on the cusp
PEDIATRIC DENTISTRY & ORTHODONTICS

NEW PATIENT PAPERWORK

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

How did you find out about us?
If It was a friend or doctor, please list them so we can thank them. Be as specific as possible.

_____

HEALTH HISTORY

PATIENT INFORMATION

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

SEX (Circle one) Male or Female **AGE** _____ **DATE OF BIRTH** (xx/xx/xxxx) _____

BIOLOGICAL PARENT/ LEGAL GUARDIAN INFORMATION

By law, we cannot treat your child unless you are the biological parent/legal guardian or we have proper documents on file.

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

Please include the address of the responsible party of the bill.

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 (Print) _____

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 _____

Does your child snore? (Circle one) YES or NO

Does your child mainly breathe through mouth? (Circle one) YES or NO

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

MEDICAL CONDITIONS / CURRENT MEDICATIONS

_____

PREVIOUS HOSPITALIZATIONS/SURGERIES/EMERGENCY ROOM VISITS WITH DATES

_____

_____

FOR DOCTOR USE ONLY

DOCTOR INITIALS

COMMENTS

ALLERGIES: (Specify reaction to allergen, if known)

_____

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

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.

MINOR CONSENT FORM

I, _____ (Parent/Legal Guardian),

Hereby authorize _____ the responsible relative or person, my legal consent to provide authorization to proceed with dental evaluations, and exams for minor child _____ (Print Minor's Full Name). This consent is given by me/us as parent(s) and/or guardian of said child. It is clearly understood that you are hereby fully released from any claims and demands that might arise, or be incident to the evaluation and/or treatment, provided that your duties are performed with standard care and responsibility to the best of your professional ability. I also realize the responsible party who brings the minor to our office is legally responsible for payment of all charges.

PARENT/GUARDIAN

PRINT _____

SIGNATURE _____

DATE _____

PATIENT FULL NAME (Print) _____

X-RAY CONSENT

The use of dental radiographs, or x-rays, allows the doctor to detect dental problems early before serious damage is done to your child's teeth, gums, and supporting bones and structures. If these conditions are not detected until there are visible or painful signs of disease, your child's oral health can be seriously affected. Dental xrays are a part of a comprehensive dental oral examination. Your insurance might not cover the x-rays.

Please indicate which you would like us to do:

_____ I have x-rays that were taken within 12 months and I have brought them with me or had them emailed to **xray@onthecuspdds.com.**

_____ You can take new x-rays, which may or may not be covered with my insurance; however, I know I am responsible to pay for the x-rays if my insurance company does not pay for the x-rays.

_____ I do not want x-rays taken today. I understand that the dentist will not be able to do a full exam.**

*** By checking this box, I release On the Cusp Pediatric Dentistry, PLLC from any responsibility for any condition, which may be present in my child's mouth that remains undiagnosed as a result of my request that no dental radiographs be taken.*

PARENT/GUARDIAN INITIALS _____

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, and Discover). We also offer payment plans through Care Credit, !Care, and the Lending Club. 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 _____

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 _____

CONSENT FOR DENTAL TREATMENT

I have read and understand that On the Cusp Pediatric Dentistry may provide any/all of the 13 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 _____

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 _____

By signing below I, the biological parent or legal guardian agree to inform Dr. Roberts, Dr. Orynich, or Dr. Taliaferro 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 understand my child's treatment plan is valid for 90 days. After 90 Days, the patient will require a new treatment plan.

I have received, read, and agree to all sections initialed in this document, including, but not limited to:
X-RAY CONSENT
ACKNOWLEDGEMENT OF OFFICE POLICIES
PATIENT BILL OF RIGHTS AND RESPONSIBILITIES
CONSENT FOR DENTAL TREATMENT
AUTHORIZATION AND RELEASE

BIOLOGICAL PARENT/LEGAL GUARDIAN

PRINT _____

SIGNATURE _____ **DATE** _____

IF APPLICABLE:

CONTACT NAME & PHONE NUMBER FOR CASE WORKER

_____

PATIENT FULL NAME (Print) _____

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA 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): _____