



PATIENT INFORMATION

Name: _____ Nickname: _____ DOB: _____ Gender: M F
 Street Address: _____ City: _____ State: _____ Zip: _____
 Primary number for appointment confirmations: _____ Email: _____
 Who is accompanying the child today?
 Name: _____ Relation: Biological Adopted Foster Nanny Other: _____

PARENT INFORMATION

GUARDIAN (I)

Name: _____ Gender: M F
 DOB: _____ SS#: _____
 Marital Status: Single Married Domestic Partnership
 Separated Divorced Widowed
 Home: _____ Cell: _____
 Email: _____
 Check box if Address is same as patient's listed above.
 Street Address: _____
 City: _____ State: _____ Zip: _____
 Employer: _____
 Work: _____

GUARDIAN (II)

Name: _____ Gender: M F
 DOB: _____ SS#: _____
 Marital Status: Single Married Domestic Partnership
 Separated Divorced Widowed
 Home: _____ Cell: _____
 Email: _____
 Check box if Address is same as patient's listed above.
 Street Address: _____
 City: _____ State: _____ Zip: _____
 Employer: _____
 Work: _____

Who does the patient live with? : Guardian 1 & 2 Guardian 1 Guardian 2 Other: _____

DENTAL INSURANCE INFORMATION

PRIMARY COVERAGE

Name of Insured: _____
 DOB: _____ SS#: _____
 Employer: _____
 Phone: _____
 Insurance Co.: _____
 Street Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____
 Group/Policy #: _____
 I.D. #: _____

SECONDARY COVERAGE

Name of Insured: _____
 DOB: _____ SS#: _____
 Employer: _____
 Phone: _____
 Insurance Co.: _____
 Street Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____
 Group or Policy #: _____
 I.D. #: _____

REFERRAL INFORMATION

Please share with us how you heard about our office...

Sibling(s): _____ Google
 Friend: _____ Website
 Pediatrician/Physician: _____ Facebook
 Dentist/Dental Office: _____ Angie's List
 Insurance: _____ Print Ad (magazine, newspaper, etc.): _____
 School/Daycare: _____ Community Event: _____
 Other: _____

DENTAL HISTORY

DENTAL CONCERNS

What is the primary reason for today's visit? : Cleaning Trauma/Dental Emergency Consult for Decay (Cavities)

Has your child ever been to the dentist? : Yes No (If Yes) Previous/Present Dentist: _____

Date Last Exam: _____ Date Last X-rays: _____

Describe your child: Outgoing Shy Stubborn Anxious Frightened Age appropriate

How would you expect your child to behave in our office? _____

How may we help make this visit a positive experience for your child? _____

DENTAL HABITS

Does your child currently... (Check all that apply)

Suck Thumb/Finger Suck/Bite Lips Bite/Chew Nails Bottle Feed Until what age? _____

Use Pacifier Clench/Grind Teeth Mouth Breather Breast Feed Until what age? _____

HYGIENE ROUTINE

(Check all that apply)

Fluoride Toothpaste Consume Fluoridated Water Brushing by Child: _____/day Brushing by Parent: _____/day

Fluoride Mouthwash Dental Floss: _____/week Snacks between Meals --Type of snacks: _____

MEDICAL HISTORY

Are immunizations current? : Yes No

Child's physician: _____ Phone: _____ Date Last Exam: _____

History of Hospitalizations / Operations / Emergency Room Care / Recent Illnesses (explain): _____

Current Medications: _____

Has your child been diagnosed and/or treated for any of the following? (Check all that apply)

<input type="checkbox"/> Blood Disorder/Anemia	<input type="checkbox"/> Premature/Low Birth Weight	ALLERGIES: <input type="checkbox"/> Medication: _____ <input type="checkbox"/> Food: _____ <input type="checkbox"/> Seasonal <input type="checkbox"/> Hives <input type="checkbox"/> Latex <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Comments/Details: _____ _____ _____
<input type="checkbox"/> Abnormal Bleeding/Hemophilia	<input type="checkbox"/> Asthma/Reactive Airway Disease	
<input type="checkbox"/> Immune Disorder/HIV/AIDS	<input type="checkbox"/> Mental/Cognitive/Social Delay	
<input type="checkbox"/> Cancer/Tumor/Leukemia	<input type="checkbox"/> Congenital Birth Defects	
<input type="checkbox"/> Heart Murmur/Defect/Surgery	<input type="checkbox"/> Cleft Lip/Palate	
<input type="checkbox"/> Epilepsy/Seizures/Convulsions	<input type="checkbox"/> Autism Spectrum	
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> ADD/ADHD	
<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Eating Disorder	
<input type="checkbox"/> Liver Disease/Jaundice/Hepatitis	<input type="checkbox"/> Speech Disorder	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Vision Problems	
<input type="checkbox"/> Stomach/GI Disorders	<input type="checkbox"/> Hearing Problems/Deaf	

I affirm that the above information I have given is correct to the best of my knowledge. It will be held in confidence and it is my responsibility to inform this office of changes in the child's medical status. I authorize the dental staff to perform all necessary dental treatment the patient may need. I understand that Growing Smiles Pediatric Dentistry may use and disclose pertinent health information and dental records to coordinate and manage dental care and related services to one or more health care providers or other dental specialists. I authorize the release of all information necessary to secure benefits such as obtaining reimbursement for services, confirming coverage, bill or collection activities and utilization review. I understand that I am responsible for the full balance of the account regardless of my dental benefits and directly assign Growing Smiles Pediatric Dentistry all insurance payments otherwise payable to me. In case of default, I agree to pay all reasonable costs and fees associated with the collection of the account balance, including but not limited to third party collection fees, court filing fees and attorney fees. I affirm that my signature represents my agreement to all of the terms mentioned above.

SIGNATURE _____ RELATIONSHIP TO CHILD _____ DATE _____

Growing Smiles Pediatric Dentistry, PC

Carisse Corns, DDS

1111 Cumberland Crossing Drive | Valparaiso, IN | phone: (219)286.6148 | www.growingsmilesvalpo.com



ACKNOWLEDGEMENT FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES

(YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT)

I, _____, have received or reviewed a copy of this office’s Notice of Privacy Practices.

Please Print Patient Name _____

Parent/Guardian Signature _____

Date _____

Growing Smiles Pediatric Dentistry may leave protected Health Information (including patient’s name, diagnosis, date of service, financial/account balance) on the following:

- Answering machine/voicemail: Phone Number _____
- Text message: Phone Number _____
- Email for dental appointment: email address: _____
- Other _____

AUTHORIZATION TO RELEASE INFORMATION

This section is used to obtain authorization to release information regarding you and/or your child covered under the Privacy Act to people other than yourself. I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself and/or my child(ren).

Print Name	Relationship	Phone Number
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Print Name	Relationship	Phone Number
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Print Name	Relationship	Phone Number
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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): _____

FINANCIAL POLICY

Our office is committed to providing you with the highest quality dental care using only the best material and technology available. Our Clinical and Business Teams work closely together to provide a positive environment for visits to our office and assistance with financial requirements. A member of our Business Team will be delighted to discuss our options with you!

Payment Due: The full balance of treatment is due at the time services are rendered. For your convenience we accept cash, check, debit card, most major credits cards and CareCredit®.

Financial Responsibility: The individual bringing the child to our office and authorizing treatment is legally responsible for payment of all charges. We cannot send statements to other persons.

Statements: If you have a balance on your account, we will send you a statement in the mail. It will show your previous balance, any new charges, and any payments or credits applied to your account. We are on a 30-day billing cycle.

Past Due Accounts: Unless prior arrangements have been approved in writing by our office, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the due date printed on the statement. *An interest rate of 1.5% per month may be charged on any balance that goes beyond 60 days.* If necessary, accounts that are not paid within ninety (90) days may be referred to a collection agency. If your account is turned over to collections, the responsible party(ies) will be responsible for all cost of collections, including court costs and attorney fees.

Insurance: We are happy to file dental claims for our families who have dental insurance! In general, we will file claims to any company that will pay us directly and does not restrict coverage to a list of participating providers. Filing your insurance is not a guarantee of payment. Please understand that the contract for dental insurance is between you and your insurance company. Any dispute of coverage needs to be handled through the insurance company directly by you. Please understand that the parent or guardian has the final responsibility for payment of any services rendered. Our doctor recommends treatment based on your child's needs, not on what insurance will pay. Therefore, we will do everything possible to maximize your benefits.

Your complete insurance information/card must be presented at the time services are provided and updated as necessary. Accurate and complete insurance information must be provided so we may assist you in filing your claim promptly. Most benefits will be verified before your insurance company can be billed.

In the event that your insurance has not paid your account within 45 days, the balance may be transferred to your account. We reserve the right to discontinue or refuse to file a claim.

We are not in-network with any dental insurance company.

Other Insurances: Some insurance plans will make payments directly to the member. For these instances payment in full will be collected on the day that treatment is provided.

Required Payments: At treatment visits, we collect a percentage of the total cost of treatment, determined by an **ESTIMATION** of what your insurance will cover, plus any deductible required by your insurance. In the event of underpayment, we will send you a statement in the mail. In the event of overpayment on your part, you will be reimbursed by check in the mail.

Divorce/Separation: The parent or guardian who brings the child for their initial visit is responsible for payment independent of what a divorce decree or custody arrangement may state. Reimbursement must be made between the divorced parents. We will not intervene.

Returned Checks: There is a \$35.00 fee for any checks returned by the bank.

CareCredit®: A convenient alternative to credit cards, cash or checks, CareCredit® is a health care card that is exclusively utilized for dental and medical services. They offer flexible payment options that fit your timetable and budget. For additional information, contact us or visit

www.carecredit.com.

Initial: _____

APPOINTMENT POLICY

Children tend to do better in the dental office when they are not tired. Therefore, we encourage morning appointments, especially for pre-school or nervous children. For many children, just a simple filling at the end of a long day, when they are tired, can seem like a major ordeal. Please keep in mind, one of our goals is providing dentistry that is as pleasant as possible for your child. Also keep in mind that a dental appointment is an excused absence from school.

When we schedule an appointment for your child, that time is reserved solely for your child. We do not double book and we take pride in the fact that because we value your time, as much as we hope you value ours, we make every effort to see your child at the time scheduled. For this reason, it is very important that you have your child in the office at the time scheduled. If you are more than 10 minutes late, it may be necessary to reschedule your child's visit.

Cancelling or Rescheduling: To avoid missed appointment charges we request that cancellations are made 48 hours prior to the appointment. In doing so this appointment time may then be made available to another family. A charge of \$50.00 will automatically be placed for two consecutive broken appointments. A broken appointment is considered a "no show" or cancelling an appointment the same day.

Effective Date: Once you have signed this policy, you agree to all the terms and conditions contained herein and the agreement will be in full force and effect.

Initial: _____

I have read the above policies and understand my obligations with Growing Smiles Pediatric Dentistry for my child's dental care. I affirm that my signature represents my agreement to all of the terms mentioned above.

Guardian Print Name: _____

Guardian Signature: _____

Date: _____