ability to accomplish this. If you arrive more than 10 minutes late, your appointment may be rescheduled in order to meet the needs of those who are on time for their pre-reserved visit. If this happens it will be considered a missed appointment.

We appreciate & respect you as part of our valued patient family & hope to have that same respect returned. I have read the policy above. I understand and agree to abide by the listed terms.

Signature of Financially Responsible Party: _____

Date: _____