White Smiles Pediatric Dentistry

TRAVIS R. WHITE, DMD
KOLBY LANCE, DMD

Welcome…

CHILDS NAME: First_____ MI___Last_____
Birthdate:_____ Age:_____Male / Female
Mailing Address: _____
City: _____ State: _____ Zip Code: _____
Child lives with: □Father □ Mother □Both □ Other
Marital Status of Parents: □Married □Single □ Divorced □Separated □Widowed

FATHER: _____Home Phone: _____Cell Phone: _____
Birthdate: _____ Social Security Number: _____
Father's Employer: _____ Work Phone: _____
Home Address if different from child: _____
E-mail Address: _____

MOTHER: _____Home Phone: _____Cell Phone: _____
Birthdate: _____ Social Security Number: _____
Mother's Employer: _____ Work Phone: _____
Home Address if different from child: _____
E-mail Address: _____

If appropriate – Name of Legal Guardian:_____ *Phone*: _____

PERSON FINANCIALLY RESPONSIBLE: _____
If other than parent, please write address: _____
Home Phone: _____ Cell: _____Work: _____

PAYMENT OPTIONS: Method of payment (please check)
□ Cash □Care Credit □Credit Card □ Insurance + balance due □Medicaid

PRIMARY DENTAL INSURANCE:
Subscriber name: _____
Insurance company: _____

SECONDARY DENTAL INSURANCE:
Subscriber name: _____
Insurance company: _____

****Please bring all Insurance cards with you to your appointment***

REFERRAL INFORMATION: Who may we thank for referring you to our office?
Physician / Dental Office: (Doctor's name) _____
Another Patient: (name) _____ Friend: (name) _____
School: _____Work: _____ Other: _____

EMERGENCY CONTACT: (specify someone who does not live in your household.)
Name: _____ Relationship: _____
Home Phone: _____ Work Phone: _____

ASSIGNMENT AND RELEASE:
I certify that I, and/or my dependent(s), have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to Dr. Travis R. White, DMD, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Signature: _____ Date: _____ Relationship: _____

Please print name of Patient, Parent, Guardian / Personal Representative: _____

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Dental / Medical History…

CHILD'S NAME: First _____ Last _____ MI _____

DENTAL HISTORY:

Why is your child here today? _____

Is your child currently taking Fluoride? □Yes □No How Often? _____ Dose? _____

Has your child been to the dentist before? □Yes □No Date? _____ Dentist? _____

How was your child's experience? _____

Has your child had x-rays before? □Yes □No Date last taken? _____

Is your child currently using a **Bottle?** □Yes □No **Pacifier?** □Yes □No **Sippy Cup?** □Yes □No

Nursing? □Yes □No **Thumb sucking?** □Yes □No **Grinding?** □Yes □No

Any other habits or concerns? _____

Do you currently help your child **brush?** □Yes □No **Floss?** □Yes □No

How often does he/she brush? _____ Floss? _____

Does your child have TMJ/TMD? □Yes □No **Explain**: _____

MEDICAL HISTORY:

Health problems, or medications that your child is taking, could have an important inter-relationship in the dentistry your child receives. Thank you for answering all of the following questions.

Name of Physician: _____

Date of last physical exam: _____ Any Findings: _____

Receiving Physician Care for reason other than Well Child Checks? _____

Are your child's immunizations up to date? □Yes □No Immunizations due: _____

Date of child's last Tetanus booster: _____

List all medications your child is taking: _____

_____

Has your child ever been Hospitalized? □Yes □No **Explain**: _____

Has your child had any Surgery? □Yes □No **Explain**: _____

Has your child ever had a serious head or neck injury? □Yes □No **Explain**: _____

Has your child ever had a traumatic dental injury? □Yes □No **Explain**: _____

Is your child allergic to any of the following? □**Aspirin** □**Penicillin/Amoxicillin** □**Codeine** □**Metal** □**Latex**

□**Local anesthesia** □**Other**: _____

Please Turn form over and complete other side.

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING? Please Circle as they apply to your child

Autism	Yes	No
ADHD	Yes	No
AIDS	Yes	No
Allergies to Medication	Yes	No
Artificial Joints	Yes	No
Asthma	Yes	No
Blood Disease / Disorder	Yes	No
Specify: _____		
Blood Transfusion	Yes	No
If yes Date: _____		
Behavior / Learning Problems	Yes	No
Breathing / Lung Problems	Yes	No
Cancer / Tumor	Yes	No
Radiation Therapy	Yes	No
Congenital Birth Defects	Yes	No
Cortisone/Prednisone therapy	Yes	No
Multiple Ear Infections	Yes	No
Tubes in Ears	Yes	No
Diabetes	Yes	No
Insulin Dependent	Yes	No
Endocrine Disorder	Yes	No
Fainting / Spells	Yes	No
Hearing Problems	Yes	No
Sight Problems	Yes	No
Heart Murmur	Yes	No
Heart Condition	Yes	No
Antibiotics needed:	Yes	No

Head Injury	Yes	No
Frequent Headaches	Yes	No
Kidney Disease	Yes	No
Liver Disease	Yes	No
Mental Disorder	Yes	No
Developmental Delay	Yes	No
Pregnancy	Yes	No
Due Date: _____		
GI System Disorder	Yes	No
Respiratory Disorder	Yes	No
Treatment: _____		
Rheumatic Fever	Yes	No
Seizure Disorder	Yes	No
Type/Medication: _____		
Tuberculosis	Yes	No
Down Syndrome	Yes	No
Other syndrome: _____		
Vomiting/Diarrhea	Yes	No
Seasonal Allergies	Yes	No
Frequent Infections	Yes	No
What Type: _____		
Any other Medical conditions not listed? _____		

Any comments that you feel the Doctor should know about your child's health? _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in medical/health status.

SIGNATURE OF PATIENT, PARENT, or GAURDIAN _____ DATE: _____

White Smiles Pediatric Dentistry, PLLC

TRAVIS R. WHITE, DMD
KOLBY LANCE, DMD
1620 W. Hwy 40 Vernal, UT 84078
Office: 435/789-7533 Fax: 435/789-7532

Consent to Treat

As a Pediatric Dental Provider, we strive to treat your child in a safe manner that utilizes the industries best practice techniques and standard of care. In order to ensure that your child has the best experience possible the following techniques in Pediatric Dentistry may be used;

- GENERAL ANESTHESIA
- CONSCIOUS SEDATION
- LOCAL ANESTHETIC
- NITROUS OXIDE (LAUGHING GAS)
- PROTECTIVE STABILIZATION (HAND HOLDING, REASSURANCE, TELL, SHOW, DO ETC)
- PAPOOSE (INFANTS)
- VOICE CONTROL

I understand that the above techniques may be used to offer safe and effective treatment for my child/children.

Signature: _____ Printed Name: _____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that the information can be used to, but are not excluded to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change the Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patients Name: _____

Name of Parent or Responsible Party: _____

Relationship to Patient: _____

Signature: _____ Date: _____

Office Use Only

I attempted to obtain patient's/parents signature in acknowledgement of this Notice of Privacy Practices Acknowledgement but was unable to do so as documented below.

Date _____ Initials _____ Reason _____

_____

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Financial Agreement

How do you plan to pay for your dental treatment?

☐ Cash ☐ Debit/Credit Card (Visa, MasterCard, or Discover) ☐ Care Credit ☐ Medicaid

We are dedicated to making the cost of dentistry as small a problem as possible for our patients. You can help us to do this by understanding and following the guidelines of our Financial Policy.

White Smiles Pediatric Dentistry P.C. is a dentist-owned practice, not an insurance company. As a courtesy service, we will do everything we can to assist you in obtaining the maximum of your insurance benefits. ***However, the insurance is a contract between you and your insurance carrier; therefore, you are ultimately responsible for payment in full of your account. Please be aware if the insurance company does not pay within 60 days, payment in full is expected from you.***

We strongly suggest you call and verify with your insurance company that the services you will receive are covered. Please keep in mind that all insurance companies provide a disclaimer that states they are only giving general information when we call to check on your benefits.

We will submit your claims for you with your insurance company and estimate your portion of the services at the conclusion of your visit. We ask that you pay the patient estimated portion the day the service is performed. Any variance in the estimation will be billed to you once the insurance company has paid. **If your insurance (including Medicaid) is not active on the date of service you will be required to pay for all services provided, and our office will not be obligated to back bill insurance companies for services already completed.**

If you do not have dental insurance, we ask that you pay at the end of your visit for any services performed (we accept MasterCard, Visa, and Discover).

I understand that insurance companies pay on a usual and customary fee schedule and that the fees charged by the Doctor are the actual fees. I am responsible for all differences between the Doctor's fee and the insurance fee. **If my child has been referred by another dentist my insurance may not cover the cost of the exam, or x-rays due to plan limitations, and it is my responsibility to pay.**

There will be a $25.00 returned check fee assessed to your account on all returned checks. Once an account becomes overdue (Net 30 Days from the date of invoice), a finance charge of 1 ½ percent per month (annual Percentage rate 18%) of the unpaid balance will be added monthly. Patients with accounts over 60 days will be sent to a third party collection agency. Should collection become necessary, the responsible party agrees to pay an additional 33% for collection fees, and all legal fees of collection, with or without suit, including attorney fees and court costs. Any outstanding bills need to be paid in full before being seen again. It is very important to avoid this.

When scheduling work for an oral and/or IV sedation I know my insurance will likely not cover this charge. ***The sedation fee is due in full along with all estimated dental co-payments/deductibles on the day of service.***

An Additional fee of $25.00 will be applied to your account for cancellations with less than 24 hrs notice and failed appointments. This fee must be paid before being seen again.

Thank you for your continued confidence in *White Smiles Pediatric Dentistry*.

Signature_____Date_____

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