Seastar
pediatric dentistry

Last Name:
First Name:
Date of Birth:
Age:
Birth Gender: Preferred Pronoun:
Date:

New Patient Paperwork

Patient Information

Child's Primary Language:_____ Child's Secondary Language:_____

In the event of an emergency, whom shall we contact?
Name: _____ Relationship:_____ Phone:_____

How were you referred to our office?

☐Facebook ☐Yelp ☐Sign ☐ Insurance ☐Other Doctor (Specify)_____
☐Another Patient (Specify)_____

Dental Insurance Information

Name of Subscriber: _____ DOB of Subscriber:_____
Insurance Type: _____ ID Number: _____
Group Number: _____ Company Name: _____

Parent/Guardian Information

Name: _____ Relationship:_____ SSN:_____
Employer:_____ DOB:_____
Home Address:_____ City: _____ Zip Code:_____
Home Phone: _____ Cell Phone: _____
Email Address: _____ Preferred Method of Contact: Email Text to Cell Phone Call

Patient Dental History

Reason for Dental Visit
☐Check Up/Cleaning ☐Cavities ☐Mouth Injury ☐Tooth Pain ☐ Oral Habits ☐Other: _____

Last Dental Visit: _____ Reason:_____ Dentist Name:_____
Reason for Leaving:_____

Patient Medical History

Primary Care Physician/Pediatrician Name: _____ Phone: _____

Has your child ever or does he/she currently:

☐Take Medications Explain:_____

☐Been Hospitalized Explain:_____

☐Had Surgery Explain:_____

☐Have Allergies Explain:_____

Has your child ever or does he/she currently have a history of:

☐ NONE	☐ Cancer	☐ Gastric Reflux	☐ Pregnancy
☐ Anemia	☐ Cerebral Palsy	☐ Heart Disease	☐ Premature Birth
☐ Asthma	☐ Convulsions	☐ Hearing Problems	☐ Problems with Anesthesia
☐ Autism Spectrum	☐ Developmental Delay	☐ Heart Murmur	☐ Prolonged Bleeding
☐ ADHD/ADD	☐ Diabetes	☐ Hepatitis/Liver Disease	☐ Rheumatic Fever
☐ AIDS/HIV	☐ Down Syndrome	☐ High/Low Blood Pressure	☐ Seasonal Allergies
☐ Birth Defect	☐ Epilepsy	☐ Kidney Disease	☐ Tuberculosis
☐ Blood Disorder	☐ Ear/Eye/Nose Trouble	☐ Lung Disease	☐ Thyroid Disease

Others:_____

Comments: _____

ACKNOLWEDGEMENT OF PATIENT INFORMATION / AUTHORIZATION FOR INITIAL EVALUATION

The information I have given is correct to the best of my knowledge. I understand that all information is confidential, and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services for my child for an initial evaluation. Any other dental services required will be explained and authorized by me after the initial visit.

DELEGATION OF POWER BY PARENT OR GUARDIAN

I give my consent to allow person(s) named below other than myself to accompany and oversee my child for appointments, to release healthcare information for the appointment or to secure payment for dental services. I understand I can revoke this consent at any time by providing written notice.
Persons who have consent in my absence are: _____

_____

I confirm that I have read and fully understand the above.

Patient/Relative or Guardian* _____ _____

Signature Print Name

Relationship (if signed by person other than patient): _____

*Signature of the patient must be obtained unless the patient is unemancipated minor under the age of 18 or is otherwise incompetent to sign

Seastar pediatric dentistry

Patient Name

DOB

NOTICE OF OFFICE PRACTICES

Our practice is fully committed to providing you with an excellent dental experience and the best possible care we are able to render. We are open and available to discuss our professional fees with you at any time. Your clear understanding and acceptance of our financial policies is important to us and important to establishing a sound professional relationship.

VERIFYING INSURANCE

As a courtesy to you, we will verify your insurance benefits prior to your new patient appointment, as well as any time you notify us of an insurance change thereafter. The insurance companies do not guarantee payment based on the information you tell us, therefore you are responsible for knowing of any required waiting periods. Any amounts on your treatment plans that are not covered are your financial responsibility.

PAYMENT

Payment is due at the time the service is rendered. The adult accompanying the child is responsible for payment at the time of the appointment. Additionally, if you have a balance following an insurance payment from a previous visit, you will be expected to pay that amount in full as well.
During treatment it may be necessary to change or add procedures due to conditions found while working on your teeth.
Payment for services rendered will be due at the time of service. The insurance portion of the treatment plan is an estimate and not a guarantee of coverage. Your estimated portion will be due at the time of service. If your insurance carrier pays less than the anticipated amount, you will be responsible for the unpaid balance.
I understand that I am responsible for any unpaid balance for the procedures that are performed.
I authorize the dentist or qualified assignee to perform the work described above and to make any necessary changes or additions thereto.

CHANGES IN PERSONAL INFORMATION

Any changes to your personal information or contact information should be given to our office immediately.

PAYMENT PLANS

Will be determined on an individual basis

BALANCES

If your account balance exceeds 60 days, you will receive a notice informing you that your account is overdue. If you do not pay your balance or arrange a payment plan within 10 days, your account will be turned over to a collections agency. If this happens, a collection fee will be added to your balance. The collections agency will report any unpaid balances to the credit agencies.

RETURNED CHECKS

There will be a $30 fee for all returned checks. The amount of the check plus the fee must be paid within 10 days of notification by money order, cash, credit card, or your check will be turned over to the appropriate authorities. Once a check has been returned, the office can no longer accept personal checks for payment.

CANCELATIONS/FAILED APPOINTMENTS

We request 24 hour notice if you are canceling an appointment. In case of a cancelation without 24 hour notice, or failed appointment, there will be a $50 fee. The fee will be posted to your account and additional appointments will not be made until the balance is settled. If your child misses 3 visits (<24 hour cancel or no show), this is grounds for dismissal from the practice.

INSURANCE

I certify that my child is covered by insurance and benefits are assigned to the office. I understand that I am financially responsible for all charges not covered by dental insurance. I hereby authorize the office to release all necessary information to secure payment of benefits. I authorize the use of this signature on all insurance submissions.
We bill your insurance as a courtesy to you. It is YOUR responsibility to be familiar with your plan coverage, limitations and copays, etc. We advise that you follow-up with your insurance carrier on any claims unpaid after 60 days from date of service. CLAIMS THAT ARE NOT PAID FOLLOWING 90 DAYS FROM DATE OF SERVICE will become patient responsibility for payment AT TIME OF VISIT.

I confirm that I have read and fully understand the above.

Patient/Relative or Guardian* _____ _____

Signature Print Name

Relationship (if signed by person other than patient): _____

*Signature of the patient must be obtained unless the patient is unemancipated minor under the age of 18 or is otherwise incompetent to sign

Seastar
pediatric dentistry

Patient Name

DOB

CONSENT FOR OUTPATIENT TREATMENT ASSIGNMENT OF BENEFITS

AUTHORIZATION

I hereby authorize the dentists and other health care professionals to provide such health care and to administer such treatment as deemed necessary or advisable to me of the named patient each time I or the named patient present to the office. To the extent possible I have been informed or risks and complications that may occur and alternatives that may be available.

I acknowledge that no guarantees or assurances have been made to me concerning the results intended from my treatment.

MEDICARE/MEDICAID PATIENTS

I authorize any holder of medical or other information about me to release to Social Security Administration or its intermediaries or carries any information needed for this or a related Medicare/Medicaid claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

GUARANTEE OF ACCOUNT

For and in consideration of service rendered to (patient name) _____ by the office, I hereby agree to pay the full bill for all charges which are not covered by the insurance, or any balance due which is not covered by insurance or excluded by a co-insurance clause.

RELEASE OF INFORMATION

I permit the office to disclose all or part of the above patient's medical record to any person, corporation, or agency when required for the collection of benefits or payment of hospital charges.

ASSIGNMENT OF BENEFITS

I assign to the office all benefits from any corporation, agencies, and person for these services. Additionally, I authorize payments of these benefits directly to the office.

I confirm that I have read and fully understand the above.

Patient/Relative or Guardian* _____ _____

Signature Print Name

Relationship (if signed by person other than patient): _____

*Signature of the patient must be obtained unless the patient is unemancipated minor under the age of 18 or is otherwise incompetent to sign

Seastar
pediatric dentistry

Patient Name

DOB

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of this office's Notice on Privacy Practices.

I confirm that I have read and fully understand the above.

Patient/Relative or Guardian* _____ _____

Signature Print Name

Relationship (if signed by person other than patient): _____

*Signature of the patient must be obtained unless the patient is unemancipated minor under the age of 18 or is otherwise incompetent to sign

Seastar
pediatric dentistry

Patient Name

DOB

Authorization For Use Or Disclosure Of Patient Photographic and/or Video Images

Authorization:
I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by the practice listed below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

Purpose:
The photographic/video images, and/or testimonial will be used for: *Social Media and/or Advertising, or Teaching*

Revocability:
I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice via registered mail. Revocation affects disclosure moving forward and is not retroactive. This authorization expires 99 years from date signed.

No Treatment Conditions:
I understand that the practice cannot condition treatment on whether or not I sign this authorization.

If desired, copy provided:
◯ *"Yes, I would like a copy of this form."*
(initialed by team member, copy provided by _____)

Practice Name: _____

Patient Name: _____

Date: _____

Signature: _____

If Personal Representative

Name: _____

Date: _____

Signature: _____

Relationship to Patient: _____

If Patient is a Minor

Parent / Legal Guardian: _____

Date: _____

Signature: _____

Form provided courtesy of:
MySocialPractice