Pediatric & laser DENTISTRY
Nick A. Prater, DDS, LLC

Today's Date_____

Child's First Name_____Child's Last Name_____Nickname_____M F

Child's Age_____Child's Date of Birth_____/_____/_____

Residence Address_____City_____State_____

Zip_____Residence Phone_____

Email Address_____(for appointment confirmation)

School_____Grade_____

Please list any special interest, favorite toys, movies, ect._____

1. **Who is accompanying the child today?**

Name_____Relation_____

Do you have legal custody of the child? Yes____No____

Parents Marital Status: Single___Married___Widowed___Divorced___Separated___

Whom may we thank for referring you?_____

2. **Mother's Information**

Stepmother___Guardian___

Name_____Date of Birth___/___/___

Wk/Cell #_____Home#_____

SS#_____

Present Employer_____

Father's Information

Stepfather___Guardian___

Name_____Date of Birth___/___/___

Wk/Cell #_____Home#_____

SS#_____

Present Employer_____

3. **Person Responsible for the Account**

Name_____Relation_____

Billing Address_____City_____State_____Zip_____

4. **Insurance Information**

Dental Insurance Company Name_____

Insurance Company Phone #_____

Claims Mailing Address_____City_____State_____Zip_____

Subscriber ID#(must have this information to file claim)_____

Group#_____

Policy Holder's Name_____Policy Holder's Date of Birth___/___/___

Policy Holder's Employer_____

Patient Name:_____

HEALTH HISTORY QUESTIONNAIRE

Has your child had previous Anesthesia/Sedation or Surgery? YES NO

If Yes, please list:_____

Complications, please list: _____

Does your child take any medications? YES NO

If Yes, please list:_____

Does your child have any allergies to any medications, food, or nickel? YES NO

If Yes, please list:_____

Does your child have a reaction to local anesthetics (i.e. Novocain) or antibiotics? YES NO

If Yes, please list:_____

Please answer the following questions to the best of your ability:

Has your child ever had any of the following (please circle all that apply):

Respiratory: Asthma Sleep Apnea Snoring Seasonal Allergies Recent Cold/Flu Frequent Ear/Tonsil Infections Sinus Tuberculosis Other:_____

Cardiovascular: Murmur Congenital Defect Rheumatic Fever High Blood Pressure Heart Attack Angioplasty/Stents Chest Pain Abnormal Heart Rhythm Other:_____

Liver/Gastrointestinal: Hepatitis Heartburn Ulcers Hernia Bowel/Colon Other:_____

Neurological/Musculoskeletal: Seizures Developmental Disability ADD/ADHD Migraines/Headaches Autism Anxiety Depression Stroke Hearing Impairment Numbness/Tingling Arthritis Back Pain Learning Disability Speech Other:_____

Renal/Endocrine: Diabetes Thyroid Kidney Stones Recent Weight Loss/Gain Other:_____

Hematologic: Cancer/Chemotherapy HIV Bleeding Problems Low Blood Count Other:_____

Is your child under the care of a physician for any chronic medical problems? YES NO

Please list the name of the supervising Physician responsible for your child's care:

Physician Name:_____Physician Phone:_____

Physician Address:_____

DENTAL HISTORY

Last visit to a dentist:_____ _____

(Approximate Date) (Dentist Name)

What concerns regarding your child's teeth prompted this visit?

_____I desire comprehensive dental care for my child

_____I have specific dental concerns. My concerns are:_____

_____My child has complained about dental problems

_____My child suffered an injury to the head/mouth/teeth, if so please explain:_____

Has your child had any history of the following habits?

Thumb-sucking Finger-sucking Lip Biting Nail Biting Pacifier

Are any of these habits currently active? YES NO

Child attitude toward dentistry:_____

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CONSENT FOR EVALUATION

State Law requires us to obtain your consent for any contemplated dental treatment or oral surgery. However, prior to any treatment, it is necessary to perform a thorough clinical evaluation including any diagnostic aids necessary. Please read this and ask about anything you do not understand. We will be happy to explain anything in further detail.

I hereby authorize and direct Dr. Nick Prater and Dr. Breanna Prater to perform upon my child (or legal ward) a complete dental examination including the advisable radiographs (x-rays) and any other diagnostic aid deemed necessary by the Dentist in order to properly diagnose the dental condition of my child. I also understand that if any dental treatment is necessary, I will be required to sign consent for treatment after having been explained the proposed treatment.

GENERAL CONSENT FOR TREATMENT

State Law requires us to obtain your consent for contemplated dental treatment. This form serves as a general consent for dental treatment. Please read this form carefully and ask about anything you do not understand. We will be happy to explain anything in further detail.

1. After consultation with Dr. Nick Prater and/or Dr. Breanna Prater and an explanation about any proposed procedure, I hereby authorize and direct the treating Dentist and/or dental auxiliaries of his/her choice to perform upon my child (or legal ward) the following dental treatment or oral surgery procedure(s) including the necessary or advisable local anesthesia, radiographs (x-rays) or diagnostic aids:
   In general terms the dental procedures **may include one or a combination** of the following:
   *Cleaning of the teeth and the application of topical fluoride
   *Application of plastic "sealants" to the grooves of the teeth
   *Treatment of diseased or injured teeth with dental restorations
   *Removal (extraction) of one or more teeth
   *Treatment of diseased or injured oral tissues (hard and/or soft)
   *Treatment of malposed (crooked) teeth and/or developmental abnormalities
   *Treatment of Orthodontia

2. Alternate methods of treatment, if any, will also be explained to me, as well as the advantages and disadvantages of each. I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee as expressed or implied either as to the result of the treatment or as to the cure.

I hereby state that I have read and understand this consent, and that all questions about this consent or any planned procedures have or will be answered in a satisfactory manner prior to any treatment. I understand that I have the right to be provided with answers to questions that may arise during the course of my child's treatment. I further understand that this consent will remain in effect until such time that I choose to terminate it.

X_____ _____

Signature of parent or guardian

_____

Print name of parent or guardian

X_____

Signature of witness

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Welcome to the office of Dr. Nick Prater and Dr. Breanna Prater. We want to make your visit productive and enjoyable. We are happy to answer any and all questions regarding insurance plans and payment policies you may have.

I. FINANCIAL POLICY

1. Patients WITH insurance coverage:
   *Please understand that your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We will be glad to help you obtain the appropriate benefits from your insurance carrier as a courtesy to you. However, you are responsible for understanding your individual benefits and for the payments of your account.
   *Regarding insurance plans where we are a participation provider, all co-pays and deductibles are **due prior or at the time of treatment.**
   *Regarding insurance plans where we are NOT a participating provider, estimates will be collected **prior to or at the time of treatment** and the difference will be billed as necessary.
   *If your insurance company has not paid the claim within 45 days, the balance will be automatically transferred to you.
   *In some cases, insurance carriers may pay for alternative benefits other than the treatment performed. In this case, you are responsible to pay for the difference.
   *Even if you have dual coverage there may still be a portion that is your responsibility.

2. Patients WITHOUT insurance coverage:

   *Patients without insurance coverage are required to pay for services rendered **at or prior to the time of treatment**.

II. CANCELLATION POLICY

*We require a 24 hour cancellation notice for a scheduled appointment.

*Patients who fail to show for their scheduled appointment without giving notice will be charged a $50.00 fee.

III. BILLING POLICY

*Checks returned unpaid from the bank are subject to a $35.00 service fee

*Accounts delinquent more than 45 days from the date of billing are subject to a 1% per month (12% annually) finance charge.

*When your bill is unpaid, a collection agency may be chosen to manage delinquent accounts. If your account is sent to our collection agency you will be responsible for collection and court costs along with attorney's fees.

BY SIGNING, I AGREE I HAVE READ AND UNDERSTAND PEDIATRIC & LASER DENTISTRY'S FINANCIAL POLICY, CANCELLATION POLICY, AND BILLING POLICY AND THAT I AM THE PERSON RESPONSIBLE FOR THIS PATIENT'S ACCOUNT.

_____ _____

Signature of parent or guardian Date

_____

Printed name of parent or guardian

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

*Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

*Obtain payment from third-party favors.

*Conduct normal healthcare operations such as quality assessments and physician's certification.

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it's *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at their current address and obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient name: _____

Relationship to patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices, but was unable to do so, as documented below:

Date:_____Initials:_____

Reason:_____