On the Cusp Pediatric Dentistry New Patient Paperwork

Welcome! Please fill out the necessary paperwork provided. It is our pleasure to serve you and your family.

If for any reason you have questions or concerns, feel free to call us at

918.970.4944 or email contact@onthecuspdds.com

Health History

Patient Information

Name (First) _____ (M.I.) _____ (Last) _____

Sex: (circle one) Male or Female Age _____ Date of Birth (xx/xx/xxxx) _____

Parent/ Legal Guardian Information

1. Parent/Guardian: (circle one) Mother / Father / other _____

Name (First) _____ (M.I.) _____ (Last) _____

Employer: _____

2. Parent/Guardian: (circle one) Mother / Father / other _____

Name (First) _____ (M.I.) _____ (Last) _____

Employer: _____

Family Information

Home Mailing Address _____

City _____State _____ Zip _____

Home phone _____ Work phone _____ Cell Phone _____

Email _____

Primary Insurance Information

Name of insured

_____

Date of birth (xx/xx/xxxx)_____

SSN _____

Dental Insurance Name

_____

Group/Policy #

_____

Insurance phone #

_____

Secondary Insurance Information

Name of insured

_____

Date of birth (xx/xx/xxxx)_____

SSN _____

Dental Insurance Name

_____

Group/Policy #

_____

Insurance phone #

_____

Patient Full Name: _____

Dental History

Date of last dental visit _____

Reason for current visit

_____

Current Dental Concerns/problems:

_____

_____

Medical History

Child's Physician_____ Phone _____

Date of last physician exam _____

Are your child's immunizations up to date? (Circle one) YES or NO

Medical Conditions / Current medication list:

_____

_____

Previous Hospitalizations/Surgeries with dates:

_____

_____

Allergies: (Specify reaction to allergen, if known)

_____

Has a physician recommended your child take antibiotics prior to dental treatment? (Circle one) YES or NO

***HOW DID YOU FIND OUT ABOUT US? *** IF IT WAS A FRIEND OR DOCTOR, PLEASE LIST THEM SO WE CAN THANK THEM.

_____

Please check at least ONE below:

_____ I am requesting an EMAILED version of your Privacy Practices, Forms of Dental Treatment, and Bill of Rights & Responsibilities.

_____ I am requesting a PAPER COPY of your Privacy Practices, Forms of Dental Treatment, and Bill of Rights & Responsibilities.

Patient Full Name: _____

Acknowledgement of Office Policies

FINANCIAL POLICY

On The Cusp Pediatric Dentistry is a fee-for-service office. This means that payments for services are due and appreciated the day the services are performed. We offer a variety of payment options. We accept cash, checks, or credit cards (Visa, MasterCard, American Express, and Discover). We also offer payment plans through Care Credit. **Please be advised that the parent/guardian who brings the child to our office is legally responsible for payment of all charges.**

INSURANCE INFORMATION

On The Cusp Pediatric Dentistry accepts most insurance plans and will accept payments from these plans directly. **The ESTIMATED out-of-pocket expense will be due the day services are performed**. The remaining balance, if any will be billed after we have filed your insurance. However, some plans only reimburse the patient. In this case payment is due and appreciated the day services are performed.

Please take time to read and understand your dental plan. Your plan is a contract between you and your employer. Your employer determines what benefits will be paid based on the policy they choose to offer. **Be aware that no plan pays 100% of benefits**. Most plans pay an average of 50-75% for any given procedure. Some procedures may not be covered by your plan. If treatment is needed a detailed treatment plan with associated costs and estimated insurance benefits will be presented by one of our Doctors and our financial coordinator.

APPOINTMENTS

The patient has a responsibility to arrive on time for scheduled appointments. The patient will be considered late when they arrive 10 minutes after their scheduled appointment time and may be asked to reschedule for a later date. Patients with multiple late arrivals may be dismissed from the practice and asked to find another dental provider.

The patient has a responsibility to keep appointments and when unable to do so, to notify the dental office within 48 hours. Any appointments that are canceled or rescheduled with less than 48-hour notice will be considered as a NO SHOW. **The patient is allowed 2 NO SHOWS**. After this, the patient will be asked to find another dental provider.

****Parent/Guardian INITIALS: _____**

Authorization and Release

As the legal guardian of my child, I hereby agree that all questions on this form were accurately understood and answered to the best of my knowledge. I understand that if any health information is withheld, my child's health status could be at risk. It is my responsibility to report any medical changes to On the Cusp Pediatric Dentistry. I authorize the dentist and/or office employees to release any information including the diagnoses and records of any treatment or examination rendered to my child to third party payers and or/ other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefit. Otherwise, all payments are payable to me. **I understand that my dental insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my behalf or my dependents.**

****Parent/Guardian INITIALS: _____**

Consent For Dental Treatment

I have read and understand that On the Cusp Pediatric Dentistry may provide any/all of the 12 dental treatments described on our Forms of Treatment list.

(A new copy can be requested at our front desk or at onthecuspdds.com/NPforms)

****Parent/Guardian INITIALS: _____**

Bill of Rights & Responsibilities

I have read and understand my rights as a patient and On the Cusp Pediatric Dentistry's rights as a dental practice stated in the document: Bill of Rights & Responsibility.

(A new copy can be requested at our front desk or at onthecuspdds.com/NPforms)

****Parent/Guardian INITIALS: _____**

Patient Full Name: _____

By signing below I, the legal parent/guardian agree to inform Dr. Roberts, Dr. Orynich, or Dr. Bonner of any questions about the treatment(s) recommended for your child. They will be happy to address any and all concerns you might have.

I have been informed of the treatment options/explanations and give my consent to the treatment necessary to improve the dental health of my child.

I have received, read, and agree to follow all sections initialed in this document, including, but not limited too:

Acknowledgement of office policies
Authorization and release
Consent for dental treatment
Patient bill of rights and responsibilities

Parent/Guardian

(Print) _____

(Signature): _____

Date: _____

Acknowledgement of Receipt of Privacy Practices

You may refuse to sign this acknowledgement

I am acknowledging I have received an____emailed or ____paper copy of On the Cusp Pediatric Dentistry's Notice of Privacy Practices.

(A new copy can be requested at our front desk or at onthecuspdds.com/NPforms)

Parent/Guardian SIGNATURE: _____ DATE: _____

*****For Office Use Only*****

We attempted to obtain written acknowledgement of receipt of On the Cusp Pediatric Dentistry's Notice of Privacy Practices, but acknowledgement could not be obtained because:

____ Individual refused to sign

____ Communication barriers prohibited obtaining the acknowledgement

____ An emergency situation prevented us from obtaining acknowledgement

____Other (please specify):

_____