DEMOGRAPHIC INFORMATION

1 Child's Name____ Birthdate ________________

Child's Name____ Birthdate ________________

Child's Name____ Birthdate ________________

Child's Name____ Birthdate ________________

Child's Name____ Birthdate ________________

Address ____City, State, Zip ____

2 Mother (or Guardian) ___________________________________

Address ☐ Same____

City, State, Zip____

Primary Phone ____________________________ ☐ (h) ☐ (c) ☐ (w)

Alternate Phone ___________________________ ☐ (h) ☐ (c) ☐ (w)

Email ____

SSN____

Employer Name____

Employer Address ____

Employer Phone____

3 Father (or Guardian) ___________________________________

Address ☐ Same____

City, State, Zip____

Primary Phone ____________________________ ☐ (h) ☐ (c) ☐ (w)

Alternate Phone ___________________________ ☐ (h) ☐ (c) ☐ (w)

Email____

SSN ____

Employer Name____

Employer Address ____

Employer Phone____

4 Whom may we thank for referring you?____

5 Who is responsible for the account?:____

Primary Dental Insurance ____ Ins. Phone___________________________

Ins. Address ____ Group # __________________________________

Name of Policy Holder _________________________________DOB:________________________ Subscriber ID _________________________

Secondary Dental Insurance ____ Ins. Phone:___________________________

Ins Address ____Group # __________________________________

Name of Policy Holder _________________________________DOB:________________________ Subscriber ___________________________

TREATMENT CONSENT

6 I hereby give my authorization as a parent (or guardian) to Amy Adair, DMD, PLLC for the completion of all agreed upon dental services for my child, including the use of local anesthetic and/or nitrous oxide sedation. I agree to assume responsibility for fees associated with those procedures. I am aware there is a returned check fee of $25, and the balance on accounts greater than 30 days may be subject to finance charges.

Signature: ____ **Relationship to Patient:** ____________________________________

Print Name:____ **Date:** ____

7 You may designate another family member or adult to bring your child to subsequent dental appointments. ***However***, we reserve the right to contact the child's legal guardian prior to any appointment or treatment. Failure to reach a legal guardian may result in rescheduling.

Name: ____ Relationship: ____

Name: ____ Relationship: ____

OFFICE POLICIES

Please initial on each line and sign where indicated

8

_______**APPOINTMENT/CANCELLATION POLICY**

Patients are seen by appointment only. Please arrive at least 5 minutes prior to scheduled appointments. If you are more than 10 minutes late, we will try to fit you into the schedule, or you may be asked to reschedule out of courtesy to other patients. Please provide at least 24 hours notice if you must cancel or reschedule an appointment. Failure to provide advanced notice or failure to show up to your appointment may result in an appointment failure fee and/or restricted future scheduling.

_______**FINANCIAL POLICY**

The following payment methods are available: Cash, Check, MasterCard, Visa, American Express

Participating Insurance (PPO's only): United Concordia, MetLife, Delta Dental, United Healthcare Benefits, Aetna

If you have a participating insurance, you will be responsible for the portion of charges that your insurance plan does not cover. We will submit the claim on your behalf. If a balance remains on your account after the insurance company processes your claim, the balance will be due immediately.

Non-Participating Insurance: Payment is due in full at the time of service.

PLEASE NOTE: THE BALANCE OF YOUR ACCOUNT IS DUE IMMEDIATELY UPON THE PAYMENT OR DENIAL OF YOUR CLAIM. REGARDLESS OF YOUR INSURANCE STATUS, YOU ARE ULTIMATELY RESPONSIBLE FOR THE BALANCE OF YOUR ACCOUNT FOR WHICH ANY PROFESSIONAL SERVICES ARE RENDERED. NOT ALL SERVICES ARE A COVERED BENEFIT IN ALL INSURANCE CONTRACTS. IT IS YOUR RESPONSIBILITY TO KNOW YOUR INSURANCE COVERAGE. PLEASE READ YOUR POLICY GUIDELINES AND COME PREPARED. WE UNDERSTAND THAT TEMPORARY FINANCIAL PROBLEMS MAY AFFECT TIMELY PAYMENT OF YOUR ACCOUNT. IF SUCH PROBLEMS DO ARISE, WE ENCOURAGE YOU TO CONTACT US PROMPTLY FOR ASSISTANCE IN THE MANAGEMENT OF YOUR ACOUNT.

I agree to pay all costs of collection and attorney fees. **I also understand that dental appointments will be limited to emergency appointments only for any account greater than 90 days past due.**

_______**CELL PHONE/MEDIA DEVICES POLICY**

In accordance with HIPAA laws and to protect the privacy of your child, other patients, and our staff, cell phone or any other media device use is strictly prohibited in treatment areas.

9

I have read and understand the terms and conditions set forth above and agree to the terms and conditions therein. I further understand that failure to comply with these and any other policies of the office of Amy Adair, DMD, PLLC may result in termination of dental services.

Signature:____ **Relationship to Patient:**______________________

Print Name: ____ **Date:**__________________________________

10

HIPAA ACKNOWLEDGEMENT FORM

I acknowledge that I have received and reviewed the Notice of Privacy Practices for the office of Amy Adair, DMD, PLLC.

YES	NO	
☐	☐	You may leave Protected Health Information on my answering machine/voicemail. Phone:____________________________
☐	☐	You may send me a text message (unencrypted) for dental appointments: Phone: ____________________________________
☐	☐	You may email me (unencrypted) for dental appointments: Email address: ____

Signature ____ **Relationship to Patient:**________________________

Print Name: ____ **Date:**____________________________________

(*For office use only)* In the event that you do not agree to sign this form, our office must indicate the reason why you declined .

Reason for parent/guardian refusal: ____

Privacy Official's Signature ____ Date ____________________________