Dr. Doug's Pediatric Dentistry Registration

PATIENT INFORMATION

Legal First Name:	Legal Last Name:	DOB:	Gender:

RESPONSIBLE PARTY INFORMATION

As the Responsible Party, you are responsible for appointments, updating contact/insurance information, and you agree to pay all fees related to the patient's care.

Our practice management software only allows for one parent/guardian to be listed as Responsible Party for each patient/family. Therefore, we **cannot** accommodate split billing. Such arrangements are the responsibility of the Parents/Guardians. We can provide itemized receipts for services & payments made upon request. Because payment is due ***at the time of service***, payments from multiple parties can be made over the phone before or on the day of service as well.

Relationship to Patient: ☐ Biological Mother ☐ Biological Father ☐ Legal Guardian ☐ Other:	
Name:	
DOB:	
Phone:	If unable to reach me: ☐ You may leave a detailed message ☐ Only leave a message asking me to return your call.
SSN:	
Email:	
Mailing Address:	
City, State, Zip:	
Marital Status:	☐ Single ☐ Married ☐ Divorced ☐ Other:
If Divorced, custody status:	

COMMERCIAL DENTAL INSURANCE

Insurance information must be filled out at time of service, or you will be asked to **pay for your visit in full**. We cannot accept medical insurance.

Policy Holder:	DOB:
SSN(required by most insurances):	
Relationship to Patient:	Phone:
Employer that insurance is provided by:	
Dental Insurance Company:	
Insurance Address:	Insurance Phone:
City/State/Zip:	
Subscriber/Member ID:	Policy/Group #:
*If you have a Primary Medical policy or a Secondary insurance, please see the front desk for an additional insurance form. *	

MEDICAID DENTAL INSURANCE

Patient Name(s) as listed on the Medicaid Card:	Member ID #:

Dr. Doug's Pediatric Dentistry Policies

Insurance

Your coverage is based on a contract between you & your insurance company. It is your responsibility to know what your insurance covers. We do not determine the quality of care we provide based on insurance coverage.

- You are responsible for providing current insurance information, including a card, at the time of your appointment.
- All quotes given by our office for Restorative treatment are **estimates**. Please contact your insurance company directly for exact coverage details, including deductibles, copays, limitations, exclusions, frequencies, etc. **Fees estimated not to be covered by insurance will be due in full at the time of service.**
- As a courtesy we will file claims on your behalf. However, **if we do not receive payment from your insurance company within 60 days of submission, the claim(s) will be closed, and you will be billed the full amount.**

Adult Supervision: All patients must be accompanied by an adult. Per Utah law, minor children cannot give consent for medical/dental procedures including routine cleanings/exams. Consent for treatment must be given to our office no more than 48 hours before treatment is rendered. If you plan to have someone else bring them to an appointment, you will need to call our office to give verbal consent, or we will have to reschedule. The person accompanying your child will not be allowed in the exam room unless you have given written consent. *See the HIPPA Authorization form for more details.

Missed Appointments: Arriving more than 10 minutes late will be considered a missed appointment. We require 24-hour notice to cancel, otherwise a fee will be charged for the following types of appointments: Cleaning/Exam: $15.00; Treatment procedure: $50.00; Sedation: $100.00; Surgery @ Logan Regional Hospital: $200.00. Our office will not be able to reschedule any appointments until missed appointment fees are paid in full. Excessive missed appointments could result in dismissal from our office.

'Standard of Care' for Routine 6 Month Cleanings: Our office provides every patient the same Standard of Care recommended by the American Dental Association. *Your insurance may not cover these services at the same frequency as the ADA recommends.* **Any services not covered are your responsibility**.

Financial Policy: In consideration for the professional services to be rendered to me, or at my request, to my minor child or ward by the dentist, I agree to pay the fees charges for the dental services provided to the dentist or his/her assignee at the time the services are rendered, or within (5) days of billing if credit should be extended. I agree to pay the remaining balance along with a collection agency commission. Should your account be turned over for collection, the undersigned agrees to pay all costs to collect the debt, including, but not limited to, interest in the amount of 18% per annum, attorney's fees, court costs, and collection fees in the amount of 40%. The obligation to pay the collection fees shall be imposed at the time of assignment of the debt to a third-party debt collection agency. *The undersigned certifies that he/she has read and understands the foregoing disclosure.*

Wireless Communication & Consent: By Providing Dr. Doug's Pediatric Dentistry (Dr. Doug's) with a phone # and/or email address, you, or anyone authorized to act on your behalf, are providing express consent authorizing Dr. Doug's to contact you at any phone # or email you provide at any time with information related to your account via phone, text (SMS/MMS) message, or email. You also confirm that you will notify Dr. Doug's immediately if you no longer own or are no longer authorized to use any phone number or email address you provide to Dr. Doug's. If you'd like a copy of our full Communication & Consent policy, please ask at the front desk.

Your Rights Regarding Your Health Information: A copy of your privacy rights is available at the counter. If you would like a copy to take with you, please ask and we would be happy to get you a copy. I acknowledge that I have been offered or received a copy of Dr. Doug's Notice of Privacy Practices. **I give consent for this patient to receive treatment in an oral exam today and any possible treatment that might be proposed in the future by the office of Dr. Doug's Pediatric Dentistry. I give consent for the use and disclosure of any protected health information that may be used to carry out treatment, payment activities, and healthcare operations. I have read and understand all the above information.**

Responsible Party Name (please print): _____

Children's names: _____

_____

Signature:_____ Date: ____ /_____ /_____