STARSHIP
PEDIATRIC DENTISTRY

Family Form: Please fill out one form per family

Child Information:

Child name: _____ DOB: _____

Child name: _____ DOB: _____

Child name: _____ DOB: _____

Child name: _____ DOB: _____

Children's Home Address: _____ Apt/Unit: _____

City: _____ State: _____ Zipcode: _____

Child's Home Phone: (_____) _____ - _____

How did you hear about us? _____

Person filling out forms: ☐ Mother ☐ Father ☐ Other _____

Mother/Legal Guardian:

Name: _____ Birthdate: _____ / _____ / _____

Cell Phone: (_____) _____ - _____ Occupation: _____

Email: _____

Father/Legal Guardian:

Name: _____ Birthdate: _____ / _____ / _____

Cell Phone: (_____) _____ - _____ Occupation: _____

Email: _____

Dental Insurance Information: Insurance Company Name: _____

Group Number: _____ Identification Number: _____

Policy Owner's Name (last, first) _____

Policy Owner's SSN: _____ Policy Owner's Birthdate: _____ / _____ / _____

Relationship to Child: ☐ Mother ☐ Father ☐ Legal Guardian ☐ Other _____

Insurance Company Phone Number: (_____) _____ - _____

Do you have secondary insurance coverage? ☐ Yes ☐ No Secondary Insurance Company: _____

Secondary Insurance Policy Holder: _____ Secondary Policy Holder's Birthdate: _____

Secondary Insurance ID number: _____ Secondary Policy Holder's SSN: _____

Authorization for a Babysitter/Grandparent/Non-Parent/Family Member over 18 years old to bring my child in for treatment:

If a parent/legal guardian is unable to bring my children for treatment, I authorize _____ to accompany my children and provide consent for all general treatments including, but not limited to: Examinations, prophylaxis, radiographs, restorations, pulpotomies, primary tooth root canals, crowns, and nitrous oxide. A separate consent must be signed by a legal guardian for extractions and use of medical immobilization.

Adult authorized to accompany children: _____

Relation to children/family: _____ Phone number: _____

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Individual Child Form: Please fill out one for for each child being treated at our office.

Patient's Name: _____ Nickname: _____

Date of birth: _____ Age: _____ School grade (if applicable): _____

Pediatrician/Medical Specialist Information:

Pediatrician name: _____ Office Name: _____

Date of last physical: _____ Please provide the name and number of any specialty doctors, if applicable: _____

_____

Please review carefully and check ☑ if your child has any history, or condition related to, any of the following:

☐ Anemia	☐ Chronic Sinusitis	☐ Hyperactivity	☐ Snoring
☐ Asthma	☐ Diabetes	☐ ADHD/ADD	☐ Speech/Hearing
☐ Autism	☐ Enlarged Tonsils	☐ Latex Allergy	☐ Thyroid
☐ Bladder/Kidney	☐ Epilepsy/Seizures	☐ Liver/Hepatitis	☐ Tuberculosis
☐ Bleeding Disorders	☐ Fainting	☐ Pregnancy (teens)	☐ Vision Disorders
☐ Bone Disorders	☐ Growth Problems	☐ Prosthetic Heart Valve	☐ Other _____
☐ Cancer	☐ Heart Murmur	☐ Rheumatic Fever	☐ **None**
☐ Cerebral Palsy	☐ HIV+/AIDS	☐ Sickle Cell	

Health History:

Yes / No

☐ ☐ 1. Is your child taking any medications (prescription, over-the-counter, vitamin supplements)?
If yes, please list: _____

☐ ☐ 2. Is your child allergic to (please explain if yes to any)…
- Any medications? _____
- Any foods? _____
- Other? _____

☐ ☐ 3. Has your child ever been hospitalized or had surgery? Please explain: _____

☐ ☐ 4. Does your child have any mental, developmental, or physical impairment?
Please explain: _____

☐ ☐ 5. Have you ever been told you child has a heart murmur or other heart condition?
Please explain: _____

☐ ☐ 6. If you answered yes to #5, were you told your child needs antibiotic prophylaxis?

☐ ☐ 7. Has your child been diagnosed with any other illness not yet discussed in this form?
Please explain: _____

☐ ☐ 8. Are your child's immunizations up to date? If not, please explain: _____

Dental History:

Yes / No

☐ ☐ 1. Is this your child's first dental visit? If not, date of last visit? _____

☐ ☐ 2. Has your child ever had an unfavorable experience or reaction to a previous dental visit?
Please explain: _____

☐ ☐ 3. Does your child take fluoride supplements?

☐ ☐ 4. Has your child complained of recent dental pain? Please explain: _____

☐ ☐ 5. Any other dental concerns or comments? _____

Parent Signature: As this child's parent or legal guardian, I acknowledge that the information I have given is correct to the best of my knowledge. I understand that misrepresenting or withholding medical/dental information can be harmful to my child during treatment.

Parent or legal guardian's signature (sign at office if completing form at home):

_____ Today's date: _____

Doctor Comments:

Doctor's Signature: _____ Doctor's name: _____ Date: _____

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Financial Policy and Agreement

Insurance:

As a courtesy to our patients, if we are in network with your insurance provider, we will gladly file the forms necessary to see that you receive the full benefits of your dental coverage. If we are out of network, you will be responsible for payment at the time of treatment, and will be reimburse once insurance payment is received. We ask that you read your policy to be fully aware of any limitations of the benefits provided. *Please note: Many plans have frequency limitations pertaining to a number of the procedures done in our office. These limitations may change from benefit-year to benefit-year. If you are concerned about coverage for these services, please contact your insurance company prior to your visit.*

If your insurance company denies coverage, or we otherwise do not receive payment 30 days from filing your claim, the amount will then become due and payable by you. Remember that your coverage is a contract between you and your insurance company and/or your employer and your insurance company. Although we will make a good faith effort to assist you in obtaining your benefits, we cannot force your insurance company to pay.

Estimates:

Our practice software enables us to estimate your insurance benefits after the dentist has identified any necessary treatment. Regardless of estimated insurance coverage, any fees incurred for services received will be your financial responsibility.

Your Payment is Due at the Time of Treatment:

The estimated uninsured portion of your dental treatment fees is due at the time of service.

Payment Options:

For your convenience, the following options are available:

- Cash or check (returned checks will be subject to a $35 return check fee. If the check is returned for any reason, your account becomes due and payable within 7 days).
- Credit Card and Debit Cards: Visa, MasterCard, Discover and American Express

Appointment Cancellations:

We gladly reserve appointment times for your children. As a courtesy, we will attempt to remind you of your appointment 4,3, and 2 days prior to your appointment (by email, text, and phone call respectively) if you have yet to confirm. In the event that you have not provided us with a mobile number, have designated our sending email address as spam, your mailbox is full, or line is busy, our efforts to contact you may be unsuccessful. An appointment is a contract of time reserved for your child's/children's treatment. We respect our patients' valuable time and we request the same courtesy from our patients. Please extend this courtesy should you need to cancel and/or re-schedule your appointment. **There will be a $50 charge for broken appointments that are cancelled less than one full business day prior to the date of the appointment.**

Patient/Parent/Guardian Responsibility:

- I understand that whoever accompanies my child to the dental appointment has authorization to consent to dental care as needed, and is responsible for payment of dental services.
- I acknowledge my responsibility for payment of all dental services provided by Drs. Wilbur and Berdahl in accordance with their fees and terms.
- In cases where a parenting plan exists, the parent that brings the child for the appointment is considered the guarantor and is responsible for payment. They may then seek reimbursement from the other parent.
- I understand that this account becomes delinquent if not paid within 60 days after billing and that, at that time, the unpaid balance will be subject to a financial charge of 18% annually. Any further delinquency will warrant the account being assigned to a collection agency . All charges incurred from the collection agency as a result of the delinquent account will be the responsibility of the parent/guardian.

Assignment and Release:

I authorize payment to be made directly to the dentist by my insurance company and I accept financial responsibility for all services not covered by my insurance. I authorize release of any dental care information requested by my insurance company.

My signature below acknowledges that I have read and understand this information:

Patient Name: _____

Patient/Parent/Guardian Signature: _____ Relationship to patient: _____

Printed Name: _____ Date: _____

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Patient HIPPA Awareness

With my permission, Starship Pediatric Dentistry may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to the Starship Pediatric Dentistry Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Starship Pediatric Dentistry reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the office.

With my permission, Starship Pediatric Dentistry may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO. This may include, appointment reminders, insurance items, account balances and any call pertaining to my clinical care, including laboratory results, among others.

With my permission Starship Pediatric Dentistry may mail to my home or other designated location any items that assist the practice in carrying out TPO. This may include appointment reminders, account statements, and insurance documents, among others.

With my permission, Starship Pediatric Dentistry may e-mail or text message any items that assist the office in carrying out TPO. This may include but is not limited to appointment reminders and account statements. I have the right to request that Starship Pediatric Dentistry restrict how it uses or discloses my PHI to carry out TPO.

By signing this, I am allowing Starship Pediatric Dentistry to use and disclose my PHI for TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my request.

Signature of Patient or Legal Guardian: _____
(please sign at the office if completing form at home)

Print Name of Legal Guardian: _____

Date: _____