Child's Full Name:_____

Name child prefers to be called:_____

Please tell us if there have been changes in the following information

To assist us in keeping your child's medical history current, please answer the following questions:

1. Have there been any changes in your child's general health since your last visit to our office? If yes, please explain: YES NO
   _____
   _____
   _____

2. Has your child been in the hospital within the last year? If so, for what reason? YES NO
   _____
   _____
   _____

3. Is your child currently under the care of a physician? If so, what is the condition being treated? YES NO
   _____
   _____
   _____

4. Is your child taking any drugs or medications at the present time? If so, please list them below: YES NO
   _____
   _____
   _____

5. Is there any additional information that you think we should know about your child's physical or emotional health state? YES NO
   _____
   _____
   _____

<OVER>

My Kids' Dentists requires two direct contact numbers and one email address to ensure that our office staff is able to reach you to confirm your child's appointment.

Please note that is your responsibility to provide our office with working contact information and to alert our office of any changes immediately.

If My Kids' Dentists is unable to reach you to confirm or give notice of expected out of pocket expenses, we reserve the right refuse treatment on the scheduled day. As seen in our financial policy, broken and or missed appointments without 48 business hours notice a $50, per child, fee may be assessed.

Preferred phone_____ Secondary phone_____

Email_____

Signature of Parent or Guardian_____ Date_____

My Kids' Dentists Policies

Thank you for choosing our practice for your child's dental care. We are committed to their successful treatment. Please understand that payment of your bill is considered a part of your child's treatment. We ask that you review and understand the following details of My Kids' Dentists financial policy and patient responsibilities.

- Please be aware that the parent/legal guardian accompanying the child to My Kids' Dentists as the responsible party is legally responsible for payment of charges. Statements cannot be sent to other persons.
- Payment is expected in full on the day of your child's appointment, as services are rendered. For your convenience we accept cash, VISA, MasterCard, American Express, and Discover. We also offer patient financing through Care Credit.

My Kids' Dentists is in network with Cigna PPO, Humana PPO, and United Concordia. My Kids' Dentists accepts most other insurance plans and will file claims on your behalf. *Please be aware there is no direct relationship between our practice and your insurance company. The plan chosen by you, and/or your employer determines your insurance benefits. As such, we have no say in selection of your insurance company, no control over the terms of your contract, the methods of reimbursement, or the determination of your insurance benefits. We will accept assignment of benefits from your insurance company; however, you are responsible for the entire balance including any amount that is not paid by your insurance company.*

- We will file your claim electronically as a courtesy, but if your insurance company does not pay us directly, you are responsible for the entire balance and the insurance company will send payments directly to you.
- Please note, that any out of pocket expenses paid at time of service are just an estimate. Our practice works diligently prior to your visit to create the best estimate based on the history of past insurance payments. However, there may be an account balance or credit due to you following your appointment. Refund checks are issued on a monthly basis.
- Our office will happily share any estimated out of pocket expenses with you when confirming your appointment. However, note that this information cannot be left on a voicemail due to privacy policies. It is your responsibility to contact our office to confirm your appointment if you wish to receive any financial information.
- My Kids' Dentists requires that all outstanding balances be paid in full within thirty (30) days unless other arrangements have been made. If we have not received payment or you have not contacted us within that time, further action may be taken with a collection agency or small claims court.
- In the event that your account becomes more than thirty (30) days past due a monthly fee of $5.00 will be assessed to your account, as well as a $30.00 fee if a collection agency is necessary.

***Broken and Missed Appointments**

- **We kindly request that when our staff reaches out to remind you of your child's appointment, if you are unable to be reached, that you contact our office immediately to confirm. Our office reserves the right to remove your child from the schedule should we not be able to confirm your reserved appointment time.**
- **If your appointment is broken or missed without a forty-eight (48) business hour notice, My Kids' Dentists will assess a $50.00 broken appointment fee.**
- **Our office offers a fifteen (15) minute grace period for all appointments. If you arrive after that grace period our office is happy to make every attempt to accommodate your child's appointment. Please note this is NOT a guarantee that your child will be seen. In the event we are unable to work your child back into our busy schedule, we reserve the right to assess a $50.00 broken appointment fee.**
- **All broken appointment fees must be paid prior to scheduling a new appointment.**

A Courtesy for You

Although some offices refuse to file insurance claims for their patients, it is our pleasure to extend this courtesy to our patients. When we file insurance claims, please be aware that this courtesy requires significant amount of time and expense on the part of our staff. Be aware that it takes, on average, thirty (30) minutes to one full business day to verify benefits. Additionally, it is imperative that we are informed of any insurance policy changes at a minimum of forty-eight (48) business hours prior to appointment. Our office reserves the right to remove your child from our schedule should we be unable to verify your benefits prior to your child's visit.
Note, that should this occur, a $50.00 broken appointment fee may be assessed.

Acknowledgement

I acknowledge that I have read and understand the above information. I acknowledge that I am financially responsible for all costs of treatment, including any balance unpaid by insurance. I acknowledge that I have read and understand all policies relating to broken appointments as well as unpaid balances.

Signature_____Date_____

Witness_____Date_____