stellar Kids Dentistry

Family Information

Today's Date: _____

How did you hear about our office: _____

Primary Responsible Party Information:

Parent/Guardian Name: _____ ☐ Male ☐ Female Date of Birth: _____

☐ Mother ☐ Father ☐ Grandparent ☐ Foster Parent ☐ Legal Guardian ☐ Other: _____

Social Security Number: _____ Employer: _____

Email: _____ Cell phone: _____

Address: _____ Work phone: _____

City _____ State _____ Zip _____

Secondary Responsible Party Information:

Parent/Guardian Name: _____ ☐ Male ☐ Female Date of Birth: _____

☐ Mother ☐ Father ☐ Grandparent ☐ Foster Parent ☐ Legal Guardian ☐ Other: _____

Social Security Number: _____ Employer: _____

Email: _____ Cell phone: _____

Address: _____ Work phone: _____

City _____ State _____ Zip _____

Please list the names and dates of birth of the children in the family:

Child's Name	DOB	Child's Name	DOB

Please list family members (not already listed above) whom we can share information with and who may make treatment decisions for the children if they are accompanying the patients to the appointments.

Name	DOB	Name	DOB

Cell phone: _____ Cell phone: _____

Appointment Policies

We value your time and strive to stay on schedule for our patients. We ask that our patients respect our schedule and arrive to your appointments 5 minutes prior to the scheduled start time. If you are late, we may not be able to complete the necessary treatment and reserve the right to reschedule that appointment.

Permissions: A parent or legal guardian must be present in the office at all times. If you are having a family member transport your child, a release/permission form will need to be signed and brought to the appointment.

Appointment Changes

Due to the high demand of our specialty doctors, we **require two business days' notice to change appointment times or dates.** Without proper notification, a $50.00 charge per appointment may be charged to your account. With continued disregard to this policy, we reserve the right to dismiss your family from our practice.

Confirmations: Every effort is made to confirm our appointments. You may either respond by text, email, or phone. **Unconfirmed appointments may be rescheduled in order to see another child in need.**

Financial Policy and Agreement

As a courtesy, we will be happy to file for your insurance benefits. Your insurance plan is a contract between you, your employer, and the insurance companies and therefore we cannot guarantee your eligibility or the payment amounts. We will estimate your patient portions with the information that we are given from the insurance company. If you are no longer eligible or the insurance company pays less than anticipated, you are responsible for the entire amount.

ALL ESTIMATED PATIENT PORTIONS ARE DUE AT THE TIME OF THE APPOINTMENT. These can be paid by cash, check, Visa, or MasterCard. If there is a remaining balance, a statement will be sent after the claim is paid. If the claim is unpaid for 90 days, the balance reverts to patient responsibility. Certainly, if any overpayment has occurred, a prompt refund will be issued. **All accounts that remain unpaid at 60 days will be subject to a 1.5% finance charge per month**.

AUTHORIZATION. I understand that the information I have given is correct and to the best of my knowledge, and that it will be held in the strictest of confidence. Since my child/children are minors, it is necessary that signed permission be obtained from a parent or legal guardian before any dental service can be started. I grant the doctors and staff of Stellar Kids Dentistry consent to do an oral exam, take appropriate x-rays, clean the teeth, give a fluoride treatment, and provide oral hygiene instructions, as deemed necessary. I understand I will be consulted before another treatment is rendered. I understand that this information will be used by the dentist to help determine the appropriate and ideal dental treatment. If there is any change in my child's medical status, I will inform the dentists immediately. I authorize all insurance payments be sent to Stellar Kids Dentistry for all services rendered. I authorize the use of this signature on all insurance submissions. I authorize Stellar Kids Dentistry to release all information necessary to secure payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

FAMILY STATEMENT OF PRIVACY POLICIES ACKNOWLEDGEMENT. I acknowledge that I have received or been offered a copy of the Statement of Privacy Practices for Stellar Kids Dentistry. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of the office's health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility. Stellar Kids Dentistry reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If the privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY. In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health information to the persons indicated on the prior page.

Parent's or Guardian's Signature_____ Date_____

Print Name_____