

# PIMA PEDIATRIC DENTISTRY - REGISTRATION

## BACKGROUND INFORMATION

TODAY'S DATE: \_\_\_\_\_  
Patient's name: \_\_\_\_\_ Nicknames: \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home phone: (child's) \_\_\_\_\_ Parent: \_\_\_\_\_  
Child's Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Male: \_\_\_\_\_ Female: \_\_\_\_\_  
School Attending: \_\_\_\_\_ Grade: \_\_\_\_\_  
Child's Hobbies: \_\_\_\_\_  
Siblings (with age): \_\_\_\_\_  
Are siblings patients of Pima Pediatric Dentistry? \_\_\_\_\_ Yes \_\_\_\_\_ No  
Whom may we thank for referring you to our practice? \_\_\_\_\_

## PARENT/GUARDIAN INFORMATION

**A. Parent/Guardian:** \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Marital Status: \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widow \_\_\_\_\_ Widower  
SSN: \_\_\_\_\_ How do you wish to be addressed? \_\_\_\_\_  
Your address(if different from child's): \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone: Residence \_\_\_\_\_ Business \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
How may we contact you? \_\_\_\_\_ Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Other  
Employer \_\_\_\_\_ How long \_\_\_\_\_  
Employer's address \_\_\_\_\_  
E-mail address: \_\_\_\_\_

**B. Spouse/Other Responsible Party** \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Marital Status: \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widow \_\_\_\_\_ Widower  
SSN: \_\_\_\_\_ How do you wish to be addressed? \_\_\_\_\_  
Your address(if different from child's): \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone: Residence \_\_\_\_\_ Business \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
How may we contact you? \_\_\_\_\_ Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Other  
Employer \_\_\_\_\_ How long \_\_\_\_\_  
Employer's address \_\_\_\_\_  
E-mail address: \_\_\_\_\_

## EMERGENCY INFORMATION

In case of an emergency, whom should we notify? \_\_\_\_\_  
Relationship \_\_\_\_\_ Telephone \_\_\_\_\_

## RESPONSIBLE PARTY INFORMATION

Who is responsible for this account? \_\_\_\_\_  
Social Security # \_\_\_\_\_ Drivers license No. \_\_\_\_\_

## DOES YOUR CHILD HAVE DENTAL INSURANCE?

### 1<sup>ST</sup> COVERAGE:

Name of Insurance Co.: \_\_\_\_\_ Telephone of Insurance Co.: \_\_\_\_\_  
Address of Insurance Co.: \_\_\_\_\_  
Subscriber name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ SS#: \_\_\_\_\_  
Employer: \_\_\_\_\_ Member or Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

**2<sup>ND</sup> COVERAGE**

Name of Insurance Co.: \_\_\_\_\_ Telephone of Insurance Co.: \_\_\_\_\_

Address of Insurance Co.: \_\_\_\_\_

Subscriber name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Employer: \_\_\_\_\_ Member or Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

**CONSENT AND RELEASE**

I authorize Pima Pediatric Dentistry (Marc A. Auerbach, D.D.S.) to perform those diagnostic procedures and treatment as may be necessary for proper dental care. I authorize release of any information concerning my child's health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I hereby authorize payment of insurance benefits directly to Pima Pediatric Dentistry, otherwise payable to me. I understand that my dental care insurance carrier or the payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payment in full of all accounts and, if my insurance carrier does not pay the claim within 45 days, the entire claim becomes my responsibility. I authorize the release of any medical or dental information necessary to process all claims and I authorize Pima Pediatric Dentistry to communicate with pharmacists and physicians as necessary by letter, phone or fax. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor. I attest to the accuracy of information contained within this Registration Form.

Parent/Guardian signature \_\_\_\_\_ Date \_\_\_\_\_

**CHILD'S HEALTH HISTORY**

**DENTAL HISTORY- PLEASE ANSWER ALL QUESTIONS FULLY**

What is the reason for your child's visit today? \_\_\_\_\_

Date of last dental visit: \_\_\_\_\_ Last dental cleaning: \_\_\_\_\_

What was done at the last dental visit? \_\_\_\_\_

Previous dentist's name: \_\_\_\_\_

Address \_\_\_\_\_ City/State \_\_\_\_\_ Telephone: \_\_\_\_\_

How many times daily does your child brush his/her teeth? \_\_\_\_\_

Does your child floss his/her teeth daily? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you help your child brush/floss his or her teeth? \_\_\_\_\_ Yes \_\_\_\_\_ No

Does your child eat between meals? \_\_\_\_\_ Yes \_\_\_\_\_ No

Does your child eat sweets such as candy, soda pop or chewing gum? \_\_\_\_\_ Yes \_\_\_\_\_ No

Does your child receive fluoride? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes - describe? \_\_\_\_\_

Have any cavities been noted in the past? \_\_\_\_\_ Yes \_\_\_\_\_ No

If so, were they treated? \_\_\_\_\_ Yes \_\_\_\_\_ No

Has your child sustained any injuries to the face, mouth or teeth? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please describe \_\_\_\_\_

Has your child had any problem with dental treatment in the past? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please describe \_\_\_\_\_

Has anyone on the family, including parents, had orthodontics? \_\_\_\_\_ Yes \_\_\_\_\_ No



## HERBAL MEDICATIONS AND OVER-THE COUNTER DRUGS

Many people use herbal medications and over-the-counter remedies daily. Several of these medications/remedies interact with medications used in dentistry. Please note - we cannot list every herb, vitamin supplement, dietary supplement or over-the-counter medications that exist as such a list would be enormous. For example, there are over 166 herbs presently recommended for various matters.

### **IS YOUR CHILD PRESENTLY USING OR WERE THEY PREVIOUSLY USING ANY OF THE FOLLOWING:**

- A. Dietary Supplements: Yes \_\_\_\_\_ No \_\_\_\_\_  
Name of Supplement(s): \_\_\_\_\_  
Reason for taking the Supplement(s): \_\_\_\_\_  
Who instructed you to give your child the Supplement(s): \_\_\_\_\_
- B. Herbal Medications: Yes \_\_\_\_\_ No \_\_\_\_\_  
Name of Herbal Medication(s): \_\_\_\_\_  
Reason for taking the Herbal Medication (s): \_\_\_\_\_  
Who instructed you to give your child the Herbal Medications(s): \_\_\_\_\_
- C. Vitamin Supplements: Yes \_\_\_\_\_ No \_\_\_\_\_  
Name of Vitamin Supplement(s): \_\_\_\_\_  
Reason for taking Vitamin Supplement(s): \_\_\_\_\_  
Who instructed you to give your child the Vitamin Supplement(s): \_\_\_\_\_  
\_\_\_\_\_
- D. Over-the-Counter Medications: Yes \_\_\_\_\_ No \_\_\_\_\_  
Name of Over-the-Counter Medication(s): \_\_\_\_\_  
Reason for taking Over-the-Counter Medication(s): \_\_\_\_\_  
Who instructed you to give your child the Over-the-Counter Medication (s): \_\_\_\_\_
- E. Is your child taking any other medications, supplements or other things: Yes \_\_\_\_\_ No \_\_\_\_\_  
Name: \_\_\_\_\_  
Why: \_\_\_\_\_

### VERIFICATION OF INFORMATION

I understand the above information found above (pages 1-4) is necessary to provide my child with dental care in a safe and efficient manner. I have answered all questions correctly and fully and to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, which may release such information to you. I will promptly notify you of any change in my child's health or use of medications.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**CONFIDENTIALITY STATEMENT:** This office follows all rules and regulations regarding confidentiality of patient dental/medical records. Employees of Pima Pediatric Dentistry have access only to patient information necessary to properly carry out the functions of their jobs. Only information necessary to process claims is released to insurance companies.

## **FINANCIAL POLICY**

Thank you for choosing Pima Pediatric Dentistry as your child's oral health care provider. We would like to assure you that we will do our utmost to provide your child with the highest quality pediatric dental care possible in a caring, compassionate child-friendly atmosphere. In order to eliminate any confusion, the following represents the financial policies followed by the Pima Pediatric Dentistry. Please read this Financial Policy carefully. We require that you sign this Financial Policy prior to any treatment being rendered. Please understand that this Financial Policy is enforced to keep costs at a reasonable level, thus preventing frequent fee increases. Should you have any questions, please ask. Having open lines of communication allows us to concentrate on what we do best . . . *provide quality dental care for your child.*

### **PATIENTS WITH VERIFIABLE INSURANCE COVERAGE**

Insurance coverage is a contract between you, the patient (or parent) and the insurance company. The terms of that contract determine the amount of coverage (benefit) you have for any procedure or visit. As a courtesy to you, we will be glad to assist you in obtaining the appropriate benefit from your insurance carrier by completing your insurance forms and mailing (or electronically filing) it with your insurance provider. We must have accurate and up-to-date insurance information in order to bill your insurance company. We require that you pay any deductibles and co-payments at the time of service. We also require that you pay the estimated portion of your treatment (that portion the insurance carrier is not expected to pay) prior to, or at each visit. As treatment is completed, we will bill your insurance carrier for the services rendered. In the event your insurance carrier has not paid their portion within forty-five (45) days, the full balance becomes your responsibility.

Should you request in writing that we do so, we will request a pre-estimate of benefits from your insurance carrier. Routine treatment is generally performed without submitting a request for pre-estimate of benefits.

Certain patients have double coverage (this is possible if more than one party has dental insurance) - we will only bill the primary carrier for services rendered. However, as a courtesy to you, we will submit to the secondary carrier after your account has been paid in full.

### **PATIENTS WITHOUT INSURANCE COVERAGE OR WITH INSURANCE WE DO NOT ACCEPT**

Patients without insurance coverage or with insurance coverage we do not accept are expected to pay in full for services as they are rendered. We accept many major credit cards as well as personal checks and cash. We generally do not extend credit to patients/parents, instead we ask that you use the services of an outside financing company such as CareCredit.

**Missed appointments:** Appointments canceled with less than 48 hours notice are subject to a \$50.00 cancellation charge. Please help us serve you more efficiently by keeping your scheduled appointments.

**Returned Checks:** Checks returned by the bank due to insufficient funds are subject to a \$25.00 processing charge. No further appointments will be scheduled unless payment is received in full prior to such appointments. Such payment must be by certified check or cash.

**Finance Charges:** Accounts unpaid after 45 days from the date of service are subject to a finance charge at the rate of 1.5% per month (18% per year).

**Unpaid Accounts:** Accounts 90 or more days past due may be sent to a collection agency. Should the account be referred to for collection, you will be responsible for collection costs, together with court costs and reasonable attorneys' fees.

**Credit Card on File:** We request that all parents/guardians maintain a credit card on file. If we have filed insurance on your behalf and your insurance carrier has not paid us within 45 days of date of treatment, we may charge your credit card for any balances remaining unpaid as of that date.

Mastercard Account # \_\_\_\_\_ Exp. Date \_\_\_\_\_  
Visa Account # \_\_\_\_\_ Exp. Date \_\_\_\_\_

**I, the undersigned, assume financial responsibility as stated above and agree to be responsible for all collection and legal fees if my account becomes past due. I HAVE READ, UNDERSTAND AND AGREE TO THE FINANCIAL POLICY OF Pima Pediatric Dentistry. I will be paying for treatment by:**

\_\_\_ check \_\_\_ cash \_\_\_ charge \_\_\_ other

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**PIMA PEDIATRIC DENTISTRY  
ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES**

**\*\*You May Refuse to Sign This Acknowledgement\*\***

I, \_\_\_\_\_, have received a copy of Pima Pediatric Dentistry's Notice of Privacy Practices.

\_\_\_\_\_  
{Please Print Name}

\_\_\_\_\_  
{Signature}

\_\_\_\_\_  
{Date}

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For Office Use Only

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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)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_