Welcome To Our Practice

We are pleased to welcome you and your child to our practice! Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health!

Date _____

Patients Name _____
Last First MI

Nickname _____ Birthdate _____ / _____ / _____ Sex M_____ F_____

Home Address _____
Street City State Zip

Mother's Name _____ Father's Name _____

I UNDERSTAND THAT DR. TERNISKY'S OFFICE WILL BE CONTACTING BY PHONE, TEXT OR EMAIL TO CONFIRM ALL APPOINTMENTS THAT I SCHEDULE WITH THE OFFICE.
I AUTHORIZE DR. TERNISKY'S OFFICE TO CONTACT ME AT THE FOLLOWING NUMBERS:

Home Phone # _____

Mom's Cell # _____ Dad's Cell # _____

Mom's Work # _____ Dad's Work # _____

Email(s) _____

We prefer to reach you directly, otherwise we will leave a message and ask that you call back to confirm. If a cancellation is unavoidable, please call the office 24 hours in advance to avoid the $50.00 cancellation fee.

In case of an emergency whom should we contact (name, relationship, and number)?

_____

How did you hear about us? _____

Pediatrician/General Physician _____
Name Office Phone Number

Under the care of any other physicians? ☐ Yes ☐ No If yes, for what? _____

MEDICAL HISTORY:

- Please list any medications the minor/child is taking:
- Please list any allergies your child may have (latex, food or dye, medication, etc):
  ****ALLERGIC TO:**

- Has your child had any history of or difficulty with any of the following? If yes please (√).

____A.I.D.S./H.I.V.	____Cerebral Palsy	____Heart Problems	____Sensory Issues
____ADD/ADHD	____Developmentally Delayed	____Hepatitis	____Sinus Issues
____Anemia	____Diabetes	____Kidney Disease	____Thyroid Issues
____Asthma	____Epilepsy	____Liver Disease	____Tuberculosis
____Autism	____Fainting	____Mononucleosis	____Other
____Cancer	____Hearing Problems	____Seizures	_____

☐ **I will inform the office of any future medical changes concerning my child.**

FINANCIAL AND INSURANCE INFORMATION:

If you have an insurance company that we do not submit for, you will be required to pay in full at the time of service (cash, check, Visa, American Express, MasterCard, or Discover). We will provide you with an insurance claim that you may submit for your reimbursement.

WE PARTICIPATE WITH: AETNA PPO, *DELTA DENTAL PREMIER, CONCORDIA, CIGNA (Total DPPO or DPPO), UNITED HEALTHCARE DENTAL, DENTAQUEST CHOICE) OR VA SMILES FOR CHILDREN (MEDICAID).* PLEASE FILL OUT THE FOLLOWING INFORMATION SO THAT WE MAY SUBMIT FOR YOU.

Policy Holder's Name _____ Birthdate _____ / _____ / _____

Employer _____ Plan Name _____

Soc. Sec # _____ Group # _____ Policy #_____

Insurance Mailing Address_____

Secondary Dental Insurance ☐ No ☐ Yes If Yes, Plan Name _____

☐ I authorize the dentist to release all information needed to secure the payment of benefits and I authorize the use of my signature on all my insurance submissions, whether manual or electronic.

☐ I understand that I am financially responsible for all charges whether or not paid by insurance.

If it is necessary for your child/children to have extensive dental treatment, a monthly payment plan can be arranged with the office. A credit card must be placed on file in order to pay in monthly installments. Any balance remaining unpaid for 90 days, will receive a final notice letter before being sent to collections. In the event that my account is sent to collections, I will be responsible for any and all costs incurred in the collection of this debt. This includes: interest rates of 21% of the unpaid balance from the last date of service, attorney fees at the rate of 33% and court costs.

CONSENT AND AUTHORIZATION

I am the parent, guardian, or personal representative for the above patient and there are no court orders in effect that would prevent me from signing this consent. I hereby request and authorize the doctors of this practice and the dental staff to perform necessary dental services, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when treatment is rendered.

To the best of my knowledge, the above information is complete and correct. I have read and understand this document in its entirety outlining office policies, patient and family responsibilities, and agree to abide by all terms stated herein.

Date _____

Signature _____ Print Name _____

Social Security #_____ **OR** Driver's License #_____