WELCOME

Your Child

Name _____

Nickname _____ Sex _____

Birthdate _____ Age _____

School _____ Grade _____

Would you prefer to receive appointment confirmations via text and/or email messages? ☐ Yes ☐ No

Email Address _____

Responsible Party Mailing Address _____
Address State Zip

Responsible Party

Name _____

Relationship _____

Home Phone _____

Cell Phone _____

Which number do you prefer to receive calls? _____

Please present your child's picture ID (if available) and/or responsible party's ID.

Email Address _____

Mother ☐ Stepmother ☐ Guardian

Name _____

DOB _____ SS# _____

Home Phone _____ Cell Phone _____

Employer _____ Work Phone _____

Marital Status ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Widowed ☐ Separated

Father ☐ Stepfather ☐ Guardian

Name _____

DOB _____ SS# _____

Home Phone _____ Cell Phone _____

Employer _____ Work Phone _____

Marital Status ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Widowed ☐ Separated

Primary Insurance

Insured's Name _____

DOB _____ SS# _____

Insurance Company _____

Employer _____ Date of Hire _____

Group or Plan # _____ Subscriber ID _____

Additional Insurance

Have you or your family had dental claims submitted elsewhere during the benefit year? ☐ Yes ☐ No

Insured's Name _____

DOB _____ SS# _____

Insurance Company _____

Employer _____ Date of Hire _____

Group or Plan # _____ Subscriber ID _____

Please provide us with your dental benefit cards for verification.

Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer.

Payment in full at each appointment.

☐ Cash ☐ Personal Check

Credit Card ☐ Visa ☐ MC ☐ Discover

☐ I wish to discuss the office's payment financial arrangements.

Late Charges

If I do not pay the entire new balance within 30 days of the monthly billing date, a late charge of $2.50 will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

_____
Initial

Dental & Health History

Name _____ DOB _____

How often does your child brush? _____
Is your child's water fluoridated? ☐ Yes ☐ No
Does your child:
Suck thumb/finger ☐ Yes ☐ No
Suck/Bite lip ☐ Yes ☐ No
Bite/Chew nails ☐ Yes ☐ No
Chew hard objects (pencils, etc.) ☐ Yes ☐ No

How often does your child floss? _____
Does your child take fluoride supplements? ☐ Yes ☐ No
Grind teeth ☐ Yes ☐ No
Clench jaws ☐ Yes ☐ No
Gag easily ☐ Yes ☐ No
Tonsils/Adenoids removed _____ age ☐ Yes ☐ No
Speech Problem ☐ Yes ☐ No

Apprx. date of last dental visit? _____ Previous dentist _____

Has your child had difficulty with previous dental visits? ☐ Yes ☐ No (if yes, please explain) _____

Previous Hospitalizations/Surgeries/Serious Illnesses?

Is your child currently taking medications?

_____ ☐ Yes ☐ No (if yes, please explain) _____

Does your child have a history of allergies/sensitivities/adverse reactions to any drugs, medications or other substance such as penicillin or latex? ☐ Yes ☐ No (if yes please explain) _____

Has your child ever had any of the following:

Asthma ☐ Yes ☐ No
Cancer ☐ Yes ☐ No
Hepatitis ☐ Yes ☐ No
HIV ☐ Yes ☐ No
Hemophilia ☐ Yes ☐ No
A persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks) ☐ Yes ☐ No
Acid Reflux ☐ Yes ☐ No
Stomach, liver or kidney problems (circle) ☐ Yes ☐ No
Tuberculosis ☐ Yes ☐ No
Diabetes Type I Type II (circle) ☐ Yes ☐ No
Rheumatic Fever ☐ Yes ☐ No
Congenital Heart Defect ☐ Yes ☐ No
Heart Murmur ☐ Yes ☐ No
Seizures/Epilepsy ☐ Yes ☐ No
Hearing Impairment ☐ Yes ☐ No
Handicap/Disabilities ☐ Yes ☐ No

Please explain any medical problem that your child has: _____

Health History Review: **Initials:**

Date_____ Comments_____ Patient_____ Provider _____
Date_____ Comments_____ Patient_____ Provider _____
Date_____ Comments_____ Patient_____ Provider _____

Authorization & Release

I understand that providing incorrect information can be dangerous and it is my responsibility to inform the office of any changes in the child's medical status. I also authorize the staff to perform the necessary services the child may need.

I also authorize the release of any information including the diagnosis and the records of treatment or examination rendered, to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the Dentist or Dentist's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____
Signature of patient (or parent/guardian if minor) Date

Annual Information Update:

Date_____ No Changes ☐ or Please update the following information _____

Date_____ No Changes ☐ or Please update the following information _____

Date_____ No Changes ☐ or Please update the following information _____

Nordstrom Family Dental
Wee Care Pediatric Dentistry

PAYMENT FOR SERVICES POLICY

Please read, initial where indicated, and sign below.

INSURANCE BILLING

- Insurance coverage is not a guarantee of payment. (_____ *initial*)
- We will bill your insurance if you present your insurance card(s) at the time of your appointment. It is important for you to understand that you are responsible for monitoring the processes of your claim, and that you are ultimately responsible for payment of services rendered. (_____ *initial*)
- Any co-payments or "patient responsibility" must be paid at the time of service. (_____*initial*)
- **If we do not receive a response from your insurance company within sixty days from the date we bill them, the balance will become your responsibility.** *(_____ initial)*
- You will receive a statement for any remaining balance after all applicable insurances have been applied. That balance is due in full at that time. (_____ *initial*)

We also recommend that you research your insurance benefits prior to your office visit, as there could be reasons why your insurance may not pay for your visit. These reasons might include the following:

- Your deductible has not been met.
- The services or procedures are not covered under the plan due to exclusions or frequency limits.

We will inform you when we know a procedure will not be covered, but many times it is not possible for us to know with certainty, as this varies greatly among insurance companies, and because they will not make a final determination until they have received the claim. We will be happy to provide you with an estimate of your fees before treatment is given. You are responsible to pay for the non-covered services at the time of the visit.

The following authorizations are included on all dental claims. Because we submit the claims for you, a 'Signature on File' must be kept in your record. Please sign both authorizations.

AUTHORIZATION TO RELEASE INFORMATION: I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry our payment activities in connection with this claim.

X _____ Date _____
Signed (patient, parent or legal guardian if minor)

AUTHORIZATION TO PAY BENEFITS TO NAMED DENTIST: I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____ Date _____
Signed (patient, parent or legal guardian if minor)

PATIENT RESPONSIBLILTY AND PAYMENT

We accept cash, check, VISA, Mastercard and Discover. If a payment in check form is returned to us because of insufficient funds, you will be charged a $25 fee. Payment ***in full*** at the time of service is required in the following circumstances:

- You do not have insurance coverage.
- You have not provided your insurance information.
- Your insurance benefits have maxed for the year.
- Any procedures we believe are not covered.

By my signature below, I acknowledge that I have read and that I understand the above statements and am willing to accept responsibility to pay for services rendered if my insurance does not cover them. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

_____ _____
Patient Signature (or financial responsible party) Date

Authorization for Assigned Person (Agent) to Consent to Dental Treatment of a Minor

I hereby authorize _____
{an adult into whose care the minor(s) has been entrusted}

to consent to any X-ray examination, anesthetic, or dental diagnosis or treatment of:

_____
{name and date of birth of minor(s)}

That is deemed advisable by a dentist or hygienist and provided by that dentist or hygienist or under that dentist's or hygienist's supervision regardless of where that treatment is provided.

Signature
_____**Date**_____

Please specify your relationship to the minor(s):

- ☐ **Parent with legal custody**
- ☐ **Guardian with legal custody**

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Phone: (907) 357-6800
nordstromfamilydental@mtaonline.net
kellymaixner@gmail.com

(Print and Sign Page One ONLY)

Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

I understand that I should ask our practice's Privacy & Security Official if I have any questions about these policies and procedures.

_____
{Name of dependent(s) if applicable}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)_____

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