

**New Patient Medical and Dental History**

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate\_\_\_/\_\_\_/\_\_\_\_ Age: \_\_\_\_\_\_ Sex: M F

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate\_\_\_/\_\_\_/\_\_\_\_ Age: \_\_\_\_\_\_ Sex: M F

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Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child under the care of any specialist physician? [ ] Yes [ ] No

If so, please state name and specialty\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your child’s last medical check-up? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are all immunizations current? [ ] Yes [ ] No

Is your child allergic to anything? (e.g. Medications, Latex, Foods) [ ] Yes [ ] No

If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child currently taking any medications? [ ] Yes [ ] No

If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child ever been hospitalized? [ ] Yes [ ] No

If yes, reason for hospitalization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child ever had surgery or general anesthesia? [ ] Yes [ ] No

If yes, list reason and if any complications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child ever been diagnosed with any of the following? \*check if yes\*

ADD/ADHD [ ] Congenital Birth Defects [ ] Nutritional Deficiency [ ]

Anemia [ ] Diabetes [ ] Orthopedic Problems [ ]

Arthritis [ ] Emotional Disturbance [ ] Premature Birth [ ]

Asthma [ ] Eye Problems [ ] Pregnancy [ ]

Autism [ ] Fainting [ ] RSV [ ]

Brain Injury [ ] Handicaps/Disabilities [ ] Seizure Disorder [ ]

Behavioral Problems [ ] Hearing Impairment [ ] Sickle Cell Anemia [ ]

Breathing Problems [ ] Heart Condition/Heart Murmur [ ] Speech Problems [ ]

Bleeding Problems [ ] Hemophilia [ ] Spina Bifida [ ]

Cancer/Leukemia [ ] Hepatitis [ ] Syndrome [ ] \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cerebral Palsy [ ] Kidney/Liver Problems [ ] Tetanus [ ]

Cleft Lip/Palate [ ] Learning Problems [ ] Other [ ] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this your child’s first visit to the dentist? [ ] Yes [ ] No

If not, how long since the last visit to the dentist? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Any x-rays taken? [ ] Yes [ ] No

Previous dentist’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child ever had any injuries to the teeth, face or mouth? [ ] Yes [ ] No

If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have any of the following habits?

Thumb/finger sucking: [ ] Yes [ ] No Lip Sucking/Biting: [ ] Yes [ ] No Nail Biting: [ ] Yes [ ] No Pacifier: [ ] Yes [ ] No

Does your child nurse or take a bottle? [ ] Yes [ ] No

How often are child’s teeth brushed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often are they flossed? \_\_\_\_\_\_\_\_\_\_\_\_

Is your child’s water fluoridated? [ ] Yes [ ] No Is the child receiving fluoride supplements? [ ] Yes [ ] No

Has your child ever had a serious or difficult problem associated with previous dental work? [ ] Yes [ ] No

If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your reason for bringing your child to the dentist today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there anything else you feel we should know about your child? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LAKE WYLIE PEDIATRIC DENTISTRY

Authorization for Release of Information – Compound Release

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate\_\_\_/\_\_\_/\_\_\_\_

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate\_\_\_/\_\_\_/\_\_\_\_

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate\_\_\_/\_\_\_/\_\_\_\_

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate\_\_\_/\_\_\_/\_\_\_\_

## LAKE WYLIE PEDIATRIC DENTISTRY is authorized to release protected health information about the above-named patient in the following manner and to the identified persons.

|  |  |
| --- | --- |
| **Entity to Receive Information.** Check each person/entity that you approve to receive information. | **Description of information to be released.** Check each that can be given to person/entity on the left in the same section. |
| * Voice Mail
 | * Appointment Reminders
* Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
|  Other person (s) (provide name and phone number)(i.e. Grandparent, Stepparent, Aunt, Uncle etc.) | * Financial
* Treatment
 |
| * Email communication-Provide email address\*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\*For email communication to occur, please accept the disclosure below: | * Financial
* Treatment
* Appointment reminders
* Breach notification
 |
| * Text communication – Provide number \*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\*For text communication to occur, accept the disclosure below: | * Appointment reminder
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |

##### Patient Rights:

* I have the right to revoke this authorization at any time.
* I may inspect or copy the protected health information to be disclosed as described in this document.
* Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
* Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
* I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing*.*

## This authorization will remain in effect until revoked by the patient.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Personal Representative

\*Description of Personal Representative’s Authority (attach necessary documentation)



 **New Patient Registration**

1. **Tell Us About Your Child**

Child’s Full Name Prefers to be called Today’s Date \_\_\_/\_\_\_/\_\_\_\_\_\_

Date of Birth \_\_\_/\_\_\_/\_\_\_\_\_\_ Age \_\_\_\_ I I Male I I Female Names and ages of siblings

Home address Parents’ Marital Status [ ] M [ ] S [ ] D [ ] Sep[ ] W [ ]

City State \_\_\_\_\_ Zip School Grade

Home Phone How did you hear about us?

1. **Parent 1 Information**

I I Mother I I Father I I Step Mother I I Step Father I I Legal Guardian I I Other

Name Prefers to be called Date of Birth \_\_\_/\_\_\_/\_\_\_\_\_\_\_\_\_\_

Address I I Same as child’s Occupation

City State \_\_\_\_\_ Zip Work Phone

Home Phone Email

Cell Phone Preferred method of contact

Is this person legally responsible for the health care decisions of the above patient? I I Yes I I No

1. **Parent 2 Information**

I I Mother I I Father I I Step Mother I I Step Father I I Legal Guardian I I Other

Name Prefers to be called Date of Birth \_\_\_/\_\_\_/\_\_\_\_\_\_\_\_\_\_

Address I I Same as child’s Occupation

City State \_\_\_\_\_ Zip Work Phone

Home Phone Email

Cell Phone Preferred method of contact

Is this person legally responsible for the health care decisions of the above patient? I I Yes I I No

1. **Person Responsible for This Account**

Name Relationship

Billing Address I I See Above Home Phone

City State \_\_\_\_\_ Zip Work Phone

1. **Dental Insurance Information (If Applicable)**

**Primary** Insurance Co. Name Insurance Co. Phone

Insurance Co. Address Group# Policy#

City State \_\_\_\_\_ Zip Social Security #

Policy Owner’s Name Policy Owner’s Employer

Relationship to Patient Policy Owner’s Birthdate I I See Above \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

 ****

I, undersigned parent/guardian, give my permission for my child(ren) (listed below) to be seen at Lake Wylie Pediatric Dentistry.

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate\_\_\_/\_\_\_/\_\_\_\_

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate\_\_\_/\_\_\_/\_\_\_\_

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate\_\_\_/\_\_\_/\_\_\_\_

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate\_\_\_/\_\_\_/\_\_\_\_

I authorize the rendering of diagnostic and treatment procedures, such as fluoride, local anesthesia and/or sedation, by the Doctors and dental staff of Lake Wylie Pediatric Dentistry that, in their professional judgement, may be deemed necessary and beneficial to my child/children. However, prior to rendering any definitive treatment, the proposed treatment plan will be presented and discussed with me (the parent/guardian).

The American Academy of Pediatric Dentistry recommends fluoride be applied twice per year to help aid in the formation of tooth enamel, to repair early stages of tooth decay, and to help prevent decalcification. For these reasons, I am aware fluoride will be applied at each cleaning unless I notify otherwise.

I further understand this consent will remain in effect until such time I choose to terminate it.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Name

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, undersigned parent/guardian, have received a copy of the Notice of Privacy Practices for Lake Wylie Pediatric Dentistry.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

* An emergency existed and a signature was not possible at the time.
* The individual refused to sign.
* A copy was mailed with a request for a signature by return mail.
* Unable to communicate with the patient for the following reason

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Name

**Financial Policy**

We are glad you have chosen Lake Wylie Pediatric Dentistry. Welcome to our practice. We feel it is extremely important to build a relationship with your family based on trust and communication. The following information is to introduce our financial policy to you. We welcome any questions you have and will do our best to answer them adequately.

**Insurance/Payment Policy**

Please be aware that the parent/guardian bringing the child into our office is legally responsible for the payment of all charges incurred. This parent/guardian will be responsible to us for fees regardless of any custody, financial, or other disputes. We operate on a fee-for-service basis and therefore payment is required at each appointment. We accept Visa, MasterCard, Discover, cash and personal checks. \*Personal checks accepted for amounts $200 and less only.\*

Any insurance policy is a contract solely between you, as a subscriber, and the carrier of your insurance; Lake Wylie Pediatric Dentistry is privileged to very little information about your policy. Please be aware of the benefits of your specific policy. If you have any questions concerning fees, please do not hesitate to ask our Insurance Coordinator.

**Account balances (Please initial)**

30 days – I will receive a statement by mail and phone correspondence to contact information on file. \_\_\_\_\_\_

60 Days – I will receive a statement by mail and phone correspondence to the contact information on file. \_\_\_\_

90 Days – I will receive a statement by mail and phone correspondence to the contact information on file. \_\_\_\_

120 Days – I understand any unpaid balance due will be forwarded to collections. \_\_\_\_\_\_

\*Account balance may be from date services were provided. \*

**Appointment Policy**

In consideration of our patients that are waiting to be scheduled, it has become necessary to charge for appointments cancelled without a 48-hour notice or for patients who do not show for appointments. The minimum fee will be $48.00. When calling after business hours, please leave a message with our answering service.

I, the undersigned parent/guardian, understand the above stated policies. I understand that I will be responsible for any and all charges not covered by my insurance company (if insurance is applicable). I understand that I will need to give a 24 hour notice for any appointment that I cannot attend.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Name

**Non-Covered Insurance Items**

At Lake Wylie Pediatric Dentistry, we do our best to verify all insurance coverage, eligibility and usage history prior to your child’s appointments. In addition, we strive to notify parents of frequencies and coverage of services provided by their insurance carrier. The most frequent discrepancies we mail statements for are the following:

1**.)    Posterior Composite Downgrade**: Your insurance may limit the amount they pay for a filling (restoration) on a molar to a silver colored filling (amalgam) rate. Our office does not provide silver fillings, we offer tooth colored (composite) fillings only. A statement will be generated reflecting the balance due from you once payment has been received from your insurance carrier.

**2.)    Fluoride**: Many insurers cover fluoride twice a year, however some only cover the service once a year. In following with the ADA and the American Academy of Pediatric Dentistry, we recommend fluoride placement at 6-month cleaning intervals. Should your insurance company not provide coverage every 6 months you will receive a statement for the cost of service, unless notified by you, the policyholder, beforehand.

**3.)**    **Limited/Emergency Exams:**  Most insurers cover at least 2 exams per year, as well as 2 emergency exams per year. However, some only provide patients with 2 exams TOTAL per year. This will cause a parent to receive an invoice for a balance after an emergency/limited exam. We encourage our parents to call their insurer and better understand their benefits, and in such cases, notify us of their plan limitations.

**4.)**    **Periapical Xrays:** Some insurers cover periapical films for evaluation of root development or infection. However, a more common trend has insurance companies requiring this fee as part of the patient’s deductible. As a result, our parents may receive an invoice when these films are indicated and taken.

**5.)**    **Nitrous Oxide / Behavior Management**: These services are typically reserved for patients requiring sedation in some capacity. Most insurers do not cover Nitrous Oxide/Anxiolysis or Behavior Management (used for IV sedation cases). In these events, it is our office policy to collect the fee up front, however, on some occasions a parent may receive an invoice after payment has been applied from your insurer.

**6.) Space Maintainer Removal:** A space maintainer that we place in office will be removed as an included service with the placement fee. For the patients who have a space maintainer previously placed by another provider that we need to remove in office, we will apply a fee that will be the patient’s responsibility prior to removal.

While this is certainly not an exhaustive list, we want to give you, our parents, the most accurate information we can regarding statements, collections, insurance benefits and how it might directly affect you. While we strive to provide accurate out of pocket estimates, it is simply not possible to keep up with each patient’s insurance coverage and plan benefits. We strongly recommend all our parents familiarize themselves with their unique insurance plan and highly encourage questions to your carrier! We hate sending statements out as it is time consuming, costly, and like any parent, none of us enjoy seeing bills in the mail. However, we know that at times it is indicated and necessary to handle account balances.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Name

 **Authorization to make Medical & Dental Decisions for Minor**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the parent/legal guardian of:

­Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

­Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

­Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

­Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

hereby authorize the following individuals to make permanent, irreversible, and reversible medical and dental treatment decisions on my behalf. I understand this permission will remain in effect until I notify Lake Wylie Pediatric Dentistry in writing. Only listed individuals will be allowed to accompany my child/children to necessary dental appointments & must be at least 18 years old.

1)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Name

These policies are effective 5/1/2016