We are pleased to welcome you and your child to Dental Designers! Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you! We look forward to working with you in maintaining your child's dental health.

Date_____ SS#_____ Date of Birth _____ Age _____

Name of Minor/Child _____ _____ Sex ☐M ☐F
Last Name First Name Middle Initial

Nickname_____ Hobbies_____

Address _____ City _____ State ____ Zip Code _____

School Name_____ School Phone (___) _____

Person Financially responsible for child _____

Cell Phone ( ) _____ Work Phone (__) _____ Home Phone ( ) _____

How did you hear about us? _____

Father/Guardian's Name_____

Address (if different than patient) _____

Cell Phone ( ) _____ Work Phone ( ) _____ Home Phone ( ) _____

Employer_____ Soc. Sec#_____

Birth date_____ Do you have insurance for the minor/child? ☐ Yes ☐ No

Plan Name_____ Phone (__)_____

Address: _____

Group #_____ Policy #_____ E-Mail_____

Mother/Guardian's Name_____

Address (if different than patient) _____

Cell Phone ( ) _____ Work Phone ( ) _____ Home Phone ( ) _____

Employer_____ Soc. Sec#_____

Birth date_____ Do you have insurance for the minor/child? ☐ Yes ☐ No

Plan Name_____ Phone ( ) _____

Address:_____

Group #_____ Policy #_____E-mail_____

Dental History

Former Dentist_____ Date of last visit_____

Reason for Visit: _____

	YES	NO
Has child complained about dental problems?	☐	☐
Does child brush daily?	☐	☐
Does child floss daily?	☐	☐
Is Fluoride taken in any form?	☐	☐
Have there been any injuries to mouth, teeth, or head?	☐	☐
Any unhappy dental experiences?	☐	☐
Any mouth habits- thumb sucking, nail biting etc?	☐	☐

If yes, please explain _____

Medical History

Minor/Childs Physician _____Phone ( ) _____

Date of last physical_____ Results _____

	YES	NO	
Is minor/child under care of physician now	☐	☐	Medications _____
Receiving any medications or drugs	☐	☐	_____
Ever been hospitalized	☐	☐	_____
Ever had surgery?	☐	☐	Allergies_____
Is there excessive bleeding when cut	☐	☐	_____

Has minor/child had any history of or difficulty with any of the following? If yes please check

☐ A.I.D.S/ H.I.V.	☐ Cerebral Palsy	☐ Epilepsy	☐ Kidney disease	☐ Rheumatic Fever
☐ Anemia	☐ Chicken Pox	☐ Fainting	☐ Liver Disease	☐ Sinus Problems
☐ Asthma	☐ Convulsions	☐ Measles	☐ Thyroid disease	☐ Bladder problems
☐ Diabetes	☐ Heart Problems	☐ Tuberculosis	☐ Mononucleosis	☐ Cancer
☐ Hepatitis	☐ Hearing Problems	☐ Mumps	☐ Drug/alcohol abuse	☐ Other_____

In the event of an emergency whom should we contact?

Name_____Relationship_____ Phone_____ __

Name_____Relationship_____Phone_____

To the best of my knowledge, the above information is complete and accurate. I understand that it is my responsibility to inform my doctor if there are any changes in my child/dependent's medical condition.

Minor/Child Consent

I am the parent, guardian, or personal representative of _____

Print Name of Child

and there is no court orders now in effect that prohibit me from signing this consent, I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but no limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

Insurance Assignment and Release

I certify that my dependent (s) is covered by insurance with _____.

I assign directly to Dr. Hansen 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 of Parent/Guardian Date

_____ _____

Print name of Parent/Guardian Relationship to Patient

INSURANCE ASSIGNMENT AND FINANCIAL RESPONSIBILITY AGREEMENT

I hereby assign to Dental Designers all of my claims and rights to payment under any insurance policy for which I am a beneficiary. By the assignment I grant Dental Designers full power and authority to exercise my rights, under said insurance policy, to collect and receive payments thereon, to bring a legal action to exercise said rights and to do all things that I might do. I further promise to cooperate with Dental Designers in any action that I might become involved in to enforce my rights to payment under any policy of insurance.

FINANCIAL RESPONSIBILITY AGREEMENT

I understand and agree that I am financially responsible to Dental Designers for all charges incurred for which payment is not received by Dental Designers from the insurance company. I understand that many insurance companies require the patient to call the insurance company for pre-certification prior to treatment being rendered. Failure of the patient to obtain pre-certification may result in denial of payment by the insurance company.

If I have not obtained the required pre-certification and a denial of payment results, I understand and agree that i am financially responsible for these charges. I further understand and agree that I am responsible for all charges that considered not covered by my insurance policy and for care that is, in the opinion of my insurance company or their authorized utilization review agent, subsequently found to be necessary. I agree to pay any amount I receive from my insurance company to Dental Designers within thirty (30) days of treatment being rendered.

I agree that Dental Designers may, upon my default, take any action, including filing a law suit to collect all sums due. I agree to pay Dental Designers all costs of collection, including attorneys fees, court costs and collection agency's fees which may greatly increase the outstanding amount due.

I hereby authorize release of information, including record copies, as may be required by my insurance company or group policy holder, or their authorized agent for payment of my insurance claim.

I am aware that any account **over thirty (30) days past due** will incur an 18% account handling charge and billing charge on the balance due. Any ***insurance*** balance **over thirty (30) days past due** is the responsibility of the patient/account holder.

I am aware that if an appointment is **not kept or not canceled with a forty-eight (48) hour advance notice** there will be a charge of ***$40 per hour*** for each appointment. I am also aware that id a ***Saturday appointment*** **is not kept or not cancelled with a forty-eight (48) hour advance notice** there will be a charge of ***$60 per hour*** for each appointment.

_____ _____

Patient's name Date

_____

Insured Person/Guardian (if other than patient)