WE MAKE YOU SMILE

We are pleased to welcome you and your child to our practice. Please fill out this form as completely as possible. We look forward to working with your child.

Dr. Jeff Leal, Dr. Vic Spangler & Dr. Ben Johnson

Child's Information:

Child's name:_____ Preferred name:_____
First Middle Last

Child's address:_____ City:_____ State:_____ Zip:_____

Phone:_____ Email:_____

Gender: M/F Age:_____ Date of birth:_____

School:_____ Grade:_____ Hobbies/sports:_____

Mother's name:_____ Father's name:_____

With whom does the child live? _____both parents _____mother _____father _____other

Family members seen at our office: _____

Whom may we thank for referring you? _____

Account Information:

Person responsible for account:_____ Relation to child:_____

Employer:_____ Occupation:_____

Business Address:_____ Business Phone:_____

Date of birth:_____ Social Security #:_____ Email:_____

Address (if different from child):_____ City:_____

State:_____ Zip:_____ Phone:_____ Cell:_____

Insurance Information:

Is the child covered by dental insurance? Y/N

Subscriber employed by:_____ Insurance company:_____

Subscriber's name:_____ Date of birth:_____ ID#:_____

Address (if different from child):_____

Group #:_____ Relationship of subscriber to child:_____

Is the child covered by additional dental insurance? Y/N

Subscriber employed by:_____ Insurance company:_____

Subscriber's name:_____ Date of birth:_____ ID#:_____

Group #:_____ Relationship of subscriber to child:_____

Thank you for trusting us as your dental healthcare provider, and we appreciate the opportunity to serve you. Please carefully read the following guidelines for our office.

Appointments:

Once an appointment is made, this time has been reserved especially for you. We expect at least 48 hours notice prior to rescheduling/cancelling an appointment so that we may accommodate other patients awaiting treatment. After 2 missed appointments we may ask you to find another dental office that better suits your schedule. We make every effort to be on time for your appointment, and we hope that you will be patient with any delays that may occur when dental emergencies arise.

Compensation:

Patients are responsible for payment, however, we are pleased to assist you in preparing and submitting your insurance claims. Please provide a current insurance card at each visit. Our office is not in any insurance network. Some insurance companies may send the payment to the insured. If this is true with your insurance company, you will be asked to pay in full. We will file the claim for you, as a service to you.

On average, insurance policies cover approximately 50-80% of fees. At the time of service, we require that you pay the estimated portion the insurance policy does not cover along with any deductibles. We can assist in the preparation of forms, but cannot take responsibility for researching the exact coverage on your course of treatment. We are happy to send a pre-determination upon request, and urge you to contact your insurance carrier to determine benefits and extent of coverage.

Patients may pay with cash, check, MasterCard, Visa, American Express, or Discover Card on the day of treatment for any services rendered. CareCredit is also accepted and can be applied for at our office.

I authorize the insurance company to pay the dentist or dental group 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.

I have read and understand your office guidelines and agree to my part which applies.

_____	_____
Patient Signature	Date
_____	_____
Parent/Guardian Signature	Date

Authorization for Release of Information

Name of Patient:_____ Date of Birth:_____

The Practice of Drs. Leal, Spangler, & Johnson is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Person/Entity to Receive Information. Please circle each person/entity that you approve to receive information.	**Description of information to be released.** Please circle the information that can be given to person/entity on the left.
Voice Mail	All records Financial information
Spouse (provide name & phone number) _____	Financial Medical as follows:_____ All Records
Parent (provide name & phone number) _____	Financial Medical as follows:_____ All Records
Other (provide name & phone number) _____	Financial Medical as follows:_____ All Records

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

Signature of Patient/Personal Representative_____
Date_____

Description of Personal Representative's Authority (attach necessary documentation)
_____

Child's Emergency Contact Information:

Child's name:_____ Date of birth:_____
First Middle Last

Emergency contact:_____ Relationship to child:_____

Emergency contact employed by:_____ Position:_____

Emergency contact phone #:_____

Child's Medical History:

Child's physician:_____ Date of last visit:_____

Has your child had any serious illnesses or operations? Y/N

If yes, please describe:_____

Is your child currently under a physician's care? Y/N

If yes, please describe:_____

Please circle if your child has had or has any of the following:

AIDS/HIV positive
Anemia
Asthma
Blood disease
Cancer
Chemotherapy
Chicken pox
Diabetes
Epilepsy
Fainting
Heart murmur
Heart problems
(describe: _____)
Hemophilia/Abnormal bleeding
Jaw pain
Kidney disease or malfunction
Liver disease
Material allergies (latex, nickel)
Mitral valve prolapse
Psychiatric care
Radiation treatment
Respiratory disease
Rheumatic/Scarlet Fever
Thyroid disease
Tuberculosis
Other: _____
_____

Does your child have allergies to any medicines? Y/N

If yes, please list:_____

Please list any medications your child is currently taking:_____

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 dental treatment. If there is any change in my child's medical status, I will inform the dentist.

Parent/Guardian Signature:_____ Date:_____