Patient Information

Today's Date _____

Patient's Name _____ Gender _____
Last First Middle

Address _____
Street City State Zip Code

Date of Birth _____ Patient lives with (name/relation):_____

Parent/Guardian 1: _____ Parent/Guardian 2: _____

Parents/Guardians are: Married, Divorced, Separated, Single, Foster Parent (Please circle one)

Parent/Guardian Email Address: _____

Siblings that have been patients here: _____

Whom may we thank for referring you to our office: _____

Parent/Guardian Information

Parent/Guardian 1: _____
Last First Middle

Residence (if different from above) _____
Street City State Zip Code

Cell Phone _____ Home Phone _____ Work Phone _____

Date of Birth _____ Employer _____ Occupation _____

Parent/Guardian 2: _____
Last First Middle

Residence (if different from above) _____
Street City State Zip Code

Cell Phone _____ Home Phone _____ Work Phone _____

Date of Birth _____ Employer _____ Occupation _____

Insurance Information

Employee's Name _____ Insurance Company _____

ID Number _____ Group Number _____ Ins. Phone Number _____

Insurance Co. Address _____

If you have dual/secondary coverage, please complete the following:

Insured's Name _____ Insurance Company _____

ID Number _____ Group Number _____ Ins. Phone Number _____

Insurance Co. Address _____

Do you have medical assistance? Yes No (Please circle one)

Emergency Contact Information

Name _____ Address _____

Phone _____ Relationship _____

Appointments: Once an appointment is made, please remember this time has been reserved for your child. Families who miss two or more appointments without proper notification, at least 48 business hours, may be dismissed from the practice. You will be notified via phone and mail and we will provide 30-days of emergency care and will assist with forwarding of dental records to a new dental provider. We realize that unexpected emergencies can occur and reserve the right to enforce this policy on a case-by-case basis.

Insurance: We will prepare necessary forms or reports to help the persons responsible obtain benefits from insurance companies. We do not render our services on the basis that insurance companies will pay all of our fees. Each fee is individual for the individual patient and ultimately the responsibility of the parent/guardian for payment. Your estimated deductible and co-pay is due at each appointment for services rendered. Any remaining balance is due within 30 days regardless of insurance payments. Overpayments will be refunded once the insurance payment is received.

Acknowledgement of receipt of notice of privacy practices: We will provide you with our office "Notice of Privacy Practices" brochure upon request, it is posted at our front desk and you can access it on our website at www.rpdsmile.com/office-policies. This brochure explains how we protect your health care information.

Signature:
I have read the information regarding appointments and insurance. _____ (Initial)
I have been offered a copy of this office's Notice of Privacy Practice. _____ (Initial)
I consent to the use and disclosure of you and your child's protected health information by Rochester Pediatric Dentistry, LLC to carry out treatment, payment activities and healthcare operations. _____ (Initial)

I hereby authorize Rochester Pediatric Dentistry, LLC to treat my child's dental needs. As the parent or guardian bringing the child, I accept responsibility for full payment of treatment performed.
Print Name_____ Relationship to patient _____
Signature (Guardian, if minor) _____ Date _____

Interpreter (if used) _____
Print Name Signature

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
__ Communication barriers prohibited obtaining acknowledgement
__ An emergency situation prevented us from obtaining acknowledgement
__ Other: _____