

PATIENT INFORMATION FORM

DATE _____

CHILD'S NAME(S): _____ 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? _____

MOTHER/ GUARDIAN NAME _____ Marital status: _____
Last First Initial

Date of Birth _____ SS# _____

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Employer _____ Work phone _____

Our office sends appointment reminders and other important information pertaining to your account via email, please provide us with your email address:

Email _____

FATHER/ GUARDIAN NAME _____ Marital status: _____
Last First Initial

Date of Birth _____ SS# _____

Address same as above

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Employer _____ Work phone _____

Email _____

For Emergency contact please provide relative not living with you:

Name: _____ Relation to patient _____

Phone: _____

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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 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 Dr. Bittner to do recommended treatment as needed.

I state that I am the child's legal guardian and that I have 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 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 Dentistry for Kids.

Name of Parent/Guardian _____

Signature _____ Date _____

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

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

(PARENT GUARDIAN SIGNATURE)

(DATE)

OFFICE USE ONLY

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 _____

PATIENT INFORMATION FORM

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

Date