**WELCOME TO OUR OFFICE**

**Dr. Rob Oliver and Associates**

**Pediatric Dentistry**

Child’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_ Sex M F

Is this your child’s first dental visit? Yes\_\_\_\_ No\_\_\_\_

If no, name of previous dentist\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last visit\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Purpose of this visit\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GENERAL INFORMATION

**Parent/Guardian #1**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_SSN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital status: married \_\_\_single \_\_\_divorced \_\_\_partner\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_­­­\_\_

Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/Guardian #2**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_SSN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital status: married \_\_\_single \_\_\_divorced \_\_\_partner\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(excluding parents)

Authorization and Release

I authorize the dentist/dental staff to perform the necessary dental services that my child may need. I also authorize the dentist/dental staff to release any information including diagnosis and/or x-rays rendered, to my child during the period of such care to any third party payers and or health providers. I certify that I am financially responsible for the above named patient and any charges that may occur. I further acknowledge the receipt of the HIPPA Privacy Form.

**Signature of Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Dental/Medical Questionnaire

Child’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Child’s Pediatrician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child under a physician’s care now? Yes\_\_\_ No\_\_\_ If so for what reason? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child taking any medication or drugs? Yes\_\_\_ No\_\_\_ Please list\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For what reason? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child allergic to any medications? Yes\_\_\_ No\_\_\_ Please list\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have allergic reaction to: food\_\_\_\_ animals\_\_\_\_ pollen\_\_\_\_ dust\_\_\_\_ latex\_\_\_\_ other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have any of these habits: finger/thumb sucking \_\_\_ pacifier\_\_\_ nail biting \_\_\_ teeth grinding \_\_\_

lip sucking \_\_\_ snoring \_\_\_ mouth breathing \_\_\_

Does your child complain of any dental problems? Yes\_\_\_ No\_\_\_ Please describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child had any injuries to teeth, mouth or head? Yes\_\_\_ No\_\_\_ Please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child had a history or difficulty with any of the following:

Yes No Yes No Yes No Yes No

\_\_\_ \_\_\_ Premature Birth \_\_\_ \_\_\_ Delayed Development \_\_\_ \_\_\_ Emotional \_\_\_ \_\_\_ Anxiety

\_\_\_ \_\_\_ Heart \_\_\_ \_\_\_ Autism Problems \_\_\_ \_\_\_ Behavior Issues

\_\_\_ \_\_\_ Seizures \_\_\_ \_\_\_ Asthma \_\_\_ \_\_\_ Speech Disorder \_\_\_ \_\_\_ Sensory

\_\_\_ \_\_\_ Immune disorder \_\_\_ \_\_\_ Kidney \_\_\_ \_\_\_ Hearing \_\_\_ \_\_\_ ADHD/ADD

\_\_\_ \_\_\_ Brain injury \_\_\_ \_\_\_ Cerebral Palsy \_\_\_ \_\_\_ Anemia \_\_\_ \_\_\_ Rheumatic fever

\_\_\_ \_\_\_ Diabetes \_\_\_ \_\_\_ Fainting or dizziness \_\_\_ \_\_\_ Liver \_\_\_ \_\_\_ Tuberculosis

\_\_\_ \_\_\_ Hepatitis \_\_\_ \_\_\_ Cancer or malignancies \_\_\_ \_\_\_ Bladder \_\_\_ \_\_\_ Bone disorder

Additional Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The above statements are to the best of my knowledge, true and correct. I agree to report any health changes to the dentist before any treatment performed \_\_\_\_ (initial)

Please tell us some interests of your child in order to help us create a positive relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DENTAL INSURANCE INFORMATION

**Insured Parent #1** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_ \_Ins ID #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Insurance Co. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Co Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Please fill out below only if two dental insurance plans are available for child)**

**Insured Parent #2** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_ \_Ins ID #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Insurance Co. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Co. Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Assignment of Benefits****:* I hereby authorize payment directly to the above named dentist of the group dental benefits otherwise payable to me. I understand that I am financially responsible for 100% of all charges incurred regardless of any insurance benefits

.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dr. Rob Oliver and Associates**

**Financial Policies**

**Payment for services are due in full the day of treatment**. If your child has dental insurance coverage and we have verified the benefits under your plan, we will issue an insurance claim to the insurance carrier on the day of service. **In most cases insurance benefits do not cover 100% of the dental treatment.** Our financial coordinators will do their best to estimate your copayment. This portion will be due the day of service. Some insurance companies pay their subscribers directly. We would still submit your claim but payment in full would be required day of service.

**We accept payment by:**

**1) Cash**

**2) Check**

**3) MasterCard or Visa**

**4) Care Credit (6 month interest free financing) if over $200**

**Please understand** that we file dental insurance as a courtesy to our patients. We do not have a contract with your insurance company, only you do. We at no time guarantee what your insurance will or will not do with each claim. You are responsible for all copayments including deductibles and services not covered by your plan. We encourage you as a parent to understand the policies and benefits of your insurance. We will be happy to assist you with any questions or concerns. We are happy to share our experience and knowledge

**For more information regarding dental insurance please visit our website at lifeofsmiles.com**

**I have read and received a copy of Dr. Rob Oliver and Associates Financial Policies**

**Parent Name (Printed) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ParentSignature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**