Dr, Carol French
Pediatric and Adolescent Dentistry

DUE TO CHANGING MEDICAL LAWS AND IN ORDER TO PREVENT ANY CONFUSION WITH YOUR CHILD'S SAFETY, HEALTH AND WELL BEING WE NEED TO HAVE THIS INFORMATION COMPLETED ON EACH VISIT.

Today's Date: _____ Child's SS#: _____

Child's Name : _____
(First) (Middle) (Last) (Nickname)

Child's Legal Guardian: _____ Relationship: _____

Child's Place of Residence : _____
(Street Address, City, State Zip)

Is this same as guardian? YES/NO If NO Guardians' Address _____
(Circle One)

Child's Dental Insurance Provider: _____
(We must have a copy of current Insurance Card @ each visit)

Child's Medical Insurance Provider: _____
In case Medical Surgery or hospital visit is required (We must have a copy of current Insurance Card @ each visit)

Do you have more than one Insurance Provider? YES/NO (If yes we will need copies of all cards)

Name & Relationship of Parent/Guardian
who carries Child's Dental Insurance Policy: _____

Employer of Above (Parent/Guardian): _____ Start Date: _____

Address of Employer: _____ Phone: _____
(Street, City, State, Zip)

CONTACT INFO

Mom's: _____ YES/NO _____ @ _____
(Home phone) (Cell Phone – Texting) (Work Phone) FAX # (e-mail)

Dad's: _____ YES/NO _____ @ _____
(Home phone) (Cell Phone – Texting) (Work Phone) FAX # (e-mail)

Is your child taking any prescribed or over the counter medication at this time? _____ If YES please list name of medication, why prescribed and date prescribed (ex. Prescribed Ritalin – to treat ADD – since 1999)

_____
(MEDICATION) (FOR) (SINCE)

_____
(MEDICATION) (FOR) (SINCE)

If this is an EMERGENCY EXAM, please describe in detail the incident and damage you think has occurred: _____

_____

_____

Please share with us any additional comments or concerns you may have about your child's care, growth, and development: _

_____

_____

Is your child allergic to anything? (Ex. Latex, penicillin, codeine, aspirin) _____

_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(You may refuse to sign this acknowledgement)

I, _____ have received a copy of this offices Notice of Privacy Practices.

_____ _____

Signature **Date**

_____

Please print name

For office use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign
_____ Communications barrier prohibited obtaining acknowledgment
_____ An emergency situation prohibited obtaining acknowledgment
_____ Other (please specify below)

Dr. Carol French

Board Certified Diplomate
American Board of Pediatric Dentistry
P. O. Box 1813
1 Thames Valley
Irmo, South Carolina 29063
Phone: (803) 781- 2511
Fax: (803) 781- 8401

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Policy Regarding Sedation Appointments

It is our intention to make each visit to our office as uncomplicated as possible. In this effort, we will do our best to remind you in advance of each visit. ***Our office will specifically call to confirm all appointments for treatments requiring sedation at least 1 day prior to the appointment time.*** We will make every attempt to contact you with the information you have provided to us. If we do not reach you and we do not hear from you before 12:00 noon on the day prior to the appointment, the appointment will be cancelled and may not be rescheduled for that month.

Because these appointments *require a large part of our schedule each day and are an important part of our practice*, your account will be subject to a Broken Appointment Fee of **$150.00**

_____ _____

Parent/Guardian **Date**

_____ _____

Witness **Date**

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INSURANCE AUTHORIZATION

This office is happy to assist you in processing your insurance. We will complete our portion of the claim form and promptly mail it to your assigned insurance carrier at no charge to you. We ask that in exchange for this service you agree to allow payment be made directly to our office from your insurance company and understand that any payment made by them does not remove you from obligation to pay the remaining portion.

Insurance coverage is usually limited to a portion of the fee's charged by any dental office and quite frequently not the entire fee agreed upon by the patient and the office. There categorically is no such thing as a "UCR" fee for any nation, state, or zip code that is not created internally by the insurance industry. The limits of your coverage are based upon such things as premium amounts and profit margins designed solely by the insurance company.

When your child receives treatment in this office, you agree to be financially responsible for the ENTIRE FEE charged by this office independent of the insurance coverage. While we will file your claims, **you are still ultimately the responsible** party. Further, should it become necessary to collect payment through court action or otherwise, you will be responsible for reasonable attorney's fees and court costs in addition to the amount owed together with an interest rate of 1 ½% per month beginning after receipt of a statement of this office. We regret to have to include this in our policies but in order for us to provide the best Dental Care for our patients, we must also pay attention to the business end of our practice. Thank you for your cooperation.

_____ _____

I, above signed, authorize payments of insurance benefits directly to the provider

Print Name

_____

Additional Beneficiaries under Primary Insurance Policy

_____

I, authorize the release of all necessary information from my Medical Records to the Insurance Carrier and it's representatives

_____

I have read this form and understand and agree to all terms listed above

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Policies Regarding Office Visits:

1. One Adult must accompany children who have an appointment. Because afternoons are busy and we have limited space, we request that only children who have an appointment come to the dental office.

2. ***Children under age 16 must be accompanied by and adult.*** Older children may come without and adult but must be picked up promptly upon completion of their visit.

3. Because the children who are here for dental treatment are not allowed to eat, we have a **No Food or Drink** Policy in our waiting room. Thank you for being considerate and honoring this.

4. Your dental health depends on you keeping your child's scheduled appointments. In order to help us serve you better, if you must cancel and appointment, please notify us a soon as possible. If ***two appointments are missed without notifying our office, you may be dismissed as a patient.***

5. Please remember to bring proper identification and any proof of dental benefits/insurance with you at each visit.

Your dental health depends on the success of our partnership and our policies are only enforced in order to allow us to better service you. Please feel free to ask for our assistance at any time. Thank you in advance for your cooperation.

_____ _____

(Signature Parent/Guardian) (Date)

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FINANCIAL OBLIGATION/INSURANCE POLICIES

If you have dental insurance, as a courtesy to you, we will be happy to ***file your primary insurance coverage***. If you have a secondary policy, we will provide you with any information needed for you to file this secondary claim.

YOU WILL BE RESPONSIBLE TO MAKE ANY CO-PAYMENTS OR MEET ANY DEDUCTIBLES AT EACH VISIT.

You must realize that your insurance is a contract between you, your employer and your insurance company. ***We are not a party to that contract.***

Payment for services is due at the time the services are rendered. **We accept cash, Mastercard or Visa.**

If you have a dental health reimbursement account at work, we will be glad to assist you with the proper paperwork after payment has been made. Once again, **we only file primary insurance.**

Please notify us immediately if there are any changes in addresses, places of employment, or insurance carriers. We must verify coverage at each visit therefore we require you to provide your dental insurance card at each visit.

In **DIVORCE OR CUSTODY CASES**, we must consider the parent or guardian who carries the insurance policy the responsible parent

We must emphasize, as dental care providers **our relationship is with you, not your insurance company.** All charges are ultimately your responsibility effective from the date the services were rendered. All accounts due past 30 days are subject to a finance charge. All accounts due past 90 days will be turned over to a third party collection agency. Any returned checks will be subjected to a 35.00 returned check fee.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to contact us. It is our policy to give you an estimate for any extensive dental services required by your child. This is strictly an estimate based on our knowledge and history of typical claims similar to yours. At your request, we will gladly file a pre-estimate of your proposed treatment with your insurance company. This will allow you to have a more accurate idea of your financial responsibility. Fee quotes are honored for 90 days from the date of the quote. Fees are subject to change without notice

We are here to help you and make your investment in your child's Dental Health as uncomplicated as possible for your particular circumstances.

Children:_____

Parent/Guardian:_____ Date:_____