Patient Information

Patient/Child: _____ DOB: _____

Patient Nickname/Preferred Name:_____ Age: _____

Gender:_____ SS#:_____

School:_____ County: _____

Home Address:_____

Different mailing address?_____

Mailing address: _____

Who referred you/**how did you hear about us**? _____

Emergency contacts, other than legal parents/guardians (For us to contact in case of emergencies, loss of contact only):

1) _____ Phone(s): _____

2) _____ Phone(s): _____

Care Providers

Pediatrician: _____ Phone: _____

Other physicians, dentists, therapists involved in your child's care:

Name : _____ Phone: _____

Name : _____ Phone: _____

Name : _____ Phone: _____

Legal parent/guardian Information: Birth parent and/or must have legal custody/guardianship

Parent 1: Circle: Mother/Father Step-Mother/Father Legal guardian Other:_____

Name: _____ DOB: _____ SS#: _____

Driver's License #: _____ State of Issue: _____

Address if different from child:_____

Works outside of the home: Yes No Employer: _____

Parent 2: Circle: Mother/Father Step-Mother/Father Legal guardian Other:_____

Name: _____ DOB: _____ SS#: _____

Driver's License #: _____ State of Issue: _____

Address if different from child: _____

Works outside of the home: Yes No Employer: _____

Primary Insurance Information

Dental : _____ Subscriber: _____

Medical: _____ Subscriber: _____

Secondary Insurance Information

Dental : _____ Subscriber: _____

Medical: _____ Subscriber: _____

Clayton Pediatric Dentistry Financial Policy

Thank you for choosing us as your child's dental health care provider. **Our main concern is that they receive the proper and optimal treatments needed to improve and maintain their oral health.** To avoid any possible misunderstandings regarding payments for services rendered, we are providing you with this statement of our financial policy, which applies to all patients that you bring to CPD. If you have any questions or concerns about our payment policies, please do not hesitate to ask.

Payment is due at the time the services are rendered. Cash, checks, and for your convenience, Visa and MasterCard are accepted. An application for our patient financing companies, CareCredit and BeWell are available. We also offer our in-house discounted service plan - Smile Savers – for those without dental insurance. Please understand that:

1. Your insurance policy is a contract between you, your employer and the insurance company. We are not a party to that contract. We have an in-network contract with some insurances.
2. Insurance guidelines change and can be confusing. We offer assistance navigating these but cannot guarantee accuracy or results. For information on your policy benefits and limitations, please contact your insurance company and Human Resource department.
3. <u>All charges are your responsibility, whether your insurance company pays or not.</u> Some services are not covered benefits. Your employer selects coverage, services and how much they pay. Verify your <u>dental</u> coverage prior to your appointments.
4. When an insurance company says they pay 100% or "in full," what they may really mean is they pay 100% of the charge they want to pay the doctor – not the actual fee. This will vary based on in- or out-of network coverage. All benefits will be assigned directly to CPD.
5. We **estimate** charges for you, given all the information we have available. Your insurance company determines what they will pay on your behalf - which may change at any time.
6. Necessary treatment may change once treatment has begun and stopping may jeopardize your child's health. Sometimes there are problems under the surfaces we cannot detect except by opening up the area or treatment becomes more complicated for other reasons.
7. Account balances older than 30 days may be subject to fees and collections. A 1.5% monthly finance charge will be added to your account on unpaid balances. If your account goes to collections, you may incur a 35% collection fee.
8. Accounts are reviewed monthly. Failure to pay as agreed may result in collection proceedings and potential dismissal from our practice.
9. We may not schedule appointments (other than dental emergencies) until the account is paid in full or payment arrangements are in place. With unpaid balances or payment arrangements not met, we will see your child on an emergency basis only.
10. Parents or guardians that accompany minor children are responsible for the charges incurred that day. Guarantors are responsible for balances on the family account.

We understand that temporary financial problems may affect the timely payment of your balance. Please communicate any such problems so that we can gladly work with you. Our aim is to help your child. We want to continue our good relationship while we work through financial concerns.

I have read, understand and agree to this financial policy.

_____ _____ _____

Guarantor Printed name | Signature of Guarantor (Legal parent/guardian | Date

_____ _____

Witness | Date