DISCOVERY DENTAL
"Discover your smile"

CHILD INFORMATION

Today's Date: _____

First Name: _____ Middle Name: _____ Last Name: _____

Name that your child prefers to be called: _____

Sex: □M □F Date of Birth: _____ Social Security Number: _____

Address: _____ City _____State _____ Zip _____

PARENT'S INFORMATION

Mother's Name: _____

Phone number: (h) _____ (c)_____ (w) _____

Address: _____ City _____State _____ Zip _____

Email address: _____

Preferred method of communication: □Phone call □Text message □Email

Mother's Occupation: _____ Mother's Employer: _____

Father's Name: _____

Phone number: (h) _____ (c)_____ (w) _____

Address: _____ City _____State _____ Zip _____

Email address: _____

Preferred method of communication: □Phone call □Text message □Email Father's Occupation:

_____ Father's Employer: _____

What is the reason for seeing us today? _____

Did the child sustain an injury at school? □ Yes □ No

Are the injuries accident related? □ Yes □ No

If yes, please explain: _____

Who may we thank for referring you? _____

What can we do to ensure your experience with us is a pleasant one? _____

What was the reason you stopped seeing your previous dentist? _____

DOCTOR HISTORY

Primary Care or Referring Physician (Name & Phone): _____

Previous Dentist (Name & Phone): _____

EMERGENCY CONTACTS

Emergency Contact (Name & Phone): _____

Emergency Contact (Name & Phone): _____

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INSURANCE INFORMATION

Child's Name: _____ DOB: _____

Primary Dental Insurance:

Insurance Company Address: _____City_____ State_____ Zip_____

Subscriber Name: _____ Subscriber Employer: _____

Subscriber Social Security #:_____ Subscriber Date of Birth: _____

Group / Policy Number: _____ Is this policy:

Secondary Dental Insurance

Insurance Company Name: _____ Phone #_____

Insurance Company Address: _____City_____ State_____ Zip_____

Subscriber Name: _____ Subscriber Employer: _____

Subscriber Social Security #:_____ Subscriber Date of Birth: _____

Group / Policy Number: _____ Is this policy:

Primary Medical Insurance

Insurance Company Name: _____ Phone #_____

Subscriber Name: _____ Subscriber Employer: _____

Subscriber Social Security #:_____ Subscriber Date of Birth: _____

Group / Policy Number: _____

Do you have secondary medical insurance? _____

I hereby authorize payment of the dental insurance benefits directly to Discovery Dental. I understand that as the parent I am financially responsible for all the charges whether or not paid by the insurance carrier. I authorize Discovery Dental to release all information required by the insurance company. I understand that It is my responsibility to pay any deductibles, co-payments, and any other fess not paid by the insurance carrier. I understand payment is expected at the time of service.

Today's Date: _____

Parent's Name: _____ Parent's Signature: _____

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MEDICAL HISTORY

Child's Name: _____ Today's Date: _____
Child's Age: _____ Date of birth: _____ Sex: ¨M ¨F Date of last physical exam_____ Weight _____ Height_____

Please check if your child has ever had any of the following:

¨ ADHD
¨ Allergies (seasonal)
¨ Allergies to Latex
¨ Allergy to Local Anesthetic
¨ Allergies to Medications
¨ Autism
¨ Anemia
¨ Arthritis
¨ Artificial Heart Valve
¨ Asthma
¨ Bleeding problems
¨ Blood Disorder
¨ Bruise Easily
¨ Cancer or Tumors
¨ Congenital Disorder
¨ Congenital Heart Disease
¨ Depression
¨ Diabetes

Is your child allergic to any medications?

¨ Dizziness
¨ Earaches
¨ Eating disorder
¨ Fainting/Dizzy Spells ¨ Genetic Disorder
¨ Heart Murmur
¨ Hepatitis
¨ HIV/AIDS
¨ Immune System Disorder ¨ Jaundice
¨ Kidney Disease or Dialysis ¨ Liver Disease
¨ Mental or Physical Delays ¨ Mitral Valve Prolapse
¨ Mononucleosis
¨ Nervous Disorders
¨ Neurological Disorder ¨ Other Heart Conditions
¨ Panic Attacks
¨ Psychiatric Disorder
¨ Radiation Therapy
¨ Respiratory Problems
¨ Rheumatic Fever
¨ Ringing in Ears (Tinnitus) ¨ Severe Headaches
¨ Sinus Problems
¨ Sleep Apnea
¨ STD
¨ Stomach / Intestinal Problems ¨ Thyroid Disorder
¨ Tuberculosis
¨ Ulcers
¨ Other
_____

¨ Aspirin ¨ Codeine ¨ Erythromycin ¨ Tetracycline ¨ Penicillin ¨ Sulfa ¨ Local Anesthetic ¨ Other allergies to medications (please list): _____ If you checked any of the above or have other medical conditions, please explain: _____

_____

_____

Has your child had any hospitalizations or surgeries: _____

Are your child's immunizations up to date? ¨YES ¨NO

_____

Do your child need to be pre-medicated with antibiotics for dental treatment? ¨Yes ¨No

Please list ALL medications that your child is currently taking: ¨ NONE

_____

_____

_____

I certify that the above is true to the best of my knowledge. I understand that if there are any changes to my health or medications, I will advise my dentist before beginning any treatment.

Child's Name: _____ Today's Date: _____

Parent's Name: _____ Parent's Signature: _____

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DENTAL HISTORY

Child's Name: _____ Today's Date: _____

Date of last dental exam and cleaning: _____ Previous or referring dentist: _____

How often does your child brush? _____ How often does your child floss? _____

Do you have any concerns about your child's dental health? _____

_____

Has your child complained about dental problems? _____

Any unhappy dental experiences? _____

Any injuries to the mouth or teeth? ¨Yes ¨No _____

Does your child sleep with a bottle? ¨Yes ¨No What age was it stopped? _____

Does your child have any of the following habits?

¨ Thumb Sucking ¨ Tongue Thrusting ¨ Nail Biting ¨ Chewing Hard Objects Does your child grind his/ her teeth at night? ¨Yes ¨No _____ Is fluoride taken in any form (other than toothpaste)? ¨Yes ¨No _____ Does your child wear a mouth guard for sports? ¨Yes ¨No

Is there anything else that we should know about your child? _____

_____

If your child is currently bottle-feeding, what is fed from the bottle?

¨Water ¨Juice ¨Milk ¨ Formula ¨Other _____

Juice / Milk / Soda Intake: ¨High ¨ Moderate ¨ Low

Does your child still have his / her tonsils and adenoids? If not, when were they removed? _____

Does your child have any of the following?

¨ Bad Breath ¨ Bed Wetting ¨ Braces ¨ Crowding of Teeth ¨ Dark Circles Under Eyes ¨ Hyperactivity ¨ Loose Teeth ¨ Snoring ¨ Teeth Removed ¨ Wear of Teeth ¨ Other: _____ Parent/Guardian Name: _____ Date: _____

Parent/Guardian Signature: _____

DISCOVERY DENTAL
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DISCOVERY DENTAL INSURANCE AND OFFICE POLICY

We, the staff of Discovery Dental, thank you for choosing us as your dental/health provider. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with the highest level of care and to building a successful provider-patient relationship with you and your family.

We believe your understanding of our patients' financial responsibility is vital to that provider-patient relationship and our goal is to not only inform you of the provisional aspects of that financial policy but also to keep the lines of communication

open regarding them. If at any time you have any questions or concerns regarding our fees, policies or responsibilities please feel free to contact our office manager at 702-395-1088.

We will gladly submit dental claims on your behalf. However, filing your dental claim is not a guarantee of payment for the service(s) performed. We can never guarantee coverage as quoted in our office estimates and insurance payments are not guaranteed until the claims are processed. Most dental insurance plans have exclusions and limitations, which will affect your out of pocket expense.

It is your ultimate responsibility to be familiar with your dental benefits. We encourage all patients with insurance to refer to their member handbooks or to call their plan administrators with any questions or concerns relating to specific benefits.

You will receive an explanation of benefits (EOB) from your insurance company a few weeks after the claim for services has been processed. If you have concerns about any items on your EOB, please call our office and we will glady answer any questions that you may have.

We believe this level of communication and cooperation will allow us to continue to provide quality service to all of our valued patients.

By initialing each box below you acknowledge and accept the terms of our insurance and financial policies.

_____ We are providers for most dental insurance plans and always abide by the terms of our contract with your insurance company. The fees quoted to you are set by YOUR insurance company. Your copayments, co-insurance, and/or deductibles are dictated by your plan. Any copayments, co-insurance, and/or deductibles

are due in full at the time of treatment. Understand that if payment from a dental insurance company is not received within 90 days of the date of service, the entire balance is due and payable by the patient, at which time the patient may dispute the claim and be reimbursed directly by their insurance company.

_____ Before treatment is started, the patient will receive a treatment plan, detailing any copayments, co-insurance, and/or deductibles that they will be responsible for. The treatment plan is only an ESTIMATE, and can change based on the doctor's findings during treatment. Understand that this treatment plan is only an estimate of coverage and NOT a guarantee of payment. **Any charges not paid by an insurance becomes patient responsibility.** Be advised, even a preauthorization of services does not guarantee payment from an insurance carrier and insurance companies often deny services based on initially undisclosed guidelines.

_____ **Payment for services will always be due at the time of service unless a payment arrangement has been approved in advance by the Discovery Dental staff.** For any unpaid balances by insurances, the patient will need to contact our office within 30 days to make full payment or set up a payment arrangement. Interest will incur if a balance remains unpaid after 60 days.

_____ Please remember that insurance policies are a contract between the patient and their insurance carrier. We will, as a courtesy, bill your insurance and help the patient receive the maximum allowable benefit under their policy. We have found that patients who are involved with their claims process are more successful at receiving prompt and accurate payment services from their insurance carrier. We do expect patients to be interactive and responsible for communicating with their insurance carrier on any open claims.

_____ We make payment as convenient as possible by accepting (cash, money order, all major credit cards, and personal checks). Additionally, you may authorize us to keep your credit card on file for your convenience knowing that we adhere to the highest level of information security.

_____ We require photo identification for all patients. It is the patient's responsibility to know if our office is participating or non-participating with their insurance plan. Failure to provide all required information may necessitate patient payment for all charges. When insurance is involved, we are contractually obligated to collect copayments, co-insurance and deductibles, as outlined by your insurance carrier.

_____ **We require notice of cancellations 48 hours in advance.** This allows us to offer the appointment to another patient. If you fail to keep your appointments without notifying us in advance: a missed appointment fee will apply. These fees are typically $35.00 but not to exceed one-half of the cost of your scheduled appointment. Repeated missed appointments without notification may cause you to be placed on a "same day appointment list" or discharged from the practice so that we can provide care to other patients.

_____ For Saturday appointments, we require a $100 non-refundable deposit upon scheduling. In addition, 50% of the copays are due at the time of scheduling and no later than two weeks prior to the appointment. Cancellations and rescheduling must be done no less than 48 hours prior to the appointment or the $100 deposit will be retained.

_____ Certain procedures, including elective upgrades, are not covered by your insurance plan, or may have a frequency limitation. In these cases, you will be fully responsible for full payment for said services at the time of treatment.

_____ When possible, we will assist you in filing the claim with your medical insurance and initiate correspondence with the purpose of getting you the maximum coverage your insurance will allow. **We are NOT contracted providers with medical insurance companies, therefore we are NOT able to give an estimate of the cost of your treatment.** When we bill dental services to your medical insurance, payment will be due in full, and your medical insurance will reimburse you directly.

_____ I understand that any dishonored checks will be assessed a statutory handling and collection fee of $50 plus any bank related charges. I also understand that I will bear the entire cost of collection, court costs and attorney fees on my account should this be required to collect outstanding balances at the sole discretion of this dental office.

_____ I acknowledge that I have read, understand and agree to the terms of the Discovery Dental Insurance and Financial Arrangement Policies. I acknowledge that I will be informed of the treatment plan and estimated fees. I agree that I am financially responsible for all co-insurance, deductibles and non-covered services, and any residual balances from claims processed by my insurance carrier. I understand that I will bear the entire cost of collection, court costs and attorney fees on my account should this be required to collect outstanding balances at the sole discretion of E. Mersha, DMD., PC.

CONSENT TO TREATMENT

Helping you maintain optimum oral health is our biggest priority. The benefits of a happy, healthy smile are immeasurable, and it is our goal to work with you to reach and maintain maximum oral and overall health. In order to provide you with the best care available, there are some guidelines that have been established. Please read the information below, and we would be happy to discuss any of the policies with you.

TREATMENT PLANS

_____ We will present patients with a **TREATMENT PLAN ESTIMATE** so that they can understand the estimated costs of recommended treatment prior to its start. **The TREATMENT PLAN ESTIMATE is a good faith attempt to predict the cost of your treatment based on the facts known to Discovery Dental when the estimate is furnished.** As treatment progresses, the dentist may determine in consultation that a different approach or additional treatment may be necessary. When this occurs, be advised that patient financial responsibility may change.

_____ Understand that diagnosed dental condition(s) will be discussed with the dentist and that several treatment options may be presented. The patient will receive a copy of their treatment plan. _____ Dental treatment can be unpredictable. Acknowledge that the course of treatment is not guaranteed especially as provided by an initial TREATMENT PLAN ESTIMATE. Understand that the patient will be responsible for any additional fees that may be incurred during the course of treatment.

CONSENT FOR TREATMENT

_____ The most common change in treatment plan is needing root canal therapy (RCT) following routine restorative procedures. Patient understands that at any point, following any restorative procedure (fillings, crowns, inlays, onlays, veneers), root canal therapy may be necessary; we are not always able to determine the need for RCT prior to, or at the time of treatment, and this need may occur at any point following the restorative treatment (possibly days, weeks, or months later).

_____I authorize and give consent to the doctor and the staff to administer treatment, including, but not limited to local anesthesia, analgesia, x-rays, photographs and any other treatment that in their judgment, may be necessary for dental health. I understand that the use of medications, anesthetics and some procedures may embody a certain amount of risk. This may include allergic reactions and/or other reactions/sensitivities. If I am female using oral contraceptives, I understand that antibiotics or other medications may interfere with the effectiveness of oral contraceptives. It is my responsibility to inform the doctor of any medical or dental conditions or concerns I may have.

_____I have disclosed my health history information, including allergies, reactions to medicine, diseases, and past procedures. I understand that withholding this information may affect the outcome of the procedure(s) or courses of treatment.

_____I authorize the provider and any other qualified assistants or medical professionals to perform the procedure(s) or treatment(s) listed in the "treatment plan". I also give my consent for these individuals to administer any needed medicine and to perform any compulsory life-saving procedures. I authorize any necessary life-saving procedures
to be performed in the event of an emergency during the procedure(s) or course(s) of treatment. _____I understand and agree that all photographs are the sole property of Discovery Dental. _____I hereby authorize all previously treating physicians to release my medical records to Discovery Dental.

_____I acknowledge that I have received a Notice of Privacy that was provided to me by Discovery Dental. I hereby authorize Discovery Dental to release any information necessary to process my dental insurance claims. I further authorize a release of information if necessary to refer my case to a specialist.

_____I understand that no guarantee or assurance has been given that the proposed treatment will be curative and / or successful to my complete satisfaction; I agree to cooperate completely with the recommendations of the doctor while I am under her/ his care, realizing that any lack of same could result in less than optimum results. I certify that I have had an opportunity to read and fully understand the terms and

words within the above, and consent to the operation and explanation referred to or made. I have been encouraged to ask questions, and have had them answered to my satisfaction. I hereby confirm that I understand this form and the information contained therein. I understand and speak English clearly.

Child Name: _____ Today's Date: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

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ASSIGNMENT OF BENEFITS

I understand that services rendered to me are my financial responsibility and that the provider will bill my insurance company, as a courtesy. I authorize my insurance company to pay my benefits directly to Discovery Dental and I understand that I will be fully responsible for any outstanding balance on my account. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

I have been given the opportunity to pay my estimated deductible, copayments, and co-insurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by my insurance company.

I authorize the provider to release any information necessary to adjudicate the claim and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim.

I also understand that should my insurance company send payment to me, I will forward the payment to Discovery Dental within 48 hours. I agree that if I fail to send the payment to the Provider and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies. In the event patient receives any check, draft or other payment subject to this agreement, I will immediately deliver said check, draft or payment to provider. Any violations of this agreement will, at provider's election, terminate patient charge privileges with provider and bring any balance owed by patient to provider immediately due and payable.

A photocopy of this Assignment shall be considered as effective and valid as the original. I authorize the provider to initiate a complaint or file appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials. I further authorize a release of all my patient information should such a complaint be necessitated.

Child Name: _____ Today's Date: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

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MEDICAL INFORMATION RELEASE FORM

I hereby authorize E. Mersha, DMD., PC. and its affiliates, its employees and agents to release my personal health information to _____.
Records may include:

-All medical and dental records, meaning every page in my record, including but not limited to: office notes, fact sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, social worker records, clinical records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, telephone messages, and records received by other medical providers. -All billing records including statements, insurance claim forms, itemized bills, and records of billing to third party payers and payment or denial of benefits.

I understand that any personal health information or other information released to the person or organization identified above may be subject to a re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

This authorization is valid from the date of my signature below and will remain in effect until terminated by me in writing.

I understand that I have a right to revoke this authorization by providing written notice to Discovery Dental. I also understand that I have a right to a copy of this authorization.

I further understand that this authorization is voluntary and that I may refuse to sign. Child Name:

_____ Today's Date: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Please list the full names of any individuals (family, friends, caretakers, etc.) that you would like to have access to your records. The persons listed below will also be able to call our office and discuss your treatment.

_____

_____

_____

_____