WELCOME

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with your child.

PATIENT INFORMATION

Child's Name ______________________________ Soc. Sec. # ____________
Last Name *First Name* *Initial*

Address ____

City ______________ State ______ Zip ________ Phone ____________

Sex ❑ M ❑ F Age ______ Birthdate ____________ School ____________

Grade ____________ Hobbies/Sports ______________________________

Whom may we thank for referring you? ______________________________

Notify in case of emergency ____________ Home Phone ____________ Work Phone ____________

PRIMARY INSURANCE

Person Responsible for Account ______________________________
Last Name *First Name* *Initial*

Relation to Child ____________ Birthdate ________ Soc. Sec. # ____________

Address *(if different from child)* ____________________ Home Phone ____________

City ______________ State ______ Zip ____________

Person Responsible Employed by ____________________ Occupation ____________

Business Address ____________________ Business Phone ____________

Insurance Company ____________________ Phone ____________

Contract # ____________ Group # ____________ Subscriber # ____________

Name of other dependents under this plan ______________________________

ADDITIONAL INSURANCE

Is child covered by additional insurance? ❑ Yes ❑ No

Subscriber Name ____________ Relation to child ____________ Birthdate ____________

Address *(if different from child)* ____________________ Soc. Sec. # ____________

City ______________ State ______ Zip ________ Phone ____________

Subscriber Employed by ____________________ Business Phone ____________

Insurance Company ____________________ Phone ____________

Contract # ____________ Group # ____________ Subscriber # ____________

Name of other dependents under this plan ______________________________

Please complete both sides.

Dental History

What would you like us to do for your child today? ______________________________

____

Former Dentist ______________ Address ______________ Phone ______________

Date of last dental care ______________ Date of last x-rays ______________

How often does your child brush? ______________ Floss? ______________

Does your child experience pain or discomfort in the jaw joint? ❑ Y ❑ N

Has your child ever experienced a mouth or chin injury? ❑ Y ❑ N

Does your child have speech problems? ______________________________

Have your child ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ❑ Y ❑ N

Other information about your child's dental health or previous treatment ______________________________

____

Medical History

Child's Physician ______________________________ Phone ______________

Date of last visit ______________ Has your child had any serious illnesses or operations? ❑ Y ❑ N

If yes, describe ______________________________

Is your child currently under physician care? ❑ Y ❑ N If yes, describe ______________

Has your child ever had a blood transfusion? ❑ Y ❑ N If yes, give approximate dates ______________

Has your child ever used a bisphosphonate medication? Brand names include Fosamax, Actonel, Atelvia, Didronel and Boniva. ❑ Y ❑ N

Check (✓) if your child has had any of the following:

- ❑ AIDS/HIV Positive
- ❑ Anemia
- ❑ Asthma
- ❑ Atopic (allergy prone)
- ❑ Blood disease
- ❑ Cancer
- ❑ Chicken Pox
- ❑ Convulsions/Epilepsy
- ❑ Cough, persistent
- ❑ Cough up blood
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Fainting
- ❑ Food allergies
- ❑ Headaches
- ❑ Hearing Impairment
- ❑ Heart problems Describe ______________
- ❑ Hemophilia/ Abnormal bleeding
- ❑ Immunizations current
- ❑ Kidney disease or malfunction
- ❑ Liver disease
- ❑ Material allergies (**latex**, wool, metal, chemicals)
- ❑ Respiratory disease
- ❑ Rheumatic/Scarlet fever
- ❑ Shortness of breath
- ❑ Sinus problems
- ❑ Skin rash
- ❑ Spina Bifida
- ❑ Thyroid disease or malfunction
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Other ______________

List medications your child is taking, if any:

____

____

List drug allergies, if any:

____

____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature ______________________________ Date ______________

Payment is due in full at time of treatment, unless prior arrangements have been approved.

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#80-783

University Dental Associates
435 Pine St
Rochester, MI 48307
248-652-9116

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ____, have received a copy of University Dental Associates Notice of Privacy Practices.

____
Please Print Name (patient name or name of parent or guardian)

____ Date ____________________
Signature (patient name or name of parent or guardian)

I ALLOW/DO NOT ALLOW University Dental Associates to share my Health History and Medical Information with the following family members:

Please check one:

☐ Allow ☐ low **Name** ______________________________ **Relationship** ______________

☐ Allow I ☐ ow **Name** ______________________________ **Relationship** ______________

______________________________________ ______________________________
Signature (patient name or name of parent or guardian) Date

University Dental Associates., P.C.

FINANCIAL POLICY/CONTACT INFORMATION UPDATE FORM

Our doctors and staff are proud to be a team whose primary mission is to deliver the finest and most comprehensive dental services available today. We are concerned about your dental care and want to ensure you that it is performed in the most responsible manner. In order to assist you with the investment in your dental health, the following is our financial policy.

Payment is due in full at the time of service. If you have insurance, all ESTIMATED copays, deductibles, and non-covered services are due at the time of service. For your convenience we accept cash, check, Visa, MasterCard, Discover, American Express, and Care Credit. **A $35.00 fee will be assessed on all returned checks.**

Regarding Insurance

Patients **MUST** provide the office with accurate insurance billing information **AT THE TIME** of their appointment. The balance is your responsibility whether your insurance company pays or not. Your insurance policy is a contract between you and your insurance company. The coverage a patient will receive depends upon the quality of the plan purchased by his/her employer, not the fees of the Doctor. It is your responsibility to know your individual coverage. Failure to comply with this suggestion could result in you, the patient, being responsible for all costs incurred during your office visit. Due to constantly changing insurance regulations, benefits, and deductibles, we are only able to **ESTIMATE** your insurance balance. We will be happy to file a pre-authorization for any services upon request. If your insurance company has not paid your account in full within 60 days, the balance may automatically be transferred to your account. Further insurance appeal becomes the patient's responsibility. Please be aware that some services (if not all services) may be non-covered services and not considered reasonable and necessary under your particular dental plan. We will send no more than two billing statements to the address you provide. If we do not receive payment by the second billing cycle, your account will be transferred to a collection agency. **A monthly interest rate of 1.8% will be applied to your account on any unpaid balances.**

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients. Please be aware that some services (if not all services) may be non-covered services and not considered reasonable and customary or necessary under your particular dental plan. Our fees are the Usual and Customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of Usual and Customary rates.

Minor Patients

The adult accompanying a minor, the parent (guardian) is responsible for full payment at the time of service. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-arranged.

MISSED APPOINTMENTS

We ask that a 48 hour notice be given for cancellation of appointments. A $30.00 broken appointment fee will be charged for all appointments cancelled with less than 48 hour notice or if the patient does not arrive at their appointed time.

CONTACT INFORMATION/INSURANCE UPDATE

Current Address:____

Current Phone:___________________________ **Current Email**:___________________________________

Insurance Changes (Please provide Subscriber name, Insurance name, phone number, ID Number and Group number):

____

____

Thank you for taking the time to update your information and read our financial policy.

By signing below, I agree to the above financial office policy.

Signed:_______________________________ Date:_________________