Alligator Pediatric Dentistry

Alligator Pediatric Dentistry
3365 S. Holmes Ave
Idaho Falls, Idaho 83404
(208) 542-1333
www.alligatordentist.com

Your Child

Please fill out all the information to the best of your knowledge. All answers will be kept confidential. If you have any questions, please ask us, and we'll be happy to assist you.	Date (mm/dd/yyyy):	Patient #:

Patient Information

First Name:	Middle Name:	Last Name:	I prefer to be called:

Sex:	Age:	Date of Birth (mm/dd/yyyy):	Home Phone:	School:	Grade:

Home Address:	Social Security #:	City:	State:	ZIP Code:

Please tell us where you heard about us (check all that apply):

- ☐ Friend or Relative (name):
- ☐ Search Engine (Google, etc.)
- ☐ Our Website
- ☐ Other Website:
- ☐ TV Ad
- ☐ Ad in Mail
- ☐ Saw Our Office
- ☐ Other:
- ☐ Insurance Company
- ☐ Newspaper Ad
- ☐ Radio Ad

Was our website a factor in your decision to visit our practice? ○ Yes ○ No

Emergency Contact

This should be the nearest relative who does not live with the patient.

Title:	First Name:	Last Name:	Relationship to Patient:

Home Phone:	Work Phone:	Cell Phone:	Email Address:

Emergency Contact Address:	City:	State:	ZIP Code:

Person Responsible for Account

Title:	First Name:	Last Name:	Relationship to Patient:

Date of Birth (mm/dd/yyyy):	Social Security #:	Drivers License #:

Home Phone:	Work Phone:	Cell Phone:	Email Address:

Person Responsible Address:	City:	State:	ZIP Code:

Who is Responsible for Making Appointments:

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Parent or Guardian Information

☐ Mother ☐ Stepmother ☐ Guardian

Title:	First Name:	Last Name:	Email Address:

Employer:	Occupation:

Home Phone:	Work Phone:	Cell Phone:	Social Security #:	Date of Birth:

Marital Status: ○ Single ○ Married ○ Separated ○ Divorced ○ Widowed

Parent or Guardian Information

☐ Father ☐ Stepfather ☐ Guardian

Title:	First Name:	Last Name:	Email Address:

Employer:	Occupation:

Home Phone:	Work Phone:	Cell Phone:	Social Security #:	Date of Birth :

Marital Status: ○ Single ○ Married ○ Separated ○ Divorced ○ Widowed

Dental Insurance Information

Primary Dental Insurance

Insurance Holder's Name:	Date of Birth (mm/dd/yyyy):	Ins. Holder Social Security #:	Relationship to Patient:

Employer:	Occupation:	Date Employed (mm/yyyy):

Insurance Company Name:	Insurance ID#:	Group #:

Insurance Company Address:	City:	State:	ZIP Code:

Deductible:	Copay:	Amount Already Used:	Max. Annual Benefit:

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Secondary Dental Insurance

Insurance Holder's Name:	Date of Birth (mm/dd/yyyy):	Ins. Holder Social Security #:	Relationship to Patient:

Employer:	Occupation:	Date Employed (mm/yyyy):

Insurance Company Name:	Group #:	Employee #:

Insurance Company Address:	City:	State:	ZIP Code:

Deductible:	Copay:	Amount Already Used:	Max. Annual Benefit:

Authorization

All of the above information is correct to the best of my knowledge. I authorize use of this form on all my insurance submissions and I authorize the release of information to all my insurance companies. I understand that I am responsible for my bill. I authorize Randy Smith and Mark Marlowe Pediatric Dentistry to act as my agent in helping me to obtain payment from my insurance companies. I authorize payment to Randy Smith and Mark Marlowe Pediatric Dentistry. I permit a copy of this authorization to be used in place of the original. I give Randy Smith and Mark Marlowe Pediatric Dentistry, its employees, and/or other agents express prior consent to contact me at any/all phone numbers, including cell numbers (by phone call or text message) and email addresses, for the purpose of treatment, insurance, or payment.

Signature (type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy):

Consent for Treatment

Patient Name:

• I hereby authorize the doctor or designated staff to take X-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the dental needs of the above-named patient.
• Upon such diagnosis, I authorize the doctor or designated staff to perform all recommended treatment mutually agreed upon by us and to employ such assistance as required to provide proper care.
• I agree to the use of anesthetics, sedatives, and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
•I have read, understood, and agree to the above treatment policy.

Signature (type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy):

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Please list any previous hospitalizations/surgeries/serious illnesses, other serious medical conditions, impending operations, or other medical/dental information with correlating dates that may possibly affect your child's dental treament:

HIPAA Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (a.k.a. HIPAA or The Healthcare Privacy Act). I understand that by signing this consent, I authorize Randy Smith and Mark Marlowe Pediatric Dentistry to use and/or disclose my protected health information to carry out the following:

- **Treatment which includes direct and/or indirect treatment by other healthcare providers involved in my treatment.**
- **Obtaining payment from third party payers, i.e. my dental and/or medical insurance company/companies.**
- **The day to day healthcare operations of your dental practice.**

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected personal health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may request the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to use these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent will not be affected.

Signature (type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy):

If signing on behalf of someone, explain your relationship to the patient:

For Office Use Only

Patient refused or was unable to sign. Good faith effort was made to obtain acknowledgement of receipt.

The following circumstances prohibited the patient from signing the consent form:

Describe your good faith effort to obtain the individual's signature on the form:

Office Personnel Signature:	Office Personnel Name:	Office Personnel Title:	Date (mm/dd/yyyy):

Dentists Review:

Signature of Dentist:	Date (mm/dd/yyyy):

RANDY SMITH AND MARK MARLOWE PEDIATRIC DENTISTRY
FINANCIAL POLICY

Thank you for choosing us as your Dental Care Provider. We are fully committed to your needs, and want you to have a successful experience while in our office. Please understand that payment of your bill is considered part of your treatment, and that responsibility is ultimately yours as a parent/guardian.

We do not offer in house financing, and in order to avoid collections, all accounts must be paid in full within 90 days.

- **INSURANCE:** We will file your insurance as a service to you and will do our very best to maximize your benefits. All Co-pays, Deductibles and Portions are to be paid at the time of service. Your insurance policy is a contract between you and your Insurance company. We are NOT a party to that contract. Our fees generally, but not necessarily, fall within the usual and customary fee structure determined by your carrier. Not all dental services are a covered benefit in all contracts. If we do accept assignment of benefits, we require that you be pre-approved on one our extended payment plans: *Chase Health Advance℠ by Chase, and/or CareCredit™ by GE Money Bank.* You are responsible for full payment regardless of any insurance company's determination of usual and customary rates. We reserve the right to collect full payment at the time of service even if you have insurance in force.

- **PAYMENT IN FULL:** We offer a discount to those who wish to pay in full on the date of service. ***If you DO have insurance, we can give you our discount, but you will be required to file your own insurance.*** A 5% discount applies for balances under $1000.00, and a 10% discount for balances over $1000.00. We accept CASH, VISA/MASTERCARD/DISCOVER and AMERICAN EXPRESS.

- **EXTENDED PAYMENT PLANS:** We do not offer credit terms directly, but we have entered into an agreement with *Chase Health Advance℠ by Chase and/or CareCredit™ by GE Money Bank,* to provide these kinds of services to our patients. Application is quick and easy and can be made by phone call, or if you prefer, can be applied for on-line. Approval is typically granted immediately. There are a variety of options with each plan, and we can provide you with the information necessary specific to your needs. These plans can even offer up to **12 months interest and fee free!**

- **MISSED APPOINTMENTS:** Unless canceled 24 hours in advance, our policy is to charge for missed appointments at the rate of $35.00 per appointment and/or $50.00 per family. If more than THREE appointments are missed, we have the right to dismiss you as a patient.

- **RETURNED CHECKS:** If your check is returned to us for NSF, a $25.00 service charge will be applied to your account.

- **MINOR PATIENTS:** The adult presenting a minor for treatment is responsible for FULL payment at the time of service, regardless of their relation to that patient. For unaccompanied minors, non-emergency treatment may be denied unless charges have been pre-authorized to an approved credit plan, credit card, or by cash.

These financial options should meet the needs of most families in our practice. We do our best to work with you to assist in the best financial solution to your particular situation. Please just ask us, we are here to help you. Thank you, and let us know if you have any questions or concerns.

I understand and agree to this Financial Policy

X____ Date_______________

Signature of Patient or Responsible Party