Clear Form

DEMOGRAPHIC INFORMATION

1 Child's Name________________________ Birthdate ____________

Child's Name________________________ Birthdate ____________

Child's Name________________________ Birthdate ____________

Child's Name________________________ Birthdate ____________

Child's Name________________________ Birthdate ____________

Address ________________________City, State, Zip ____________________

2 Guardian #1________________________

Address ________________________
Check if Same

City, State, Zip________________________

Primary Phone ______________ (h) (c) (w)

Alternate Phone ______________ (h) (c) (w)

Email ________________________

SSN________________________

Employer Name________________________

Employer Address ________________________

Employer Phone________________________

3 Guardian#2________________________

Address ________________________
Check if Same

City,State, Zip________________________

Primary Phone ______________ (h) (c) (w)

Alternate Phone ______________ (h) (c) (w)

Email________________________

SSN ________________________

Employer Name________________________

Employer Address________________________

Employer Phone ________________________

4 Whom may we thank for referring you?________________________

5 Who is responsible for the account?:________________________

Primary Dental Insurance ________________________ Ins. Phone______________

Ins. Address ________________________ Group # ______________

Name of Policy Holder ______________ DOB: ______________ Subscriber ID ______________

Secondary Dental Insurance ________________________ Ins. Phone:______________

Ins Address ________________________Group # ______________

Name of Policy Holder ______________DOB: ______________ Subscriber ID______________

TREATMENT CONSENT

6 I hereby give my authorization as a parent (or guardian) to Amy Adair, DMD, PLLC for the completion of all agreed upon dental services for my child, including the use of local anesthetic and/or nitrous oxide sedation. I agree to assume responsibility for fees associated with those procedures. I am aware there is a returned check fee of $25, and the balance on accounts greater than 30 days may be subject to finance charges.

Signature: ________________________ **Relationship to Patient:** ______________

Print Name:________________________ **Date:** ______________

7 You may designate another family member or adult to bring your child to subsequent dental appointments. ***However***, we reserve the right to contact the child's legal guardian prior to any appointment or treatment. Failure to reach a legal guardian may result in rescheduling.

Name: ________________________ Relationship: ______________

Name: ________________________ Relationship: ______________

OFFICE POLICIES

Please check the box on each line and sign where indicated

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_______**APPOINTMENT/CANCELLATION POLICY**

Patients are seen by appointment only. Please arrive at least 5 minutes prior to scheduled appointments. If you are more than 10 minutes late, we will try to fit you into the schedule, or you may be asked to reschedule out of courtesy to other patients. Please provide at least 24 hours notice if you must cancel or reschedule an appointment. Failure to provide advanced notice or failure to show up to your appointment may result in an appointment failure fee and/or restricted future scheduling.

_______**FINANCIAL POLICY**

The following payment methods are available: Cash, Check, ACH transactions, MasterCard, Visa, American Express

Participating Insurance (PPO's only): United Concordia, MetLife, Delta Dental, United Healthcare Benefits, Aetna

If you have a participating insurance, you will be responsible for the portion of charges that your insurance plan does not cover. We will submit the insurance claim on your behalf. If a balance remains on your account after the insurance company processes your claim, the balance will be due immediately.

Non-Participating Insurance: Payment is due in full at the time of service.

PLEASE NOTE: THE BALANCE OF YOUR ACCOUNT IS DUE IMMEDIATELY UPON THE PAYMENT OR DENIAL OF YOUR CLAIM. REGARDLESS OF YOUR INSURANCE STATUS, YOU ARE ULTIMATELY RESPONSIBLE FOR THE BALANCE OF YOUR ACCOUNT FOR WHICH ANY PROFESSIONAL SERVICES ARE RENDERED. NOT ALL SERVICES ARE A COVERED BENEFIT IN ALL INSURANCE CONTRACTS. IT IS YOUR RESPONSIBILITY TO KNOW YOUR INSURANCE COVERAGE. PLEASE READ YOUR POLICY GUIDELINES AND COME PREPARED. WE UNDERSTAND THAT TEMPORARY FINANCIAL PROBLEMS MAY AFFECT TIMELY PAYMENT OF YOUR ACCOUNT. IF SUCH PROBLEMS DO ARISE, WE ENCOURAGE YOU TO CONTACT US PROMPTLY FOR ASSISTANCE IN THE MANAGEMENT OF YOUR ACCOUNT.

I agree to pay all costs of collection and attorney fees. **I also understand that dental appointments will be limited to emergency appointments only for any account greater than 90 days past due.**

_______**CELL PHONE/MEDIA DEVICES POLICY** In accordance with HIPAA laws and to protect the privacy of your child, other patients, and our staff, cell phone or any other media device is strictly prohibited in treatment areas.

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I have read and understand the terms and conditions set forth above and agree to the terms and conditions therein. I further understand that failure to comply with these and any other policies of the office of Amy Adair, DMD, PLLC may result in termination of dental services.

Signature:_______________________ **Relationship to Patient:**_______________________

Print Name: _______________________ **Date:**_______________________

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HIPAA ACKNOWLEDGEMENT FORM

I acknowledge that I have received and reviewed the Notice of Privacy Practices for the office of Amy Adair, DMD, PLLC.

YES NO

You may leave Protected Health Information on my answering machine/voicemail. Phone:_______________________

You may send me a text message (unencrypted) for dental appointments: Phone: _______________________

You may email me (unencrypted) for dental appointments: Email address: _______________________

Signature _______________________ **Relationship to Patient:**_______________________

Print Name: _______________________ **Date:**_______________________

(*For office use only)* In the event that you do not agree to sign this form, our office must indicate the reason why you declined .

Reason for parent/guardian refusal: _______________________

Privacy Official's Signature _______________________ Date _______________________