MICHAEL VANARIA, D.M.D

WELCOME

1 ABOUT YOUR CHILD

Today's Date:____/____/____ File #: _____

Child's Name: _____
LAST FIRST MI

Child's Nickname: _____ ❑ Boy ❑ Girl

Child's Birthdate: ____/____/____ Age: _____

School: _____ Grade: ____

Child's Home Phone #: _____

Child's SS#: _____

Child's Address: _____

_____
CITY STATE ZIP

Referred By: _____
(If doctor, please give address & phone number)

_____

2 INSURANCE INFO

Primary Dental Insurance

Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: _____

Insured's SS#: _____

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

Insured's Name: _____

Relation: _____ Date of Birth:___/___/___

Insured's Employer: _____

Secondary Dental Insurance

Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: _____

Insured's SS#: _____

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

Insured's Name: _____

Relation: _____ Date of Birth:___/___/___

Insured's Employer: _____

3 CHILD'S FAMILY INFORMATION

Who is accompanying this child today?

_____ _____
FULL NAME (IF OTHER THAN PARENT) RELATION TO CHILD

Do you have Legal Custody of this child? ❑ Yes ❑ No

How many Brothers/Sisters? _____ Age(s): _____ _____ _____

Mother's Name: _____
❑ STEP MOTHER ❑ GUARDIAN

_____
(❑ **CHECK IF SAME AS CHILD'S)** HOME ADDRESS CITY STATE ZIP

(_____) - _____ (_____) - _____ ____
HOME PHONE # WORK PHONE # EXT.

_____ _____
MOTHER'S SOCIAL SECURITY # MOTHER'S DRIVERS LIC. #

Employer: _____ How Long? _____

_____
EMPLOYER'S ADDRESS CITY STATE ZIP

Father's Name: _____
❑ STEP FATHER ❑ GUARDIAN

_____
(❑ **CHECK IF SAME AS CHILD'S)** HOME ADDRESS CITY STATE ZIP

(_____) - _____ (_____) - _____ ____
HOME PHONE # WORK PHONE # EXT.

_____ _____
FATHER'S SOCIAL SECURITY # FATHER'S DRIVERS LIC. #

Employer: _____ How Long? _____

_____
EMPLOYER'S ADDRESS CITY STATE ZIP

4 ACCOUNT INFO

Person ultimately responsible for account

Name: _____

Relation to Child: _____

Billing Address: _____

_____
CITY STATE ZIP

SS #: _____

Driver's License #: _____

Work Phone #: _____

Payment Method: ❑ Cash ❑ Check

❑ Credit Card - Enter card # below (if accepted)

_____ ____/____/____
CREDIT CARD NUMBER EXPIRATION DATE

Initials I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

5 CHILD'S DENTAL INFORMATION

Reason for today's visit: ❑ Exam ❑ Emergency ❑ Consultation

Is Child in pain? ❑ No ❑ Yes ❑ How long?_____

Please indicate ☑ any of the following problems:

❑ Discomfort, clicking or popping in jaw.	❑ Lost/Broken Fillings	❑ Stained teeth	❑ Teeth grinding
❑ Red, swollen or bleeding gums	❑ Broken/Chipped tooth	❑ Locking Jaw	❑ Bad breath
❑ Blisters/Sores in or around the mouth	❑ Sensitive tooth, teeth or gums	❑ Ringing in Ears	❑ Loose Tooth

❑ Other:_____

Does child require pre-medication? ❑ Yes ❑ No ❑ Don't know

Previous Dentist:_____ ( )_____
Name Phone Number

Last Dental exam: ____/____/____ Last Dental X-rays: ____/____/____

Times a day child brushes?_____ Times a week child flosses?_____

Is the child's water fluoridated? ❑ Yes ❑ No

How would you rate the child's smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

6 CHILD'S MEDICAL HISTORY

Is child taking any of the following medications? ❑ Pain killers (including aspirin) ❑ Ritalin ❑ Stimulants
❑ Blood thinners ❑ Tranquilizers ❑ Insulin ❑ Muscle relaxers ❑ Other(s)_____

Child's Physician: _____ (____) _____
DOCTOR'S NAME OR CLINIC NAME PHONE #

_____
ADDRESS CITY STATE ZIP

Does child have or have you had any of the following diseases or medical conditions?

❑ Heart Murmur	❑ Tonsillitis	❑ High/Low Blood Pressure
❑ Rheumatic Fever	❑ Respiratory Problems	❑ Hepatitis
❑ Artificial Heart Valves	❑ Asthma	❑ Artificial Bones/Joints/Implants
❑ Congenital Heart Defect	❑ Difficulty Breathing	❑ Organ Problems
❑ Scarlet Fever	❑ Leukemia	❑ HIV+/AIDS/ARC
❑ Surgeries/Operations	❑ Anemia	❑ Tuberculosis TB
❑ Cancer/Tumors	❑ Diabetes/Hypoglycemia	❑ Psychiatric Problems
❑ Chemotherapy	❑ Hemophilia	❑ Hyper Active/ADD
❑ Jaw Problems TMJ/TMD	❑ Abnormal Bleeding	❑ Fainting/Seizures/Epilepsy

Please list any other medical condition(s) child has or ever had:_____

_____

_____

Is child allergic to any of the following? ❑ Latex ❑ Penicillin / Amoxicillin ❑ Tetracycline ❑ Aspirin ❑ Food Allergies
❑ Dental Anesthetics (Novacaine) ❑ Others:_____

Please rate the child's general health from 1-10:_____ Does child wear contact lenses? ❑ Yes ❑ No

Has this child ever taken the drug Ritalin? ❑ No ❑ Yes/How long? _____ Child's Blood Type: _____

Does this child do any of the following? ❑ Thumb/Finger Sucking ❑ Tongue Thrusting/Sucking
❑ Heavy Snoring ❑ Mouth Breathing ❑ Lip Sucking/Biting

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for the legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and I understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature_____ Date____/____/____
❑ Adult Patient ❑ Parent or Guardian ❑ Spouse

UPDATE
(OFFICE USE)

_____ ____/____/____
Initials Date

_____

_____ ____/____/____
Initials Date

_____

_____ ____/____/____
Initials Date

Office Policy

Please read and sign at the bottom, acknowledging that you were informed of these policies. Thank you.

Financial Policy

Thank you for choosing **Dr. Michael Vanaria** to service your dental care needs. We provide high-quality dental care to our patients and are committed to your treatment being successful. Please understand that your financial obligation is considered a part of your treatment. In the interest of good dental care practice, it is desirable to establish a credit policy to avoid misunderstandings. To assist our patients, we offer the following methods for taking care of their account in our office.

→ Before or on your first visit we expect you to supply our office with your insurance information. If any changes should occur during the time you are a patient, it is your responsibility to inform our office with any changes. Our office will not be responsible for claims submitted to insurance companies by which you are no longer covered.

→ Patients are required to pay their deductible and co-payments at the time of each visit.

→ While we accept most insurance plans, and are happy to aid in submission of your claims, it is your responsibility to read your policy and be aware of services covered or not covered by your individual plan.

→ As a courtesy, we will gladly bill your insurance when you provide us with the information and any necessary forms. Often times we are able to contact your insurance provider prior to your appointment, and estimate your portion of the bill. We ask that you pay your portion of the bill at the time of service. Insurance policies are a contract between you, your employer, and the insurance carrier. Please be aware that some, and perhaps all of the services rendered may not be covered under your individual insurance policy. You are ultimately responsible for payment of your account.

→ If no payment is received on an account after two monthly statements our office will make every effort to contact the responsible party. If the party responsible cannot be reached, a third bill will be sent indicating that “This will be the final notice for payment”. If the party fails to contact our office after receiving such notice, the account will be sent to a collection agency.

→ As a patient without insurance, you are always responsible for any charges at the time of service.

Failed or Cancelled Appointments

We confirm all appointments the day before your scheduled time. Please be aware that a missed appointment hurts 3 people; you, the doctor, or hygienist, and the person who could have used the time. A cancellation charge will be made for broken appointments unless 24 hours notice is given to cancel or change same. The length of time reserved and the number of prior failed appointments determines your charge. We will not offer appointments to patients who fail multiple appointments without having given us proper notice.

Estimates and Fees

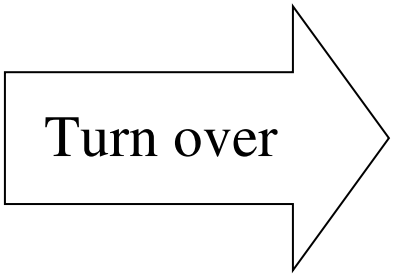
After x-rays and examination, you are entitled to and should ask for an estimate of fees to cover your treatment. All estimates are based upon conditions viewed at the time of diagnosis; unforeseen circumstances, such as pulpal therapy or cracked teeth could alter an estimated fee. It is customary to pay for dental services when they are rendered.

Delinquent Accounts

Delinquent accounts will have to be turned over to a Credit Reporting Collection Agency. The patient will be responsible for a 35% collection fee.

Notice of Privacy Practices (HIPAA)

A laminated copy of our office Notice of Privacy Practices (HIPAA) is available in our office. You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations. We encourage you to read it carefully and completely before signing this Consent.



Authorization for Signature on File

Release of Information/ Financial Responsibility/ Authorization for Payment

I (name of patient) _____ and/or (name of insured)_____

Hereby authorize **Dr. Michael Vanaria** to affix my name to any and all claims or documents as related to any and all dental benefits for me and my dependents. I herby authorize payment of dental benefits otherwise payable to me directly to the office above. I agree to be responsible for all charges for dental services and material not paid by my dental benefit plan. To the extent permitted under applicable law, I authorize release of any information relating to the claim. If dental insurance does not apply to me, I am financially responsible for charges at the time of service.

By signing below I am agreeing that I have read the office policy and Notice of Privacy Practice.

Signature of Patient (parent or guardian if minor): _____

Today's Date: _____

A photocopy of this document may act as an original.

Referrals Are Important To US

Whom may we thank for referring you to our office?

- ☐ Family/Friend _____
- ☐ Dental Insurance Website
- ☐ Internet/Google search
- ☐ Facebook
- ☐ Newspaper Mailing
- ☐ Other_____

Financial Consent

I voluntarily and knowingly request and consent to the services, treatments and/or procedures recommended by the dentist and to all diagnostic methods deemed appropriate by the dentist. I authorize the dentist to perform all such services, treatments and/or procedures and to utilize all such diagnostic methods. Further, I acknowledge and understand that the dentist may engage the assistance of others in performing such services, treatments and/or procedures and in utilizing such diagnostic methods. I understand that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the services, treatments, procedures and/or diagnostic methods that have been recommended.

I understand and acknowledge that I am fully and completely responsible for the payment of all costs associated with the services, treatments, procedures and/or diagnostic methods preformed and utilized by the dentist and others. I acknowledge that any insurance coverage that I may have is based on a contract between my insurance company and me, my spouse and/or my employer. The dentist is not a party to this contract and the services, treatments, procedures and/or diagnostic methods are provided to me. Therefore, I acknowledge that I am fully responsible for the payment of all sums owed to the dentist for the services, treatments, procedures and/or diagnostic methods provided to me. As a courtesy to me, the dental office will bill my insurance company and I acknowledge that I will remain liable for any and all amounts not paid by the insurance company for any reason (including but not limited to the insurance company declining coverage after initially approving it) or if the insurance company fails for any reason to reimburse the dentist within **30** days after being billed by the dentist. I acknowledge that it is my responsibility to provide the dentist with my current insurance and any changes thereto.

All returned checks will be subject to a **$50.00** returned check fee. Any account balances that remain unpaid for **121** days from the date of service may be referred to an attorney. In the event this occurs, I understand that I will be liable for collection costs (**35%**) that may be imposed from the attorney who acquires my account. Further, in the event any unpaid account balance is referred to an attorney for collection, I agree also to be responsible for all costs and reasonable attorney's fees incurred in connection therewith.

I consent to the dentist's use and disclosure of my health information to my insurance company and any agent thereof. I hereby assign to the dentist all of the insurance due to me for the services, treatments, procedures and/or diagnostic methods provided to me and I authorize my insurance company to make payment directly to the dentist for the costs associated therewith.

I further consent to be contacted by the dentist, any agent of the dental office, or any collection agency (or agent thereof) or attorney to whom an unpaid balance has been assigned or referred by mail at any address that I provide to the dental office an/or by facsimile, email or phone number (whether a cell phone or landline) at any facsimile number, email address or phone number (whether cell phone or landline) that I provide to the dental office or any agent of the dental office.

Patient Signature: _____ Date:_____

Print Name: _____

Parent/Guardian Signature, if minor: _____ Date: _____

Print Name: _____

Vanaria Dental