PROSPER FAMILY DENTISTRY

Jill H. Sentlingar DDS • Cara Kessler DDS

Child Acquaintance Form

Name (First, Middle, Last)		Nickname	Date of birth	Age
Home phone	Email address		Sex M F	
Address		City	State	Zip
Father's Name		Employer	Work/cell phone	Date of birth
Mother's Name		Employer	Work/cell phone	Date of birth
Child's physician	Phone (_____) -	How did you find out about our office?		
Name of person completing this form:			Relationship:	

Insurance Information:

Name of insured person	SSN ______-_____-_______	Date of birth ___/___/_____
Employer's name	Employer's address	
Insurance company	Phone number	Group number

____
(Initials)

CANCELLATION POLICY: As a courtesy to other patients, all cancellations must be made by 10:00am on the business day preceding any scheduled appointments. If cancellations occur after this time, your account may be charged a cancellation fee. These fees may vary. If you do not show for your scheduled appointment, your account may be charged a "no-show" fee.

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Medical History:

	Yes	No
Is the child taking any prescription and/or over-the-counter medications or vitamin supplements? If yes, please list:		
Is the child allergic to any medications (i.e. penicillin)? If yes, please list:		
Is the child allergic to anything else, such as certain foods? If yes, please list:		
Has the child ever had an unfavorable reaction to latex?		
Has the child ever had a serious illness? If yes, when: Please describe:		

	Yes	No
Has the child ever been hospitalized?		
Does the child have a history of any other illnesses? If yes, please list:		
Has the child ever received a general anesthetic?		
Does the child have any inherited problems?		
Does the child have any speech difficulties		
Has the child ever had a blood trnasfusion?		
Is the child physically, mentally or emotionally impaired?		
Does the child experience excessive bleeding when cut?		
Is the child currently being treated for any illness? If yes, please explain:		

Thank you for your patience while filling out these forms. Your honesty and completeness will help us serve you better.

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Has the child had any history of, or conditions related to, any of the following:

Anemia	Cancer	Epilepsy	HIV +/AIDS	Mononucleosis	Thyroid
Arthritis	Cerebral Palsy	Fainting	Immunization	Mumps	Tobacco/Drug Use
Asthma	Chicken Pox	Growth Problems	Kidney	Pregnancy	Tuberculosis
Bladder	Chronic Sinusitis	Hearing	Latex allergy	Rheumatic fever	Venereal Disease
Bleeding Disorders	Diabetes	Heart	Liver	Seizures	Other:
Bones/Joints	Ear Aches	Hepatitis	Measles	Sickle cell	

Dental History:	**Yes**	**No**		**Yes**	**No**
Is this the child's first visit to a dentist?			What type of water does your child drink?		
If not, when was his/her last visit? ____________			Does the child take fluoride supplements?		
Has the child had any problem with dental treatment in the past?			Is fluoride toothpaste used?		
Has the child ever had dental x-rays?			How many times are the child's teeth brushed per day?		
Has the child suffered any injuries to the mouth, head or teeth?			When are the teeth brushed?		
Has the child had any problems with eruption or shedding of teeth?			Does the child suck his/her thumb, fingers or pacifier?		
Has the child had any orthodontic treatment?			Does the child participate in active recreational activities?		

I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand it is very important to report any changes in my medical status to my treating doctor as soon as possible, and I agree to do so. I give permission to my treating doctor to obtain from my physician information regarding my medical history, if needed, to provide me the best treatment possible.

I hereby authorize Dr. Sentlingar and the appropriate staff members to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate for my dental needs.

Signature: ____ Date: ____________________

Printed Name: ____

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Prosper Family Dentistry Office and Financial Policies

This is an outline of our office financial policies. We ask that you provide any/all insurance information to us upon arrival of your first visit with us. If the information is provided to us prior to this appt, we will make every attempt to verify coverage of benefits for you in advance. While we do our very best to outline your plan to you, it is ultimately your responsibility to know your insurance plan benefits and restrictions. Based upon the information given to us by your insurance plan, we will ask for co-payments accordingly. Please note that our dentists are not contracted with any insurance plan. We are an out of network provider office and your benefits may vary accordingly. We do collect an additional 10 % of the charges incurred above and beyond what your insurances quotes to our office. In many cases, the end result will result in a credit balance to the patient account. These credits will be reimbursed.

It is important to remember that your insurance policy is a contract between you and the insurance company. We will do everything possible to assist you in getting your claim paid: however, all charges incurred for your dental treatment are your sole financial responsibility. Your co-payments are an estimate only. The quotes given to our office by your insurance company are merely that. They are not a guarantee of payment to us. We ask that you pay your co-payment, deductible (if required), or any balances of prior visits at the time services are rendered. If you are unable to pay your estimated portion for that time, we ask that you make prior financial arrangements with our billing representative.

If you do not have dental insurance, by signing this statement you acknowledge that you understand that you are responsible for payment in full at the time services are rendered. If you have insurance, by signing this statement you acknowledge that your insurance company may pay less than the actual bill for services and that you are fully responsible for payment of your account. By signing this statement you agree to pay for all balances not paid by your insurance company and any legal fees incurred to enforce this statement. If a balance on any account is not paid within 30 days, you could be charged interest on that account until paid in full.

We do accept personal checks, cash payments and credit card payments. We also offer a 5% Cash Professional Courtesy for any treatment prepaid to us in full. We will file your insurance as a courtesy for you. In addition to this, we offer a 5% Senior Citizen Courtesy. A Credit Card Authorization form is also available to keep on file for your account balances. See Front desk staff for these forms.

I hereby authorize the release of any information relating to insurance claims and I authorize payment of my group benefits directly to Jill H. Sentlingar, DDS and Prosper Family Dentistry P.A. I agree to give Prosper Family Dentistry permission to contact me regarding appointments and/or treatment at the phone number listed above.

I certify that the information I have provided here is true and correct.

Adult/Guardian Signature: ______________________________ **Date:** ____________

Patient Name: ______________________________ **Relationship:** ____________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse To Sign This Acknowledgement

I, ______________________, have received a copy of this office's Notice of Privacy Practices.

______________________ Signature

______________________ Date

Employee Signature ______________________

_____ Individual refused to sign

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