CHILD'S PERSONAL DATA

Child's Last Name _____ First Name _____Middle __

Address _____

City _____ State_____ Zip_____

Phone (___) _____ Cell (___) _____

Birth Date_____ School _____

Father's Name_____ Work #_____

Father's Employer _____

Mother's Name_____ Work # _____

Mother's Employer _____

Who referred you to our office? _____

FINANCIAL DATA

Person Financially Responsible _____

Relationship _____ Email_____

Address _____

City _____ State _____ Zip _____

Phone (___) _____

INSURANCE DATA

Dental Insurance Company _____ Group # _____

Name of Insured _____ Employer _____

Insured SS# _____ Insured Birth Date _____

MEDICAL HISTORY

Physician's Name _____ Phone (__) _____

Is child under Doctor's care? Yes ___ No ___ If so, why? _____

Is child taking Medications? Yes ___ No ___ List Meds _____

YES NO

( ) ( ) Excessive bleeding when cut?

( ) ( ) Has child ever been hospitalized?
Describe _____

( ) ( ) Has child ever had surgery?
Describe _____

( ) ( ) Does child have good physical condition?

( ) ( ) Are there any emotional problems?
Describe _____

( ) ( ) Is there any allergy to Penicillin or other drugs?
List _____

( ) ( ) Are there other allergies: food, pollen, animals…
List _____

DOES CHILD HAVE A HISTORY ANY OF THE FOLLOWING:

___ Anemia	___ Convulsions	___ HIV Virus	___ Heart
___ Asthma	___ Diabetes	___ Kidney	___ Mumps
___ Bladder	___ Epilepsy	___ Liver	___ Measles
___ Cerebral Palsy	___ Mononucleosis	___ Malignancies	
___ Chicken Pox	___ Rheumatic Fever	___ Thyroid	
___ Tuberculosis	___ Venereal Disease	___ Lactose Intolerant	

Are there any other Medical Conditions not listed above?

_____

DENTAL HISTORY

Date of last visit to Dentist _____Service _____

Any mouth habits—thumb sucking, nail biting, mouth breathing, pacifier, etc:

_____

Does your child brush/ floss daily? ____ Is fluoride taken in any form? ____

Is there any other dental information we should know about your child?

_____

The undersigned declares that he/she has examined the patient information and it is true to the best of their knowledge and is responsible for payment in full at the time services are rendered. If not paid, a 1% service charge will be affixed to all balances over 90 days.

SIGNATURE _____

Date_____ Relation to Child _____

ACKLEY DENTAL GROUP
FINANCIAL POLICY

This is an agreement between Ackley Dental Group, as creditor, and the patient/debtor named on this form. By executing this agreement, you are agreeing to pay at the time of service.

Payment options:

A. Cash
B. Check
C. Credit Card (Visa, Master Card, American Express, Discover)
D. Care Credit and Citi Healthcard—which offer 6 or 12 months interest free loans

Insurance:

Insurance is a ***contract between you and your insurance company***. We are ***NOT*** a party to this contract. We will bill your primary insurance as a courtesy to you. Although we may ***ESTIMATE*** what your insurance ***may*** pay, it is the insurance company that makes the final determination of your eligibility. ***You agree to pay any portion of the charges not covered by insurance.***

Finance Charge:

A finance charge will be imposed on your account which has not been paid within ninety days. The **FINANCE CHARGE** on your account is computed at the rate of **1.5%** per month or an annual percentage rate of 18%. The finance charge on your account is computed by applying the periodic rate (1.5%) to the overdue balance on your account.

Credit History:

You give us permission to check your credit and employment history if necessary. We have the option to report your account status to any credit reporting agency such as a credit bureau.

Missed Appointment Fee:

Patients who miss or cancel an appointment with less than 24 hours notice will be charged a $25 per half hour fee. The fee must be paid before a new appointment is scheduled. Patient with three missed appointments will be asked to transfer their records to another office.

Past Due Accounts:

If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer your account to an attorney, you agree to pay all attorney fees which are incurred plus all court costs.

Returned Checks:

The fee for any check returned by the bank is **$25.00.**

Divorce:

In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Transferring of Records:

You will need to request in writing, and pay a reasonable copying fee (currently $10) if you want to have copies of your records sent to another dentist. You authorize us to include all relevant information.

Patient's name:_____

Responsible party: _____

Signature: _____ **Date:** _____