

WELCOME!

We would like to welcome your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime!

1 Tell Us About Your Child

Today's Date: _____

Child's Name: _____
Last First MI

Child's Birthdate: ____/____/____ Child's Age: _____

Nickname: _____ Male Female

School: _____ Grade: _____

Hobbies: _____

Child's Home #: (____) _____ SS #: _____

Child's Home Address: _____
Apt / Condo #

City State Zip

2 General Information

Who is accompanying the child today?

Name: _____ Relation: _____

Do you have legal custody of this child? Yes No

Whom may we Thank for referring you? _____

Other siblings: _____

Previous / Present Dentist: _____ Last Visit Date _____

Dentist's Phone #: (____) _____

Relative or Friend not living with you:

Name: _____ Phone: (____) _____

Address: _____

City State Zip

3 Parent's Information

Who is responsible for account? _____ Parent's Marital Status

Single Married Partnered Widowed Divorced Separated

Father Step Father Guardian

Mother Step Mother Guardian

Name: _____ Birthdate: ____/____/____

Name: _____ Birthdate: ____/____/____

Address: (If different than Child's) Hm #: (____) _____

Address: (If different than Child's) Hm #: (____) _____

SS #: _____ DL #: _____

SS #: _____ DL #: _____

Wk #: (____) Ext: _____ Cell/Other #: (____) _____

Wk #: (____) Ext: _____ Cell/Other #: (____) _____

Email: _____

Email: _____

Employer: _____

Employer: _____

Employer's Address: _____

Employer's Address: _____

City State Zip

City State Zip

If you have Dental Insurance Coverage for the Child, please fill out below:

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Insurance Co. Name: _____

Insurance Co. Name: _____

Insurance Address: _____

Insurance Address: _____

City State Zip

City State Zip

Insurance Phone: (____) _____

Insurance Phone: (____) _____

Group # (Plan, Local, or Policy #): _____

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4 Release

I certify that my child is covered by _____ Insurance Co. and I assign all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature of Parent or Guardian _____

Date _____

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Financial Policy

The Exchange Dental Group strives to be punctual, therefore we ask that our patients keep their appointments and also arrive on time. If a patient must cancel an appointment, we require at least 24 hours notice, with the exception of Sunday appointments which must be cancelled by Friday 12pm the latest. **There will be a \$100 charge for EACH appointment missed or not cancelled 24 hours prior to the scheduled time, or by Friday 12pm respectively.**

The Exchange Dental Group will make every effort possible to assist our patients with their insurance, however please keep in mind that dental insurance is a contract between the insurance company and the patient, not the dental provider. It is up to the patient to fully understand his/her benefits to ensure the appropriate disbursement of benefits under the terms of each individual plan.

It is the patient's responsibility to notify The Exchange Dental Group should there be any change in the insurance plan. It is also the patient's responsibility to notify us of any dental procedures that have been done in **other** dental offices that may reduce the insurance benefits available for the year.

As a courtesy to our patients, The Exchange Dental Group provides a treatment plan of which includes an estimate of the recommended treatment, the expected coverage from the dental coverage as well as the patient's copayment respectively. **Benefits quoted to you are only an estimate provided by the insurance company and not a guarantee of payment or eligibility at the time the services are performed.** The Exchange Dental Group will submit claims and accept the assignment of benefits from the insurance company on behalf of the patient provided the patient pays their copayment for each visit, due at the time of treatment, unless prior arrangements have been made, as we offer various financial programs to assist our patients with affordable monthly payments.

In the event that the claim is not paid by the insurance company within 30 days, the balance becomes the patient's responsibility and is due immediately. Any balances that remain unpaid after 90 days will be turned over to collections.

* Please note that a \$25 returned check fee will be added to the balance for all returned checks.

A misunderstanding can be an obstacle in establishing a successful relationship. If at any time you have a question regarding treatment, fee or service, please discuss it with us promptly and openly.

I, the undersigned, have read and understood the above and I consent to all the terms and conditions set forth in this agreement.

Signature _____ Date _____