DRY CREEK PEDIATRIC DENTISTRY

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"Gentle Care For Little Smiles"

Patient Information

Patient Name: _____
Preferred Name: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Phone (H): _____ (C): _____
Gender: M F Height: _____ Weight: _____
Date of Birth: _____ Age: _____
School: _____ Grade: _____
Hobbies/Interests: _____
Pets: _____

Father's Name: _____
Mother's Name: _____
Legal Guardian(s): _____
Brothers / Ages: _____
_____
Sisters / Ages: _____
_____

Person Financially Responsible for Acct

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone (H): _____ (C): _____
Driver's License: _____
E-mail Address: _____
(Used for appointment reminders)

Occupation: _____
Employer: _____ # Yrs: ____
Work Address: _____
City: _____ State: _____ Zip: _____
Phone (W): _____

Spouse's Employer: _____ # Yrs: ____
Work Address: _____
City: _____ State: _____ Zip: _____
Phone (W): _____

Method of Payment: Insurance Credit Card Cash

How did you hear about us?

- ☐ Current Patient: _____
- ☐ Doctor/Dentist: _____
- ☐ Mailer (which one?): _____
- ☐ Facebook
- ☐ Instagram
- ☐ Magazine Ad
- ☐ School Ad
- ☐ Drive By
- ☐ My Insurance Company
- ☐ Internet search
- ☐ Door Flyer
- ☐ Other: _____

Emergency Contact Information

After Parents, whom should we contact in an Emergency?

_____
Phone: H C W _____
Address: _____
City: _____ State: ____ Zip: _____
Relationship to Patient: _____

Primary DENTAL Insurance

Subscriber's name: _____
Date of Birth: _____ SSN: _____
Insurance Company: _____
Group #: _____
ID #: _____
Ins. Company Phone #: _____
Address: _____
City: _____ State: ____ Zip: _____

Secondary DENTAL Insurance

Subscriber's name: _____
Date of Birth: _____ SSN: _____
Insurance Company: _____
Group #: _____
ID #: _____
Ins. Company Phone #: _____
Address: _____
City: _____ State: ____ Zip: _____

***I certify that the information on this page is correct and complete to the best of my knowledge:

Signed: _____ Date: _____

Dry Creek Pediatric Dentistry

Medical History

Patient Name:_____ Date of Birth:_____

Patients Medical History

Do you have, or have you had any of the following? (Mark all that apply)

☐ Chronic headaches	☐ Tonsillitis	☐ Radiation Treatment
☐ Heart Problems	☐ HIV/AIDS	☐ Fainting Spells
☐ Blood disease	☐ Hepatitis	☐ Liver Disease
☐ Circulatory problems	☐ Arthritis	☐ Kidney Problems
☐ High/Low blood pressure	☐ Epilepsy	☐ Seizures

Any other medical conditions:_____
Are you taking any medications?:_____

Allergies

Do you have any allergies to medications?:_____
Are you allergic to latex, metals or acrylic?:_____

Have you been under the care of a medical doctor, pediatrician or other, within the last 2 years? Name:_____ Phone Number:_____

Have you been told you need to be pre-medicated for dental treatment? _____

Have you been hospitalized?_____ When?_____Where?_____
Why?_____

Date of last dental visit:_____ Date of last dental x-rays:_____

Signature of legal age patient/ parent or guardian:_____ Date:_____

Dry Creek Pediatric Dentistry

Consent To Proceed

I authorize Dr. Branton Richter and/or such associates or assistants as he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility. This includes arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or, rarely, permanent numbness. I understand that on a rare occasion needles break and may require surgical retrieval.

I understand that as part of the dental treatment, including preventative procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. After lengthy appointments, jaw muscles may also be sore or tender. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during the routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventative and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Patient Name:_____

Signature of Parent or Legal Guardian:_____ Date:_____

Dry Creek Pediatric Dentistry
Office Policies

Insurance

No insurance pays 100% of all procedures. All levels of payment by insurance companies are governed by the dental plan the patient is signed up with. They have nothing to do with the fees we bill. Our fees are based upon a combination of our costs, our time, and our constant dedication to supplying our patients with the highest quality dental care. Every employer has the ability to determine the benefits you receive from your insurance company. As a courtesy to our patients we will give the patient a copy of their estimated benefits before treatment. With so many different benefit plans available with every insurance company it is nearly impossible to get more than an estimate for you. We will do what we can to estimate co-pays accurately, but they are just that, an estimate. Please understand that the dental insurance contract is between the insurance company and the patient who bears the ultimate financial responsibility.

If we have received all of the insurance information on the day of the appointment, we will be happy to file the claims for the patient. It is the patient's responsibility to be familiar with their insurance benefits, as we collect from them the estimated amount of the treatment. We are not responsible for how insurance handles its claims or for what benefits they pay on a claim. We at no time guarantee what your insurance will or will not do with each claim. We also cannot be responsible for any errors in filing your insurance; once again, we file claims as a courtesy.

Please keep us informed of any insurance changes such as policy name, insurance company address, or change of employment. Failure to inform us of changes may result in denied claims for which the patient will be financially responsible.

Financial Responsibility

Your estimated co-pay is due on the day of service.

If the patient does not have accurate dental insurance information at the time of dental services, all fees incurred from the visit must be paid at that time and will be reimbursed upon receipt of payment from the insurance company. Due to the design of insurance plans, actual benefits may differ from our estimate. The patient is responsible for any remaining balances on their account. A service charge of 1.5% per month on the unpaid balance will be assessed on all accounts exceeding 60 days from the date of service unless previously written financial arrangements are made. I understand that any balances acquired can only be extended for arrangements for, at most, 6 months. I agree to pay the fees charged, for the dental services provided for me or my dependent, to the provider within the time stated on billing statements sent to the patient. I further agree to pay any balance plus 40% collections fees, attorney fees or court costs acquired trying to collect your payment, should the assistance of a collection agency be required.

I authorize the release of financially identifiable information concerning my account, including charges billed, payment made, and interest charges assessed, etc. to the dentist's collection agency or attorney should collection procedures become necessary.

I authorize the release of financially identifiable information to my insurance carrier or any related entities that require such information to be submitted.

Safety and Privacy

For the comfort of the patient, one accompanying adult may accompany the child to the operatory. For the safety and privacy of the other patients, ALL others are asked to remain in the reception area. Young children in the reception room will need a supervisory adult. The use of cell phones is prohibited in the operatory.

Failure Policy

Patients are required to give 24 hours' notice for any cancelled appointments. Failure to arrive for a scheduled appointment or give the minimum required notice will result in a cancellation fee of $50 and the patient will not be rescheduled until the fee has been paid. This fee is not covered by ANY insurance company. Any patient with more than 3 subsequent cancellations may be subject to refusal of services per the discretion of the doctor. If appointments for more than one family member are cancelled or rescheduled without 24 hours' notice, the patients may not be rescheduled together. This will help us be more efficient and help to control office overhead, keeping our fees lower.

Signature of legal age patient/ parent or guardian: _____ Date:_____

Dry Creek Pediatric Dentistry
Dr. Branton Richter

FINANCIAL POLICY

We bill insurance companies as a courtesy to our patients. If the patient/responsible party does not have accurate insurance information at the time of dental services, all fees incurred from the dental visit must be paid at that time and will be reimbursed upon receipt of payment from the insurance company. Due to the design of individual and group insurance plans, actual benefits may differ from our estimate. The patient is responsible for any remaining balances on their account.

If the frenectomy procedure is done at the consultation appointment, we do waive the consultation fee. If your child is not on dental insurance we will also give you a 10% discount.

It is the patients' responsibility to know their insurance benefits. You may check with your dental insurance to see if we are in-network. We strongly encourage you to check your dental benefits and see if the frenectomy is a covered procedure before it has been completed and billed. We are contractually obligated to bill patients the portion your insurance designates as the "patient responsibility". You can decide whether to have us bill your insurance or just pay the cash price.

If you think it might be covered by your medical insurance, we can fill out a medical claim form for you to take and try to get reimbursed by them.

Signature of Responsible Party_____Date_____