

welcome

Please take a moment to fill out important background information.

Date: _____

child

Child's Name: _____

Nickname: _____

Child's Birthdate: _____ Age: _____

Child's Home Address: _____

Hm#: _____

Previous/Present Dentist: _____

parents

Your Name: _____ Relationship: _____

Do you have legal custody of this child? Yes No

Other family members seen by us: _____

E-mail Address: _____

Parents Marital Status

Single Married Divorced Widowed Separated

Mother's Name: _____ Step Mother Guardian

Birthdate: _____ SSN: _____

DL #: _____ Cell #: _____

Wk #: _____ Ext #: _____

Employer: _____

Father's Name: _____ Step Father Guardian

Birthdate: _____ SSN: _____

DL #: _____ Cell #: _____

Wk #: _____ Ext #: _____

Employer: _____

account

Person Responsible for Account: _____

Hm #: _____ Cell #: _____

Wk #: _____ Ext #: _____

Billing Address: _____

Relation: _____

SSN: _____ DL #: _____

Employer: _____

insurance

Primary Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured Name: _____ Birthdate: _____

Relation: _____ ID #: _____

Insured's Employer: _____

Insured's Employer's Address: _____

Insured's Employer's Phone #: _____

Secondary Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured Name: _____ Birthdate: _____

Relation: _____ ID #: _____

Insured's Employer: _____

Insured's Employer's Address: _____

Insured's Employer's Phone #: _____

emergency

In the event of an emergency, is there someone who lives near the child that we should contact?

Name: _____

Relationship: _____

Hm #: _____ Cell #: _____

Wk #: _____ Ext #: _____

releases

This office accepts insurance. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payments and deductibles that my insurance does not cover. **Payment is due in full at the time of treatment unless prior arrangements have been approved.**

Signature: _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in strictest confidence and it is my responsibility to inform this office of any changes in the child's medical status. **I authorize the dental staff to perform any necessary dental services that the child may need during diagnosis and treatment with my informed consent.**

Signature: _____

Name: _____

history

Has the child ever had any of the following diseases or medical problems?

- | | |
|--|---------------------------------|
| Y N Abnormal Bleeding | Y N Hemophilia |
| Y N Alcohol / Drug Abuse | Y N Hepatitis |
| Y N Anemia | Y N Herpes / Fever Blisters |
| Y N Arthritis | Y N High Blood Pressure |
| Y N Artificial Bones / Joints / Valves | Y N HIV+ / AIDS |
| Y N Asthma | Y N Hospitalized for Any Reason |
| Y N Blood Transfusion | Y N Kidney Problems |
| Y N Cancer / Chemotherapy | Y N Liver Disease |
| Y N Colitis | Y N Low Blood Pressure |
| Y N Congenital Heart Defect | Y N Mitral Valve Prolapse |
| Y N Diabetes | Y N Pacemaker |
| Y N Difficulty Breathing | Y N Psychiatric Problems |
| Y N Emphysema | Y N Radiation Treatment |
| Y N Epilepsy | Y N Seizures |
| Y N Fainting Spells | Y N Shingles |
| Y N Frequent Headaches | Y N Sinus Problems |
| Y N Glaucoma | Y N Stroke |
| Y N Hay Fever | Y N Thyroid problems |
| Y N Heart Attack | Y N Tuberculosis (TB) |
| Y N Heart Murmur | Y N Ulcers |
| Y N Heart Surgery | |

Please list any serious medical condition(s) that the child has ever had:

Is the child allergic to any of the following?

- | | |
|------------------|------------------------|
| Y N Aspirin | Y N Dental Anesthetics |
| Y N Codeine | Y N Jewelry |
| Y N Erythromycin | Y N Latex |
| Y N Penicillin | Y N Metals |
| Y N Tetracycline | |

Please list any other drugs / materials that the child is allergic to: _____

updates

I have verbally reviewed the medical/dental information above with the parent/guardian and patient named herein. Date: _____ Initials: _____

Date: _____ Patient's Initials: _____ Staff Initials: _____

Date: _____ Patient's Initials: _____ Staff Initials: _____

Date: _____ Patient's Initials: _____ Staff Initials: _____

Date: _____ Patient's Initials: _____ Staff Initials: _____

Date: _____ Patient's Initials: _____ Staff Initials: _____

dental

Why did you bring the child to the dentist today? _____

Is the child's water fluoridated? Yes No

Is the child taking fluoridated supplements? Yes No

Does the child brush their teeth daily? Yes No

Does the child floss their teeth daily? Yes No

Has the child ever had any pain/tenderness in their jaw joint? Yes No

Ever had serious / difficult problem(s) with previous dental work? Yes No

Are the child's immunizations current? Yes No

Does/did the child suck their finger/thumb? Yes No

medical

Physician's Name: _____

Phone #: _____ Date of last visit: _____

Child's current physical health is: good fair poor

Is the child currently under the care of a physician(s)? Yes No

Please explain: _____

Is the child taking any prescription / over the counter drugs? Yes No

Please list each one: _____

tracking

Whom may we thank for referring you to our office? Tracking new patients is one of the ways that helps us manage our practice. Please check ONE way that best describes how you heard or were referred to our office.

People

- Previous Patient
- Family _____
- Friend _____
- Professional _____

Phone Book

- Camas/Washougal
- Dex
- Superpages

Online

- Dex
- Superpages
- Dr. Messinger's Website
- Insurance Website
- Other: _____

Signage

- Lighted sign on the street
- Banner
- Mailer



Office Policies

OUR PHILOSOPHY - PREVENTION: We are committed to the concept of optimum dental health. You will find that prevention is the cornerstone of our practice and the foundation for maintaining healthy teeth and gums. Preventing problems before they occur is by far the most convenient and economical way to maintain good oral health. We hope that our commitment will spark in you this same initiative and enthusiasm to maintain a healthy and glowing smile.

THE INVESTMENT necessary to complete your treatment is based on an estimate derived from our examination. Should additional unforeseen problems arise as treatment progresses, this estimate may have to be revised. You will be consulted before any unexpected treatment is undertaken. This estimate will be honored provided treatment is completed within six (6) months of the date of the initial examination. Payment is due at time of service. All balances, excluding expected insurance payments, over 45 days are subject to finance charge of 1.5%.

APPOINTMENTS: To give you the best and most efficient care we must work with an appointment system. We plan very carefully to reserve the right amount of time for each patient so that the most dental care can be accomplished in the fewest number of visits. With patients' best interest in mind, appointments will be scheduled at times best suited for the treatment involved.

Except in emergency situations, you may expect us to be on time, and we would appreciate the same courtesy from you. Your appointment time has been reserved exclusively for you, and any change affects many other patients. Should it be necessary for you to reschedule an appointment, we require a **minimum 24 hours** notice to avoid a broken appointment fee. There will be a minimum charge of \$25.00 per half hour missed.

CHECKS RETURNED: You will be charged **\$30.00** for each check that is returned by the bank.

STERILIZATION TECHNIQUES: We heat sterilize our hand pieces and equipment and use as many disposable items as possible. We consistently monitor our office to exceed OSHA and Center for Disease Control requirements.

ABOUT YOUR RECORDS: We keep a record of the health care services we provide you. You may ask us to see and copy that record. You may also ask us to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so.

Insurance: Our office understands the value of insurance benefits to our patients. We will fill out and file your insurance forms at no charge. We will estimate your deductible and the portion that we feel will be covered by your insurance carrier. The amount that we estimate NOT covered by the insurance is due at the time of treatment. **Your insurance does not guarantee payment, therefore, payment for dental services are due regardless of the benefits paid by your insurance and is the patient's responsibility.**

Payment Options: Personal check or cash (if no insurance, receive 5% discount when paid in full at the time of service)
VISA, MasterCard or DiscoverCard
Outside Financing with interest free options available

WE ARE HERE TO HELP YOU: No question is too small for you to ask us, whether it is regarding your treatment, insurance or billing. We ask that you call or come by any time you have a question.

ASSIGNMENT OF DENTAL INSURANCE BENEFITS:

I hereby authorize payment of benefits owed by my insurance company to **Eric P. Messinger, DDS, PS** for these services. I understand the insurance company is responsible to the patient and the patient is responsible to the doctor. These services are rendered to a person not an insurance company and the person is responsible in full for the treatment rendered.

Signature of policy holder: _____ Date: _____

I have read and fully understand the policies of this office. Failure to sign this policy in no way negates the patient's financial responsibility for any services that will be rendered as submission to treatment implies consent.

Responsible Party Signature _____ Date: _____



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.

(Please Print Name)

(Signature)

(Date)

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 barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)
